Sheffield Health and Wellbeing Board

Better Care Fund Submission: Part 1

September 2014

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EXECUTIVE SUMMARY

NHS Sheffield Clinical Commissioning Group (CCG) and Sheffield City Council (SCC) have agreed to work towards a single budget for health and social care. This agreement was developed through the Sheffield Executive Board (SEB) and the Health and Wellbeing Board (HWB) in 2013.

We believe that through integrated commissioning of health and social care we will:-

1. Ensure service users have a seamless, integrated experience of care, recognising that separate commissioning can be a block to providers establishing integrated services.
2. Achieve greater efficiency in the delivery of care by removing duplication in current services.
3. Be able to redesign the health and social care system, reducing reliance on hospital and long term care so that we can continue to provide the support people need within a reduced total budget for health and social care.

Our decision was informed specifically by engagement work led by our HWB and by local and national public opinion on integration, and by the learning from our provider-led Right First Time (RFT) programme, which has sought to integrate our response to urgent care needs. The Better Care Fund is, of course, a pooled budget between the CCG and SCC and we have established a sister programme to the RFT programme to deliver the BCF plans; this is the Programme for Integrated Commissioning ('the Programme'). The Better care Fund builds on wider local partnerships and our Foundation Trusts (FTs), in particular, have been involved in the work that has led to our plans. Our FTs are fully supportive of the ambition to reduce non-elective admissions. The RFT Programme is evolving to better reflect the commissioner-provider relationship and will ensure the supportive strategic relationships between us continue and deliver the changes we need to see. The Programme for Integrated Commissioning is a logical build and continuation of the of the work delivered by the RFT Programme
Our ambition is that we will, over the next few years, have a single budget for all health and social care in Sheffield, so that we make decisions about how we use our resource with a focus on what the people of Sheffield need, rather than on individual budgets. This will mean that we have a shared responsibility for the statutory responsibilities of both organisations.

Our planned pooled budget of £243m has been set so that it includes all our current expenditure on four areas of citizen's need, focussing on those at risk of admission and those for whom there is the greatest opportunity for health outcomes improvement:

- Keeping people well in their communities - incorporating GP care planning, focussed on preventing avoidable crises.

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- Independent living solutions - recognising the current joint commissioning arrangements for community equipment and the opportunities presented by the expiry of the current contract.
- Intermediate care - to improve the range and efficiency of out of hospital step up and step down services, to reduce admissions to hospital and support reablement, reducing admissions to long term care.
- Long term high support care - integrating our assessment, placement, quality management and contracting processes to ensure a shared focus on achieving the most effective care for people, and avoiding the unproductive cost shift between health and social care that has often characterised approaches to achieving savings as single organisations.

In addition, we have included the NHS expenditure on non-surgical emergency admissions so that the savings released from that budget can be used to fund investment in the above commissioning projects and to ensure shared commitment to reduction of emergency admissions.

The top two themes fall under our Independence project and the latter two falls within our Active Care project

As a result of this approach to integration, our response to the Care Act, to protecting social care, to establishing 7 day services and to data sharing, will be a collective one. We will respond to the financial and service challenges presented within the pooled budget. For instance, the increased costs of social care that will result from the Care Act will be a pressure on the pooled budget and, therefore, a shared responsibility. This is not easily demonstrated in response to the questions in this submission as we are not responding by allocating a set amount for these purposes from the Better Care Fund. This will be done through our single approach to financial planning for 2015/16.

We have established an Integrated Commissioning Programme Board to lead delivery of our integrated commissioning work, jointly chaired by our CEOs and jointly owned by an Executive Director from each organisation.

This programme, the Programme for Integrated Commissioning, will take forward the commissioning projects described above and will include development of decision making and risk sharing arrangements to establish effective shared responsibility and governance of the pooled budget as well as development of business cases for innovative integrated care. This will ensure that we make single, shared decisions on all aspects of care and expenditure within the remit of the pooled budget. For example, it will mean that we have a shared responsibility for ensuring that the requirements of the Care Act are met, and similarly, that we have a shared responsibility to achieve the reduction in emergency admissions that our plans require.

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We believe that we will make better decisions about how we use the reducing resource for health and social care together, rather than separately. Together we will be able to use our resources to best effect, pooling health and social care money where business cases support that change, to provide the best care and support to our population. Working together, we avoid the risk that we make separate decisions that have an adverse effect on the services the other commissions, recognising that only savings and improvements to the whole system are helpful.

We are clear about both the potential benefits and the risks involved in our plans. Final sign off of our plans and associated budgets will be by SCC's Cabinet and by the CCG's Governing Body. Specifically, our organisations will be assured by a) our section 75 agreement, setting out the proposed approach to single decision making and to risk sharing, b) our financial plan for the pooled budget, and c) the business cases that will be required for the changes proposed in this document.

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GLOSSARY

A	
ASCOF	Adult Social Care Outcomes Framework
B	
BCF	Better Care Fund
C	
CCG	Clinical Commissioning Group
D	
DTOC	Delayed Transfer Of Care
F	
FT	Foundation Trust
H	
HWB	Health and Wellbeing Board
J	
CET	Joint Commissioning Executive Team
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
P	
PSN	Public Services Network
PSTN	Public Sector Transformation Network
Programme	Programme for Integrated Commissioning: *The Programme that Sheffield established in August 2014 to deliver the Better Care Fund plans and joint commissioning. Led by Sheffield CCG and Sheffield City Council*
Q	
QIPP	Quality, Innovation, Productivity and Prevention
R	
RFT	Right First Time: *The Programme that Sheffield established in 2011 led by SHSCT, STHFT, SCT and Sheffield CCG and Sheffield City Council to deliver a range of system improvements*
S	
SCC	Sheffield City Council
SCTFT	Sheffield Children's NHS Foundation Trust
ScHARR	Sheffield's School of Health and Related Research
SEB	Sheffield Executive Board
SHSCT	Sheffield Health and Social NHS Foundation Care Trust
STHFT	Sheffield Teaching Hospitals NHS Foundation Trust
SWYBCSU	South and West Yorkshire and Bassetlaw Commissioning Support Unit
T	
TLAP	Think Local Act Personal

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With thanks to all the following people who contributed to the delivery of this document	
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Paul Schofield	Katrina Cleary
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1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Sheffield City Council**
Clinical Commissioning Group	**NHS Sheffield Clinical Commissioning Group**
Boundary Differences	**N/A**
Date agreed at Health and Wellbeing Board Authority delegated to Ian Atkinson and John Mothersole	**18/09/2014**
Date submitted	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£12,399,000**
2015/16	**£41,239,000 (including capital grants)**
Total agreed value of pooled budget: 2014/15	**£12,399,000**
2015/16	**£242,955,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Sheffield Clinical Commissioning Group
By	Ian Atkinson
Position	Accountable Officer of NHS Sheffield Clinical Commissioning Group
Date	**18/09/2014**

Signed on behalf of the Council	Sheffield City Council
By	John Mothersole
Position	Chief Executive of Sheffield City Council
Date	**18/09/2014**

Signed on behalf of the Health and Wellbeing Board	Sheffield Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Dr Tim Moorhead and Councillor Julie Dore
Date	**26/09/2014**

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c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Joint Strategic Needs Assessment	Joint Strategic Needs Assessment
Joint Health and Wellbeing Strategy	Joint Health and Wellbeing Strategy
Children and Families Act 2014	Children and Families Act
Care Act 2014	Care Act 2014
Sheffield Programme for Integrated Commissioning Programme Definition Document v2 September 2014	Available on request from Fiona.McCaul@sheffield.gov.uk
Right First Time Dashboard September 2014	See appendix 1
Market Position Statement	Market Position Statement
Sheffield: a City Where Every Carer Matters	Sheffield: a city where every carer matters
Lowedges, Batemoor and Jordanthorpe – Keeping People Well	Available on request from Fiona.McCaul@sheffield.gov.uk
Ham, C., et al, 2013, Making Integrated care happen at scale and pace, King's Fund, pp.3-7	Public domain
Sheffield City Council Public Health team literature review	Available on request from Fiona.McCaul@sheffield.gov.uk

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2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20.

The changes we expect to have delivered by 2019/ 20
By 2019/ 20 we will have delivered integrated health and social care commissioning:

- Health and Social Care will be jointly commissioned within the total resource available to us for that purpose. The effects will have reached the whole registered population of 580,000. People will find it simpler to get round the care system and experience fewer delays.
- We will be jointly commissioning and sharing staff, budgets, risk and information in areas where there is more benefit from working together than separately.
- Commissioning for outcomes, based on a customer journey and life-course for children, young people and adults, welcoming organisations that work in partnership to achieve the outcomes we want to achieve in Sheffield.
- Be building on, and further developing, people's self-care and health condition management skills, knowledge and abilities
- Have improved quality of life for those in active care
- Be providing more equitable, accessible universal services that people ca access earlier
- Be seeing services much more based in Sheffield's communities and closer to where people live, with staff working collaboratively to achieve the best outcomes for Sheffield people.
- Have reduced the number of admissions to hospital and to long term care, having increased our spending on preventative health and wellbeing measures and, therefore, reduced spend on high cost acute services.
- Have increased the number of people who are able to stay in their own homes, reducing admissions to long term care
- Have considerably developed our approach to co-production and building assets with Sheffield people and communities, a priority identified in our recent Joint Strategic Needs Assessment (JSNA).
- Have configured appropriately according to the requirements of the Children and Families Act and the Care Act.
- Have increased independence and resilience in our communities.
- Have reduced the number of health crises through care planning and effective and targeted preventative interventions.
- Have more equitable service provision in the city, contributing to reducing health inequalities

As a result:

- More people, including children, young people and adults, will be getting the right

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care, at the right time and in the right place.
- People and their communities will be supporting each other to a greater extent and we will have improved and maintained their safety, wellbeing and greater levels of independence.
- Organisations will work together to a greater extent to help people and their communities to build and strengthen the support they provide to each other.
- More expert support will be available to help people to take control of their own care so that it is genuinely person-centred and complements and builds on the assets they already have.
- Health and care services will be more focussed on a person's needs and organisational boundaries will not get in the way

Aligned to Strategy & Public Health Vision
This overall vision for integration sits within the wider ambitions of our Joint Health and Wellbeing Strategy (JHWS), which aims to create the circumstances that help people to be healthy and well, in addition to providing the right support when people become ill.

This programme of integration work has been commissioned by the HWB. The strategic direction for other schemes of work, such as the JSNA, JHWS and commissioning plans, is set by the HWB. All are aligned to one another.

Sheffield's HWB, recognised by the Health Service Journal in its 2013 awards as being one of an equal partnership between the CCG and SCC, has oversight of the work of both the CCG and SCC and the vision we set out here is a shared one.

Our vision is based on Sheffield's vision for Public Health, where our aims are both simple and ambitious:-
- To promote good health.
- To prevent and tackle ill-health.
- To enable all of us as citizens to make healthier lifestyle choices.
- To ensure that every contact that the Council has with the people of Sheffield acts to promote their health.
- To develop Public Health capacity and know-how across organisations and communities so as to make a real difference.

Comparison between now and 2019/ 20
Certain fundamental principles of quality care such as safety, a high quality experience, equity of access and evidence-based care will continue to shape our commissioning intentions, However certain principles and features will be increasing dramatically as part of the vision for integrated care. These are set out below.

Self-Directed Customer
1. A focus on self-service, self-directed assessment yet with the ability to provide

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facilitated support where required supported by multidisciplinary professional and para-professional teams
2. A focus on early intervention and diagnosis, prevention and care co-ordination
3. New access channels and supporting capabilities

Part of the evaluation of the models to be commissioned will be to highlight where additional capacity is needed to deliver so there is no delay in treatment over the lifespan of the care delivered – or there is opportunity to look at alternative treatments or settings where this will reduce demand for services e.g. where people are reaching crisis while on waiting lists (as highlighted in recent media) or where there are access issues

Informal Networks of Care

Whilst much of our work to improve and integrate health and social care will focus on the formal parts of the system we provide and, in particular, the journey through the health and social care system, we will be recognising, encouraging, and integrating this with the informal support people already receive in their families and communities. The care and support provided by the community and by organisations, including hospitals and housing associations will be seamlessly focussed on the needs and lives of individuals and their families, supported by a single budget.

Increased Independence

We will have supported individuals, families and communities to build and strengthen their own care and support networks and, when this help is not enough we will have providing greater levels of formal support to help people regain or maintain their safety, wellbeing and independence.

Wide Angle Care

Health and social care services will be based on this whole view of the child, young person or adult in the context of their social unit, and a whole view of health and social care system. As a result of this way of thinking, we will in our plans have formally organised care and support that extends beyond traditional health and social care organisations to housing providers, leisure providers, public realm managers and even bus companies and local businesses.

Multi-professional Collaboration

We will have made changes in professional practice, and introduced new flexible ways of multi-disciplinary team-working to support integrated person focussed pathways for people with multiple long term conditions, so that together they focus on the whole individual rather than on separate health conditions. There will also be a culture change for both people and practitioners to exploit people's own experience and skills so that these can supplement and strengthen the expertise of practitioners.

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Increased Community Resilience and Social Capital

We must prevent as many people as possible from having lesser wellbeing and independence in the first place. Therefore, we recognise that delivering our vision for integration will need to be supported by progress on other aspects of the JHWS, such as increasing social capital and community resilience.

Shadow Year 2014/ 15

2014/15 will be an important year for us as we prepare for integrated commissioning in 2015/16 and beyond. We have designated this a shadow year and have put in place shared working arrangements to develop business cases, develop financial plans for future years and, as importantly, to jointly monitor and manage performance, including expenditure, in 2014/15. We have set targets for progress for what we think is achievable in 2015/16 and by 2018/19. As a key component of our integration work, we will monitor the health of Sheffield people as part of the HWB's annual check on the progress of our JHWS.

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b) What difference will this make to patient and service user outcomes?

The difference to patient outcomes will be measurable. The table below shows the difference we expect in the initial years of the programme.
See also Part 2 Tab 6 HWB Supporting Metrics

Patient Experience Changes
From 2015/ 16 people of Sheffield will begin to notice the change.
People will experience fewer handoffs as they are passed between health and social care professionals. We have well developed ways of measuring the care experience and this is discussed further in 8).

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contributes to this?

The Better Care Fund will bring about the following concrete changes to the way care services are delivered. We believe these would not be delivered without the BCF. As we are pooling all our health and social care budgets at scale, the following does not refer to precise schemes as such, but instead some concrete changes we expect to see as a combined effect. By 2018/19 we will be

Making Investment / Funding Changes for the most vulnerable
We will increase funding over and above core GMS to residential and nursing homes building on our current Care Homes Locally Commissioned Service (1 GP: 1 home model) where the most vulnerable and medically complex housebound residents are based
Supported Self Care Scheme
By 2018 there will have been improvements in coordination of care in the community. We will have redeployed an existing investment of £8.2m within local communities in community support workers, health trainers, carer support and a variety of third sector /voluntary organisations in a more focussed way linked to our risk stratification.

Anticipating Care Needs in advance & GP –Led Care Planning
Our predictive risk model is deployed in all Sheffield practices, along with additional wrap-around information about each individual from primary care and secondary records. This information set will be augmented to include social factors in order to support more effective care decision-making by integrated care teams and targeting of services.
By 2018 18,000 people of Sheffield at risk of declining health will have wellness plans with joint goals We will have robust and personalised care plans and end of life care plans in place and for every resident at the locally commissioned care homes (family involvement
The current 2% of patients who have care plans under the national GP enhanced scheme for reducing Emergency Admissions will have risen. One key change that we will

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have made to help achieve this will be that GPs will be rewarded not simply for numbers of patients with care plans but for progress towards self-care and we will have carried out a comprehensive programme for practice staff and community nursing teams

New Multidisciplinary Care Planning Support teams

We will have established four support teams made up of people from primary care, community nursing, medicines management , IT, social care. These Care Planning Support teams will work with practices on all aspects of care planning

Patient Activation Model

By 2018 this model will be rolled out across the City. This model helps determine motivation and self-support.

Collaborative Multidisciplinary Team working

Across the city we will have established flexible multidisciplinary teams working round the person and their household or social unit. These teams will be organised to incorporate the voluntary sector and flex according to peoples need and life stage

Market Development / Local Consortia

Commissioning will be via local consortia of providers made up of GP practices, VCF organisations and the private sector

Partnership working

Frontline staff such as housing officers, shop workers, district nurses will routinely and systematically collect intelligence on people at risk

Local Army of Support

Referrals will be being made by the local army of unpaid carers and supporters in people's local networks; people such as hairdressers, neighbours will be able (with the persons permission) to refer them to care services and proactively tell us about signs of deteriorating health in those they care about and we will provide advice to them

Expansion & Enhancement of Community Support Worker Role

Connecting We will have more community support workers on the ground connecting people at risk of declining wellness to a greater range of community activities / support
Fixing Community support workers will be able to provide a wider range of one-off personalised 'care fixes' like arranging transport options and arranging handy persons (though closer working with housing repairs and through additional capacity)

Introduction of new Life Navigator Role

The live navigator role will provide more intensive support for those at high risk of delivering health and wellbeing but who do not access social care and have no friends of family to support them. Through the introduction of this role Sheffield will be providing

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greater support for this group of people at key times such as when they return home from hospital and support the aim to reduce length of stay in hospital, suffer a death of a loved one, or have an accident such as a fall

Earlier Diagnosis & Intervention

Access
More people at risk will access health checks and self-care advice

Reduced Reliance on Social Care packages and re-Investment in Promotion of Wellness
The number of social care packages will be reduced and resources saved and re-invested in expansion of support to promote independence and reduce demand and dependence on social care packages. Changes in GP practices will
Changes will have happened in general practice to support this.

3) CASE FOR CHANGE

Our case for establishing integrated commissioning arrangements for health and social care, which we anticipate covering the whole of our expenditure in time, is based on:-

- The national and local evidence that integrated services result in better service user experience, increase efficiency and improve outcomes and the clear public message that services should be integrated. We believe that integrated commissioning is essential to the development of integrated services.
- Our belief that we will make better decisions about how we use the reducing resource for health and social care together, rather than separately. Together commissioning jointly we will be able to use our resources to best effect, shifting money from health to social care where business cases support that change, to provide the best care and support to our population. Working together, we avoid the risk that we make separate decisions that have an adverse effect on the services the other commissions, recognising that only savings and improvements to the whole system are helpful.

Health Analytics
In Sheffield we use the Combined Predictive Risk model for risk stratifying our population, for which we have **100%** coverage of the GP registered population (n = 580,237 at 5th September 2014).

We believe no other City has done this. In combination with other local factors such as strong leadership, this puts Sheffield at a unique advantage with the potential to become

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a leading exponent of integrated care, leading the way.

Individual predictive risk scores are updated monthly using 69 predictive variables extracted from primary care and secondary care records. Primary care teams access their population predictive risk scores through a web based tool that additionally includes information for each individual on:-

- Key GP-recorded LTC diagnoses including mental health conditions.
- Biometric measurements including BMI, blood pressure and cholesterol.
- Lifestyle factors including smoking and alcohol assessments.
- Information about whether housebound, in residential care or having a carer.

The Sheffield risk stratified population

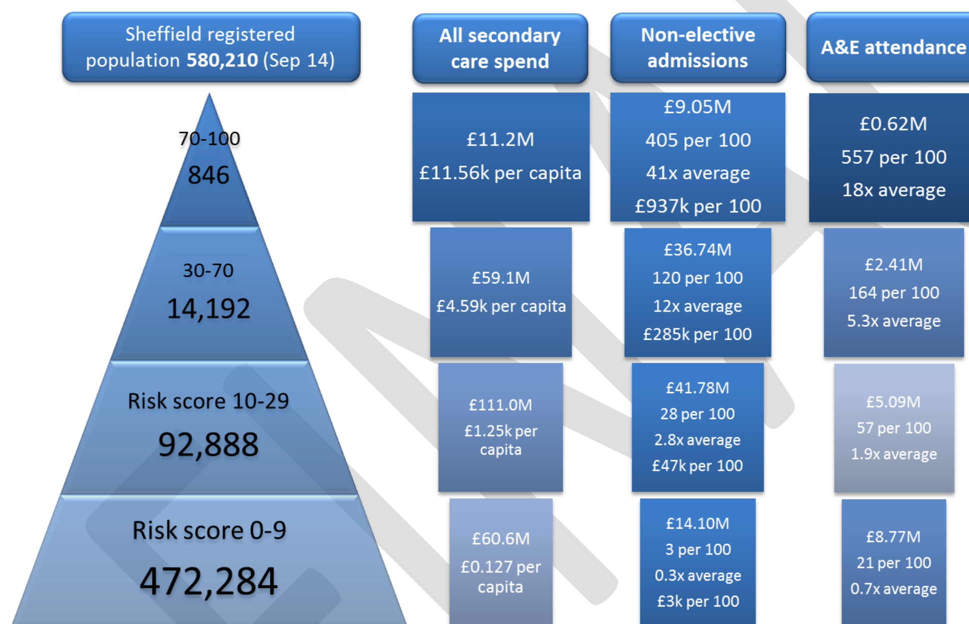

Diagram 1: Sheffield Risk Stratified Population

Health - Local Indicator

See Part 2 Tab 6 Local Metric

Our locally derived measure for the BCF is Ambulatory Care Sensitive (ACS) Emergency bed nights. It is a measure of preventable (= ambulatory care sensitive) hospital bed usage – a key indicator of the need for hospital emergency bed capacity. Prior to RFT starting in April 2012 the regression trend in monthly preventable bed usage was upward. Since April 2012 the preventable bed usage trend has consistently been downward. ●

This downward trend in bed-days since 2012/13 means that, although the number of admissions has increased over this period, those inpatient spells are using about 67 fewer emergency beds than was the case in April 2012.

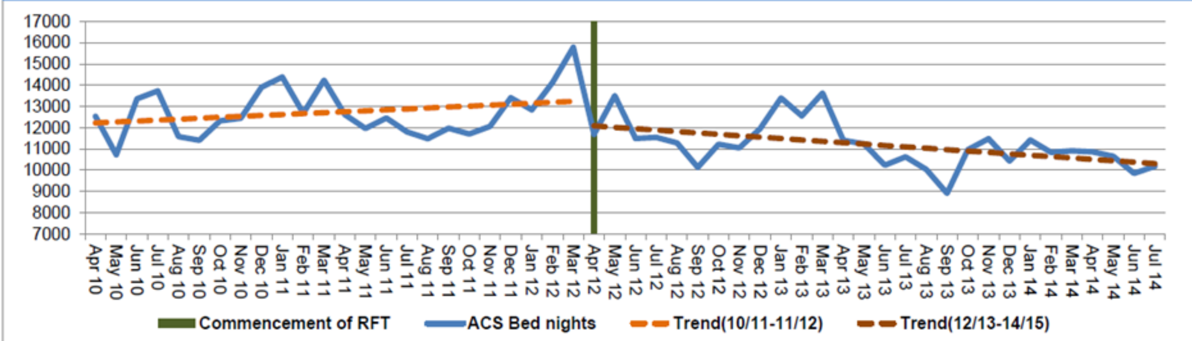

Diagram 2: Sheffield Local Metric Ambulatory Care Sensitive (ACS) Emergency bed nights

Social Care Demand

The CPM model does not extend to Social Care. However for social care also, we have taken an analytically driven view driven by tools such as our dashboard for RFT and the DH ASCOF self-assessment efficiency tool and other data.

The number of customers receiving LA commissioned care has in total remained fairly static over the past 5 years. However, there has been a significant increase in customers with a learning disability, an increase in those with mental health needs and a reduction in the number of older people and those with physical disabilities over that period. The requirements of the 2014 Care Act for people who are self-funding and new requirements in relation to carers are likely to increase the adult social care customer base in future.

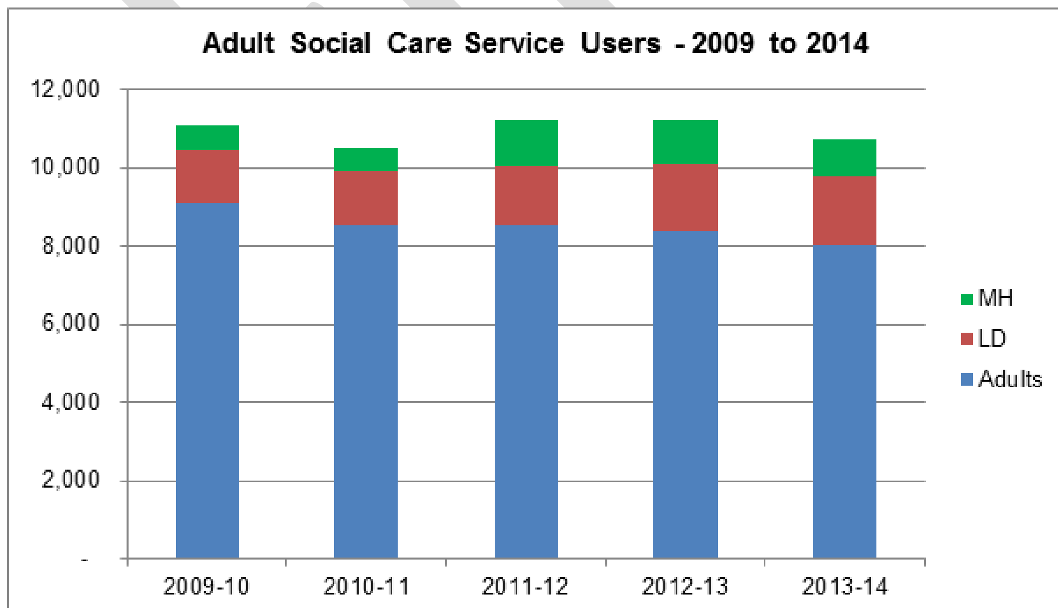

Diagram 3: Profile of Adult Social Care Users: Mental Health, Learning Disabilities, Adults*

*The data the chart above excludes customers only receiving short term prevention or reablement interventions as well as those requiring only equipment or minor adaptation services. It is also based on the number of customers getting any services over the yea

Service Users by Service Area

Year	Adults	LD	MH	Grand Total
2009-10	9,124	1,329	618	11,071
2010-11	8,506	1,399	612	10,517
2011-12	8,514	1,536	1,183	11,233
2012-13	8,409	1,687	1,144	11,240
2013-14	8,025	1,749	941	10,715

Table 1: Trends in numbers of Social Care Service Users: Mental Health, Learning Disabilities, Adults

The data shows that while the overall total of service users has remained static, there has been an overall increase of 32% in the number of people over 5 years in those receiving service in Learning Disabilities.
The significant increase in people's mental health needs through 2011/12 is partially attributable to existing customers of the Social Trust who were recorded on the Council's systems for the first time and became eligible for personal budgets.
The number of older people and those with physical disabilities has dropped over the period which partially masks that increase.
The requirements of the 2014 Care Act for people who are self-funding and new requirements in relation to carers are likely to increase the adult social care customer base. This is currently being quantified through the Care Act implementation project.
We will factor demographic changes in needs, and trends into our plans and business cases.

Adult social care current indicators
Evidence from our dashboard overview for September for adult social care shows :

- Continuing very high rates of delayed discharge from hospital ●
- Slight reduction in the percent being discharged from hospital offered reablement but significantly higher than the comparative figure for England ●
- Significantly fewer permanent admissions to residential care relative to last year, now in line with England, but not yet in line with the local plan ●
- Significantly fewer people discharged from hospital are still at home 91 days after reablement and much worse than England. This data is currently under review. ●
- Social care related quality of life measure is broadly in line with England but not improving ●
- Significantly increased service user/carer satisfaction with social care and better than England ●

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- Relative to planned expenditure there is increased expenditure on adult emergency admissions (but not children) ●
- Our gross expenditure on working-age adults with learning disabilities per head of working-age population is £188 (Vs £111 in 2005/6 and £136 in 2010/11. This is 14% higher than the median spending of our nearest statistical neighbours (£164)
- Our care provision per 1000 working age adults with learning disabilities is higher than our statistical neighbours
- Our gross expenditure on older adults per head of population is £1150. This is 1% higher than the median spending of our nearest statistical neighbours (£1137)
- Our local authority gross expenditure spending trend on older people is steadily declining form £1584 in 2005/06 to !1150 for 2012/13 (DH efficiency tool)

The change theory behind our case is whole system thinking at scale

What the BCF really provides is an important chance to create change and release benefits for Sheffield in a really inclusive way.

In this work we will take a design view at three levels:

- At the system level (strategy, governance, partnerships and allocation of resources);
- At the service level (commissioning, operations and service re-design);
- At the interface between service users or carers and their care providers. One challenge will be the management of the tension between STHFT and SCC as budgets are pooled and greater resources are put into preventative community settings

In Sheffield we are aiming towards a future operating model and care pathways for the City that offer a very wide range of people more referral and self-referral points and access to multi-disciplinary teams across health and social care.

We can only say this is a success if our plans include many different groups of people as well as a high number of people. The diagram below provides some key data that indicates clear potential for transformation. Note the number of admissions of people in key groups who have risk scores of 30 and over. Our plan has to be in line with socio-economic and demographic factors in Sheffield .This evidence provides a good starting point for the development of our plans.

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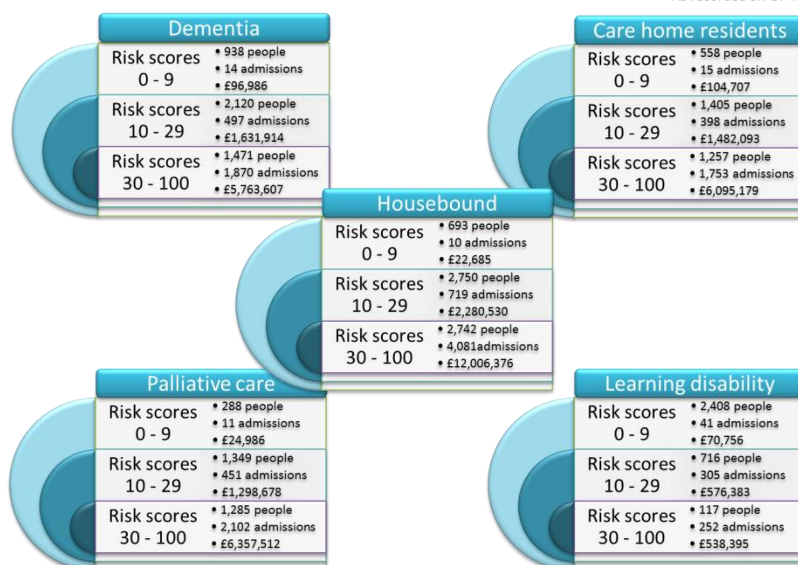

Diagram 4: A wide range of people with clearly identified risk scores can benefit from our BCF plans

We expect to be able to map and monitor the benefits and outcomes of our schemes for key populations and precisely indicate the benefits contribution that each will make to the 3.5% reduction in unplanned admissions as well as to the other indicators.

More about local timings of the Sheffield Business Case for Change

The detailed business cases for change for our specific projects are in development. In Sheffield we have a particular local need to take stock of important provider-led work currently in flight as part of the Right First Time programme. A critical success factor for us is to carefully assimilate workstreams of this programme that will benefit from integrated commissioning. Therefore currently we are now taking time to build a firm collaborative foundation between the two programmes and with the three foundation Trusts and as a result the development of our business case is extending beyond the submission deadline for this document, producing practical issues for us in the completion of the document at this date. We are currently preparing our business case for change for approval by our Programme Board later in the Autumn. This is a key milestone for the programme and marks the stage end. The following diagram convinces us of the potential that is in our hands to deliver high impact change for people and for the City

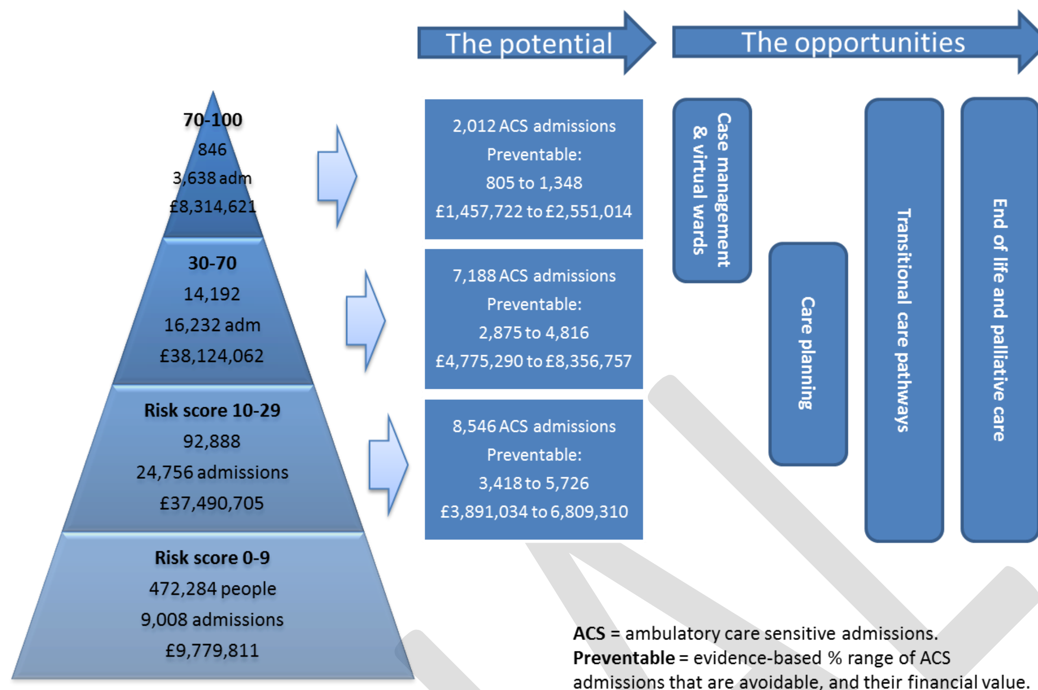

Diagram 5: The Potential for the Programme to deliver transformation

Until the delivery of our detailed business cases, the following narrative headlines the issues our case will address and its scope:

Issue 1: Improve Service Quality for Key Groups

We will do this by commissioning of integrated options that create benefits in the whole system and interdependently i.e. no cost-shunting; the scale of the BCF pooled budget offers an opportunity to manage the dependencies with the NHS provider objectives of care closer to home, early supported discharge and transformation of intermediate services while reducing the cost of hospital care and managing carefully the impact in the community care setting.

A Sheffield City integrated care pathway approach to prevent specific problems, maximise independence and promote successful ageing and simplify access for while minimising unnecessary constraints or delays. Sheffield has a figure above the national average of people who die in hospital, rather than in their usual place of residence, and we are seeking to reduce that together with reducing the number of admissions during the last year of life. perhaps by up to 10%. The issue that could be addressed would be improve quality of care and reduce unplanned admissions in last year of life and at end of life. We will use the BCF to support best healthcare i.e. care that follows consistent and proven processes where that is appropriate for the person but that can also modify or adapt to the individuals specific requirements - whether that is a combination of conditions or particular personal and social circumstances

Specifically: Palliative Care
We have an opportunity to consider making this part of our programme plans, In the north locality we want to improve co-ordination between domiciliary care commissioned by the local authority, district nursing, specialist palliative care, and the intensive home nursing service, starting at the point when a GP places someone on the palliative care register. Links with the CHC service are also critical. We are coming to the end of a 1 year pilot and we are developing a business plan to consider as part of our programme plans.
Specifically: Scheme 4 and Scheme 5 (intermediate care and active recovery) and Scheme 1 (keeping people well in their communities) will produce gains in particular for older, isolated people. The lower than the English average success rates in reablement will be addressed by developing an ageing well pathway though community to acute to target the correct resources. Sheffield has been successful in its bid for Successful Ageing lottery funding and the programme will continue to develop the business working closely to ensure mutual objectives with Ageing Successfully. The programme will also build on good links with Sheffield Age UK. Under this programme over 12,000 of Sheffield's most socially isolated older people are to benefit from a £6 million grant from the Big Lottery Fund. South Yorkshire Housing Association (SYHA) receives £5,920,107 to lead a partnership of 11 organisations, using creative and innovative methods to engage over 50's at the highest risk of loneliness. Areas of focus for the funding will include older people on low incomes, carers, BME groups, those experiencing poor mental health and those with limiting conditions living in Sheffield.
The Successful Aging Lottery Fund Programme in combination with the BCF provides Sheffield with a promising springboard for improvement and innovation and further integration with Housing.

Issue 2: Commission more simplified and efficient models of care that more value from reducing budgets

In the development of the detailed business cases for the programme we are looking to models that replace multiple entry points and duplication of services and interventions; coordinating care and giving individuals real choice and control, personalising care and driving cost reduction, improved experience and outcomes In the context of significant funding reductions over 5 years, with a real terms reduction in budgets of 30% in the period to 2015, Sheffield City Council has to manage significant further budget reductions in 2015-16 and beyond. Savings from the programme are essential to sustain social care services (some of which have already been recognised as too expensive and not sustainable without a programme of transformation) and we need to avoid losing users spending from personalised budgets who may be able to get more for the same elsewhere. There is a recognition that this must be delivered within a whole system approach. The Right First Time programme has already delivered improvements by expanding Transitional Care (Intermediate Care) capacity and aligning health intermediate care with the adult social care reablement service resulting in reducing LOS

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at Sheffield Teaching Hospital

Specifically: This will be addressed by our Active Care Project and within that our Scheme for Long Term High Support Care. Part of the objective of that scheme will be to directly reduce high costs by increasing support from community networks (Keeping People Well scheme) reducing input from statutory services.

Issue 3: Promote Innovation & Learning

The BCF will allow us to (building on the JSNA) to jointly reconsider existing commissioned models of care, collaboratively evaluating the new service models and promoting links with Ambulance Trusts, Community Pharmacy, Public Health and Voluntary Community and Social Enterprise organisations and considering how this might be further extended to include other joint developments such as joint Care Co-ordination to support people with long term high support needs and conditions to improve outcomes for individuals; or to maximise appropriate utilisation of services and physical facilities and housing stock for added service value and innovation (discussed above under issue 1)

The BCF will allow us to promote experimentation, but also to jointly through robust decision-making processes of our Programme Board agree to close down experiments that aren't working

The BCF gives an opportunity for improved community resilience, moving towards system interoperability, learning from police, ambulance and fire and rescue services and from existing collaborative models in Children's Services

The BCF will offer an opportunity to capitalise on the learning and knowledge and analysis and strong public and professional engagement of the transformation programme that has been successfully operating for three years - the 'Right First Time' programme. The Integrated Commissioning Programme (Sheffield's BCF Programme) will be a complementary programme to RFT as we essentially being the next logical phase of it.

The BCF will facilitate sharing of lessons from Leeds and Barnsley, our neighbouring integrated care pioneers and other Cities and regions of the UK as appropriate

Specifically: This quantified issue will be addressed by our scheme for Intermediate Care. We have 156 Intermediate Care Beds, only 2 for "step up". Scheme 4 (intermediate care) will review the usage against other core cities for example Leeds where 20% of the intermediate bed usage is from community as an alternative to hospital admission.

Issue 4: Increase collaboration and leverage wider networks of care

Our plans will address the need to promote further collaboration with Voluntary Community and Social Enterprises (VCSE)

The BCF will allow us to develop and invest in the unqualified workforce and engage with the large unpaid army of carers. Given the growing shortage of informal carers, the BCF plans will give us a great opportunity to consider in the new models to be commissioned

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new ways to attract and support volunteers in health and social care
Specifically: This will be addressed by the Keeping People Well Scheme

Issue 5: Improve Access & Information Sharing Capability and Customer Service Responsiveness

Will have very clearly reflected in our programme structure the vital role of facilitated exchange of information in the delivery of integrated care with the establishment of a project to deliver these aspects. We are currently urgently defining the scope of the work within those workstreams.
We will be commissioning integrated models and emphasising the role of community access and community assets and hubs in the delivery of equitable care services.
The BCF will allow us to consider new inexpensive pervasive technologies to forcing change in delivery models
It may also offer an opportunity for the Council to further develop self-service and e-access via the introduction of digitally enabled services
In our plans we will aim to ensure the information flows follow the person and show clearly how important this is in delaying deterioration and in delaying the progression of conditions
In the programmes quality and outcomes framework we will monitor the pace and progress of changes to the financial model and to information management, business systems and reporting systems in order to ensure this does not blunt or hold back the Citi's ambition.
As part of the work we will develop a universal transactional commissioned model to enable all citizens to get help when it is needed – not having to wait until the point where it is essential. For this to happen we could want to design a customer facing commissioned model that is able to address the main stages of the care transaction.
Specifically: this issue will be addresses as we define the workstreams of the access, and information sharing project.

Issue 6: Development of Capacity, Skills, Capabilities & Workforce

The BCF will allow us to build-in change capabilities and collaboration capabilities so that people are equipped for continuous change and emergence of new roles and possibilities.
This will allow us to take the opportunity to assess the infrastructure, organisational design, staffing and skills required to sustain an integrated model of services over longer lifespans of care e.g.
Will allow us to retain jobs and reduce workforce impacts in Sheffield fitting into a strategy for workforce development in the wider health and social care economy. One such development could be the introduction of a new type of joint health and social care worker which could be delivered from different providers to traditional models. In all our schemes we will be considering market development and independent and 3rd sector workforce capacity to meet future demand.
Specifically: This issue will be addressed in our schemes 4 and 5 within the Active Care

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project (Long term high support care and our scheme for Intermediate Care) which will be reviewing the role of community nursing and consideration given to including the service into the scope of BCF to allow us to make the most of important District Nursing capacity and professional capability. This issue is also addressed directly within our Keeping People Well schemes 1 and 2.

Issue 7: Care System Flexibility, Stability and Scalability

The BCF will be used to develop a scalable joint financial model given the likelihood of extension of scope and type of services to be jointly commissioned allows for reporting against the service lines being pooled

The BCF will address dissent between the Local Authority and the CCG over particular budgets, which can be a real issue.

Will provide stability for the Council and allow it to keep development costs of new types of packages to a minimum

Specifically: This issue will be addressed by the project for Financial Transition and Governance.

Issue 8: Care Inequalities

We know that care inequalities will follow if we are not able to design a model that will meet specific needs of individual or minority groups for whom, the consequences of delay in delivering individualised treatment will often lead to deterioration of an underlying condition ultimately leading to a more expensive treatment or avoidable hospitalisation. Equally it can lead vulnerable people in the wrong setting (such as waiting for discharge) increasing their exposure to risk. The programme aspiration is for **physical** and **mental** health outcomes improvement as well as improvements in **social/** emotional well-being as a result of integration. The BCF can act as a driver of equitable service provision and parity of esteem (see also section 8 engagement).

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4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Our detailed implementation planning stage starts in December 2014. Therefore it is not until the end of the current stage in November that that we will resource the programme and produce a detailed plan for the mobilisation stage up until March, as well as produce greater clarity on milestones for 2015/2016.

A key learning event is scheduled for November between the Right First Time Programme and the Programme for Integrated Commissioning after which key decisions will be made.

The next iteration of our plan will show much greater detail for 2015/16) as well as milestones for transition, key benefit drops, benefits reviews, procurement cycles, decommissioning, organisational development and peer review through 2015/16 with all the associated team restructure, and all policy, practice, procedure and protocol updates.

Pilots are planned from Jan 2015. After the evaluation of the pilots and sharing the arising reports at Programme Board, the benefits that can realistically be delivered for 2015/16 and beyond will be updated. After stress testing Jan – March 2015 we will also have a more realistic view of the volume of the work required for full change adoption and in consequence a more realistic view of timelines and firmer confidence levels about what will be achieved for 2015/16 and beyond.

Given the above, we believe it is probable that any version of the 2015/16 plan we produce now will be superseded by the date by the date of our October Programme Board meeting.

While recognising the need to work in concert with NHS England and in concert with other Cities and neighbours progressing with integration, we must in the Sheffield plan allow room to work with all our foundation trust and community partners to identify additional areas where we can be innovative in the way we commission integrated care and that offer additional potential to create high impact quantifiable outcomes and a robust business case.

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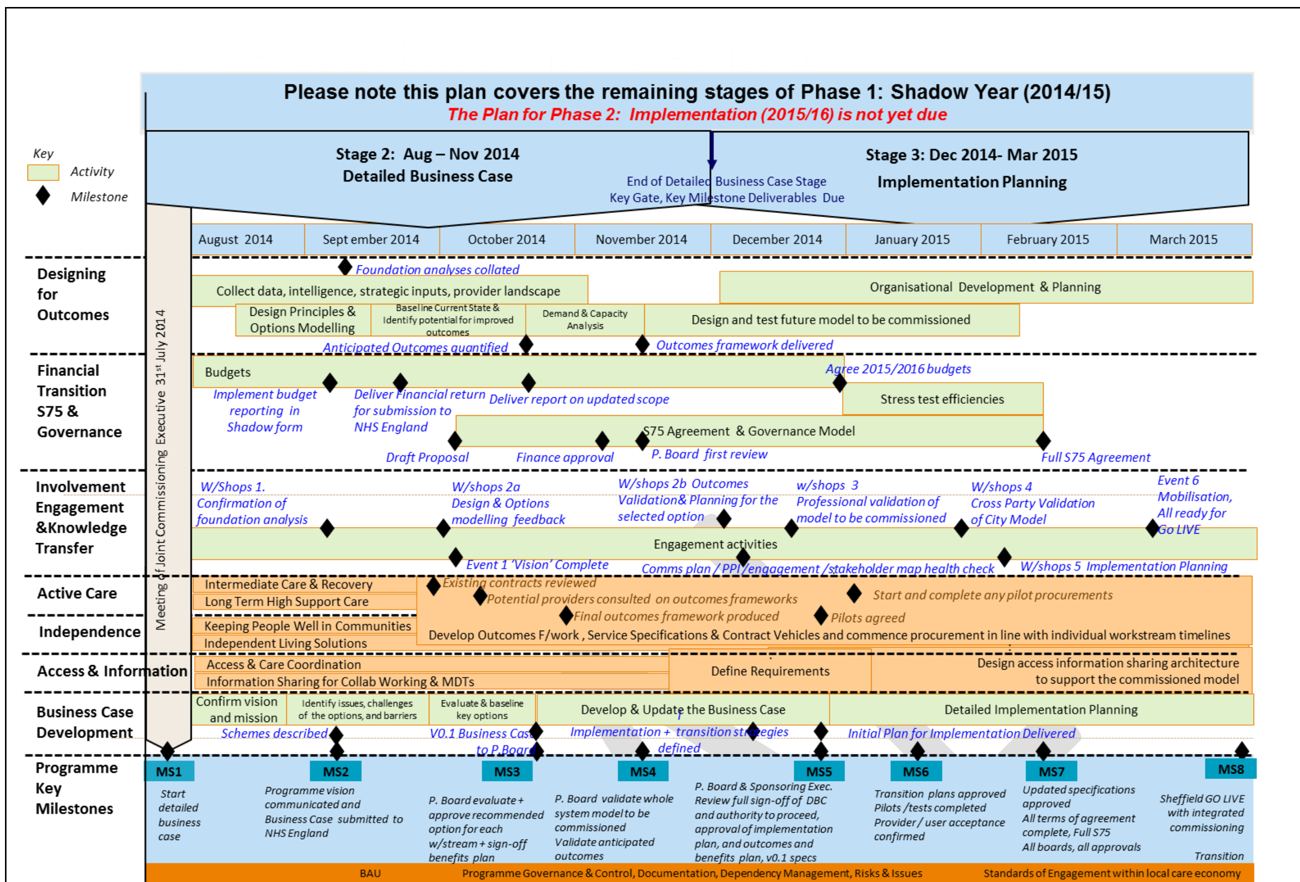

Our programme of work in 2014-15 covers:

Single decision-making

Executive Directors from the CCG and SCC, guided by the HWB, making decisions together

Single commissioning

Commissioners from both organisations working seamlessly together to produce single service specifications for the delivery of services funded from a single integrated budget. This will tie into work related to legislative changes such as the Children and Families Act and Care Act. We may choose to extend the scope of our work in 2015-16 further than the areas set out in this submission.

Extensive work with providers and GP Practice Associations

Working with our providers together to develop our supplier markets and particularly to develop GP practices' capacity to work together to deliver integrated services.

Significant engagement with Sheffield people

Adopting an asset based approach to the work we are doing, we are building on our past engagement to shape services that meet the needs of children, young people and adults and further develop individual self-care and community capacity.

Investment in supporting infrastructure

We have invested in programme management and commissioning capacity to deliver our programme of change under the banner of the 'Integrated Commissioning Programme'

Developing more meaningful measures of success

Nationally and locally we too often measure the success of component parts of the health and social care system. We will work during 2014/15 on ‘whole system’ measures of success as we develop our quality and outcomes framework for the programme.

b) Please articulate the overarching governance arrangements for integrated care locally

Close ties are currently being established between the Right First Time Programme and our Integrated Commissioning Programme (responsible for delivery of BCF plans)

We are committed to the principles of co-design and we are now evolving the RFT arrangements to ensure that there is provider, nurse and GP involvement in each of our workstreams, several of which build upon RFT projects. A strong relationship between the Chief Executives and between the Programme Managers of the two programmes will enable partnership discussions that bring together commissioners and providers and discussions on progress, implications for organisations, joint work on mobilisation of new services and other partnership issues.

Prior to formalisation of the Programme we ran an integration advisory group which included provider representatives and arranged discussions with each of our providers as part of our contract negotiation processes.

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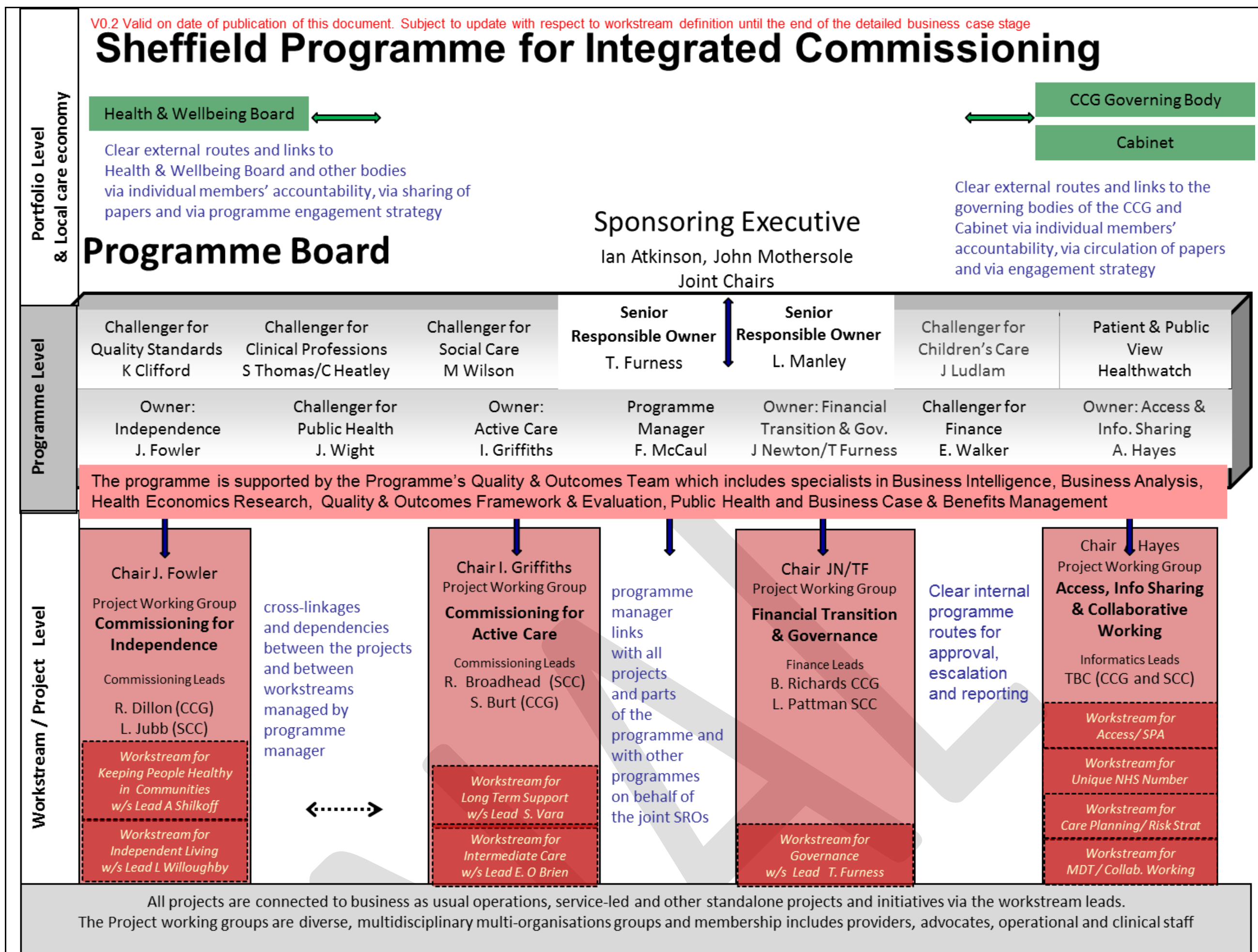

Diagram 6: Sheffield Integrated Commissioning Programme Organisation

The diagram above illustrates the programme organisation.
The programme organisation consists of a Programme Board, a Sponsoring Executive and four Project Working Groups with a number of workstreams within them. The Programme Board is a strategic decision making coalition and its diverse membership reflects that the Programme will support the integration objectives for the city as a whole.

Our logic is that a united Programme Board will act in the interest of the City without any conflict arising from members allegiances to the separate commissioning organisations Our logic is that the Programme will ensure a strategic fit and service prioritisation in the context of the wider service portfolio

Joint accountability is supported via the two Chief Executives acting as the Programme's Sponsoring Executive, providing an escalation point and joint senior level influence beyond the programme locally and nationally.

Terms of reference for the Programme Board were agreed at the meeting of the Joint Commissioning Executive Team (JCET) on 31st July 2014 and they include accountability for key members to maintain strong links and communicate with specific bodies and

Boards and with business as usual operations.

The terms of reference are also incorporated in a Programme Definition Document. This document describes the overarching governance for the Programme and the arrangements for managing and controlling it. Joint accountability is built-in to the leadership and design of the programme organisation and terms of reference of the Programme Board; the Chair is joint, there are joint Senior Responsible Owners, each project working group has ‘buddies’ as joint commissioning leads from the City Council and the CCG; activities in our plan show the names of all who need to contribute to completion for clear joint accountability and focussed on a single cooperative plan. This is not however about sides and counting out equal numbers of people or voting rights. The objective is joint accountability, inclusivity, consensus and collaborative decision-making. The Programme Definition Document has been shared with all in the programme organisation as a way of ensuring all involved parties are clear about programme roles and responsibilities and how the programme fits within existing management arrangements.

Each Project Working Group of the programme is a blended multi-disciplinary, multi-organisation group chaired by a programme board member and cooperating to deliver a shared plan. The core members of the Project Working Groups and the wider cooperative working group around it (consisting of a range of stakeholders from a diverse range of organisations) will be co-producing, reviewing and accepting key products to be approved by their Chair/Project Owner prior to these going on for authorisation to the Programme Board.

Terms of reference for each Core Project Working Group are currently being drafted for agreement at their inaugural meetings.

The diagram below shows the relationship between the Programme for Integrated Commissioning and its sister Programme, Right First Time.

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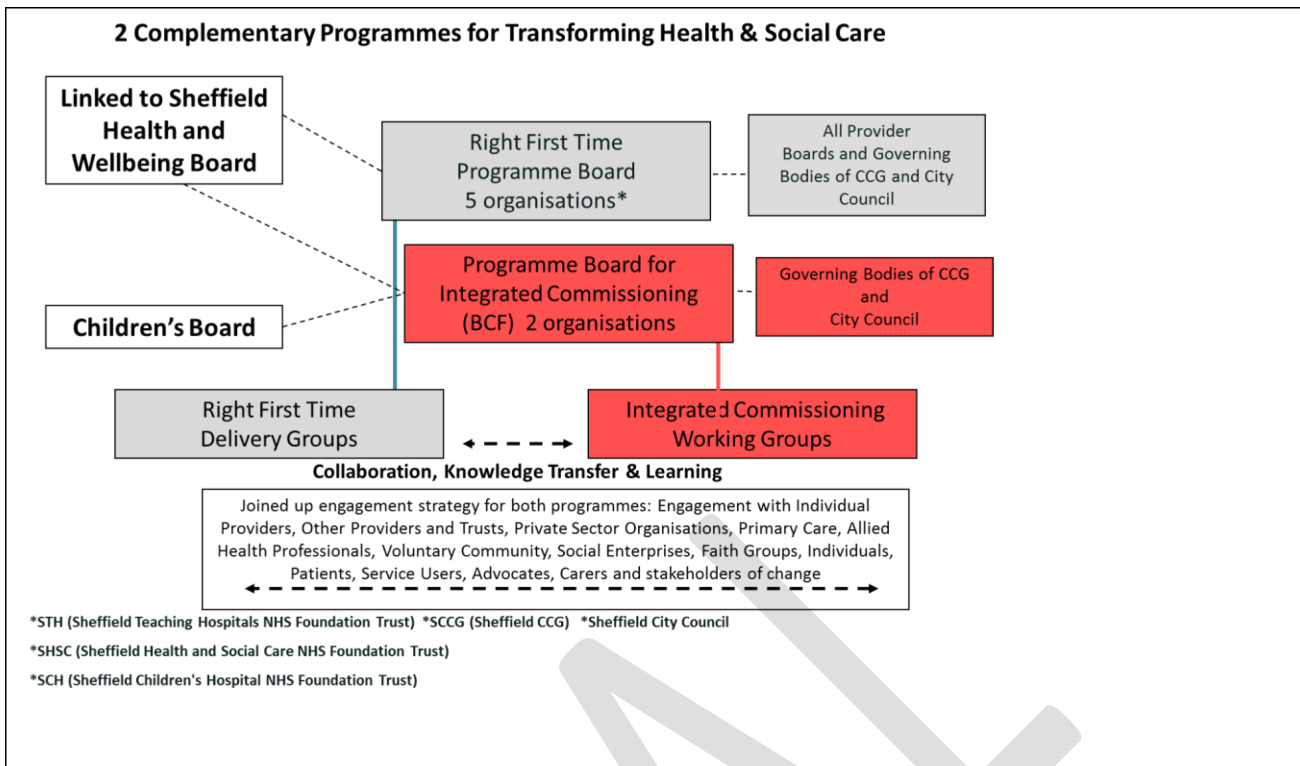

Diagram 7: Sheffield local programmes working in harmony with each other and with local Boards

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Programme management and oversight is in place to support delivery through the following means:-

Plan and programme approach

- Our programme plan will be maintained as a baseline against which our performance may be reviewed and presented at monthly Programme Board meetings.
- This is a joint plan that explicitly names all individuals contributing to completing actions of the plan and identifies their organisation. This plan is the transparent basis on which project work is carried out by departments, functions and organisations.
- Members will be involved or co-opted by taking up our invitation to become active participants of appropriate Project Working Group(s). These cooperative groups are a clear tangible way in which service, operational and corporate resources are engaged in design and delivery. Membership lists and attendance logs will record who has been involved.
- The Programme will be managed according to the OGC's Managing Successful Programmes (MSP) programme and project management standards.
- We are operating a gated staged process that ensures adequate controls, documentation, learning, assurances and approvals for a given stage and planning is complete for the next, before moving on. We are currently developing our detailed business case and are preparing the control documents for approval at the stage end in November.

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- Section 5 of the Programme Definition Document contains programme success criteria and summary of controls, including reporting, control documents and how we intend to share and learn lessons.
- The Programme will be leading joint-working by example:-
    - We have designed joint working into the Programme structure.
    - The Programme Board is a joint board with Primary Care and public (Health watch) representation.
    - We operate 'buddy leadership' in our Project Working Groups with each Project Owner supported by senior 'buddies' from partner organisations.
    - The Project Working Groups themselves are diverse and open to a range of contributors from many disciplines and organisations and they will together co-produce and co-review the outputs.

Benefits evaluation / programme quality and outcomes framework

- A measurement of the tangible benefits will be the indicator of the Programme's demonstrated success. We will be quantifying the anticipated benefits and measuring delivery of these benefits against a known baseline performance. The benefits profile will be maintained as part of business case management over the life of the programme.
- We want absolute clarity on the benefits and the performance measures (benefits metrics) that will be used to assess progress towards the realisation of those benefits.
- We are currently taking steps to establish a framework through which we can have simultaneous monitoring/evaluation of performance so that we get early warning of any failure of the Programme to achieve the desired benefits and can take appropriate corrective action.
- Using the dashboard that has been developed by the RFT Programme (see appendix 1 for the September dashboard) as a starting point, the programme's quality and outcomes team will be developing it to include the key metrics we need to demonstrate the value of the programme and so that we may assess the activity impacts and the benefits outcomes of the Programme. The RFT dashboard which measures a range of indicators. The high level dashboard domains include:-
  - Health and wellbeing of people with long term conditions (NHSOF and ASCOF measures).
  - Reducing avoidable bed days (overall rates and ambulatory care sensitive conditions).
  - Effective use of resources (operating costs, programme budgeting etc.).
  - Service User perspective.
  - Volume and variation measures across the health and social care system.
- This dashboard will be designed to be capable of meeting the dual needs to provide the top level indicators of NHS England as well as providing Sheffield with sufficient confidence in the local level metrics and that the predicted impacts of the larger local ambition are as expected and positive.
- The benefits framework will contain a comprehensive set of KPIs and metrics defined

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from the as the projects and workstream targets are defined, and cascading from the top level required benefits demanded by the BCF (see xl Part 2)

- We have recognised that it will be helpful to engage an external partner in evaluation in order to bring both capacity and expertise and, to this end, we are taking steps to engage with local universities, namely Sheffield Hallam University's Centre for Health and Social Care Research, the University of Sheffield's School of Health and Related Research (ScHARR) and the Yorkshire and Humber Academic Health Science Network to support the above.
- We are scheduling a benefits framework development workshop in autumn 2014 to clarify the benefits and the performance metrics, to discuss the development of an appropriate framework and how a simultaneous evaluation process would work.
- We will measure outcomes in the areas of user, carer and family experience and value for money for instance
- We will develop these metrics with input from all our partners
- The programme will operate to a Balanced Scorecard of Benefits, including a whole range of measures to indicate success and ensuring a balance of indicators across four quadrants - benefits for individuals (the participants in the moment of care), benefits for partnership development/integrated working, the cost and operational performance benefits, social benefits to Sheffield people.
- The primary measure of success however will be the degree to which Sheffield health and social outcomes improve
- We continue to work with the Public Sector Transformation Network (PSTN) which has expressed support for this approach. Through the PSTN, we will ensure we are a party to lessons shared across the network.
- We will seek to learn from other programmes where we have relationships and from neighbouring programmes. We have planned a key joint learning event with the Right First Time Programme in November and we have attended BCF learning events hosted by NHS England to learn and with the aim of avoiding preventable mistakes.
- The benefits profile that will be incorporated within our approved final business case the will become a living document over the life of the Programme. The Business Case will continue to be subject to regular review and update after Sheffield's planned final approval of the full business case, and as the initial assumptions of the case are replaced with knowledge the benefits and business case will be updated and shared.

Communications events

- We know that establishment of successful programme governance will depend on operational teams making adequate time for the development of change, e.g. at discussion slots in regular team meetings, so that Programme Board members can fulfil their accountability effectively.
- Our communications and events plan for Autumn includes attendance at operational forums and briefings to raise awareness and to engender support at operational level and all levels

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- Our communications strategy and plan (due during this stage) will incorporate activities to wider communications to patients and public

Meetings and reports

- Our Programme Board meetings will be held monthly. At these meetings, members will evaluate progress and review updates provided by the Programme Manager in the routine monthly Programme Highlight Report.
- Programme Board members will themselves need to provide a satisfactory update to the Board about the projects that they own at Programme Board meetings.
- Items will be brought to Programme Board by other members of the Project Working Groups for discussion, approval or information.
- Programme Board members will give routine informal updates to fellow Board members about relevant items from other boards and bodies.
- The Programme Manager will drive the delivery of agreed projects, programmes and initiatives by operating the reporting cycle and escalation process and holding regular meetings with key Project/Programme Managers, Board members, change leads and diverse stakeholders.
- The workstream leads will provide short bullet point checkpoint reports on a weekly basis or as agreed with the Programme Manger appropriate to the project stage. These will detail activity at workstream level that will both inform both the project review/progress meetings and input to be provided in the Programme Highlight Report.
- The Programme is working towards establishing and maintaining accessible project workbooks for each project. The project workbook will be a key source of information for all. It will contain the latest version of the plan, the benefits register and other logs. It will provide confidence that the Project Owner, Programme Manager, commissioning and finance leads and other key leads may access accurate updated information about that projects at all times. Information contained in them will be used by the Programme Manager to create the monthly Programme Highlight Report and to make wider communications about progress.

Assertive management of risk

- We will consider carefully the risks presented by assumptions, each of which can become a risk and also any new forces that could change the delivery model.
- We will manage the assumptions, risks, issues and dependencies associated with each change.
- Any required change to the programme plan in terms of the signed off cases, signed off base lined programme plan or to products, has the potential to adversely affect the agreed ICP objectives, timescales and deliverables.
- The Programme Manager manages a RAID (Risks, Assumptions, Issues, and Dependencies) register. The review of the RAID will form a standing item in all Project Working Group meetings. Risks that are escalated to Programme Board and onward to the Sponsoring Executive will be subject to the CCG's and SCC's risk management and controls assurance cycles.
- We will keep management control of risks and dependencies by ensuring milestones, resources, risks, mitigation actions and timelines are managed and appropriately escalated through the reporting and checkpoints and through regular joint project meetings.

- Risks are scored according to guidelines. They are assessed on a scale that reflects likely impact and probability.
- Each risk has a clear owner.
- Risks will be passed to the partner best able to manage them.
- Contingencies for each major risk will be identified and if necessary implemented.
- Our mitigating actions will contain a clear known target date for resolution contained in the register.
- We will also log ICP constraints.
- We will ensure at Project Working Group inaugural meetings that everyone has a common understanding about standards regarding reporting of risks, of risk thresholds themselves and of escalation routes and actions required of them so that we collectively control the programme.
- The Programme Manager will take responsibility, unless otherwise agreed, for providing information on progress, risks and issues and ensuring timely escalation and exception reporting.

d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref No	Scheme
1	Keeping people well in their communities – community based services
2	Keeping people well in their communities – locally commissioned services with GP services
3	Independent living solutions
4	Intermediate care – Active Recovery and bed based services
5	Intermediate care – proactive hospital admissions and flow management
6	Long term high support care
7	Hospital medical emergency admissions (adults only)
8	Capital grants

Table 2: Sheffield BCF Schemes

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5) RISKS AND CONTINGENCY

a) Risk log

We are already actively sharing risks now in our shadow year. We will be developing a single approach to risk-sharing as part of the work of our financial transition and governance project.

Our programme uses a detailed risk register that uses a consistent scale understood by all partners that describes the likelihood of the risk arising. People understand clearly the thresholds for escalating risks from workstreams to project working groups and from project working groups to Programme Board and from Programme Board to Sponsoring Executive.

The programme risk management framework dovetails with the master corporate risk registers of SCC and the CCG and into our review process for serious cases. This will ensure we are effectively communicating risk fast from the programme and across organisations to where it can be managed most effectively. We have also decided based on the same rationale to include on our register the need to escalate to Boards outside the programme.

The fields logged on our register are as follows:

Risk ID
Description of risk to programme outcomes
Probability
Risk Score
Proximity Date
Action taken to control
Date of last update
Is this reportable to any other Trust / Partner or other assurance framework (outside of Programme Governance)
Responsible Lead
Risk Owner
Owning Organisation or department

Risk No.	Risk to Programme Outcomes	Potential Impact on Programme Outcomes 1-5	Prob -ability	Risk Score	Proximity Date	Action taken to control (include dates)	Date of Last Updat e	Is this reportable to any other Trust/ Partner's Assurance Framework outside of Programme Governance?	Responsible Lead	Risk Owner	Owning organisatio n or department

We have shown key risks to programme outcomes in table 3 below. The nature of these risks reflects the current stage of maturity of the programme.

Table 3: Extract from Programme Risk Register showing key risks to outcomes

Risk No.	Risk to Programme Outcomes	Potential Impact on Programme Outcomes 1-5	Probability	Risk Score	Action taken to control (include dates)
1	Risk that the contribution that Sheffield City Council can make the single budget will reduce in 2015/16 as a result of further budget cuts. This could undermine the viability of the integrated fund.	4	4	16 High	Apply a shared approach to budget monitoring and planning in 2014-15 Ensure we collectively work up savings targets and proposals for 2015-16.
2	Risk that the programme will not deliver the target reduction in adult acute hospital admissions and/or that there will be a shortfall against the other key BCF indicators and insufficient improvements in timely hospital discharge (flow).	4	3	12 Moderate	Produce an assurance/evaluation framework for the programme in partnership with an academic partner against which progress is monitored monthly at programme board Carry out scheduled benefits reviews and have the programme peer reviewed Be prepared to take necessary action to adjust the plans radically if necessary Through effective sponsorship, maintain strong programme planning, leadership and oversight to provide assurance that the programme will deliver the benefits target of £3.6 million in 2015/ 16 ; ensure that the investment required to deliver the programme will be made available; that the savings and total benefits to be delivered are accurately forecasted; be explicit about what and when and how integration between health and social care will be promoted adopted and measured Work closely with providers at the design stage to ensure change is mutually beneficial Evaluate RFT projects to learn lessons Model with Sheffield Teaching Hospitals the changes to intermediate care services Analyse flow to support development of the new service specifications.

3	Risk that there will be Insufficient workforce capacity to support this ambitious work and that the level of current resources will drive quality of the future model to be commissioned.	4	3	12 Moderate	Provide an agreed programme budget. Produce a resource profile and assign resource to match the scale of the plans, utilising substantive roles where possible.
4	Risk that there will be insufficient market development; meaning groups of providers are unable to successfully bid to deliver on our outcomes-based specifications.	4	3	12 Moderate	Plan careful and considered engagement over the course of the 2014-15 to develop our local providers. Ensure that our specification is suitable and appropriate for the market we have. Pilot in certain areas of the city giving space for other areas to continue to develop if they require more time.
5	Financial risk - non delivery of existing savings programmes for 2014-15 particularly from within adult social care.	4	3	12 Moderate	Focus on our savings plans including detailed monitoring of the 2014/15 plan. Ensure that the integration work is in line with ongoing budget recovery work. Use risk stratification and modelling to help us to target spend most effectively. Manage de-commissioning.
6	Closed				
7	Risk to the CCG and NHS more generally of tying budgets in the context of cuts to the local authority.	4	3	12 Moderate	Refocus on shared values and care principles to support partnership working
8	Risk that proposed options for change will be difficult for organisations, individuals professionals and users to adopt	3	3	9 Moderate	Provide adequate change management support to recognise that the success of a new integrated model will also be predicated on a change in mind-set from those working in the field Provide the tools of cooperation collaboration and change as part of the programme, especially around risk sharing, planning, sustainability and contingencies so that organisations and individuals can collaborate better
9	Risk that NHS England control over primary care and specialised commissioning will mean commissioning is not entirely integrated	4	3	12 Moderate	Work closely with NHS England, particularly in relation to the developments in the commissioning of primary care Continue to support the concept that NHS England's commissioning budgets can be part of an integrated commissioning process in Sheffield.

					Continue to work in close partnership with NHS England as a member of our Health and Wellbeing Board
10	Risk of impacts arising from the Care Act: -That it will to increase costs significantly in Sheffield and that these costs may not be met by any increased national funding -That newly integrated assessment and care management functions will be designed without full clarity about Care Act requirements.	4	3	12 Moderate	Carry out detailed work with partners, peers and national networks. Apply a statement of readiness (for integration) to all the workstreams of the programme that includes a statement of compliance with the Care Act Make the Care Act project lead a default reviewer of all new models of care contained within the business cases of the schemes
11	Risk that timescales for implementation will not be met	4	3	12 Moderate	Put robust programme management arrangements in place Resource appropriately to avoid delays Plan effectively and realistically Phase the delivery and new service roll-out and manage programme dependencies Ensure the plan is subject to regular update
12	There is a risk of unintended impacts on people's safety due to incorrect planning, impact and benefit assumptions (e.g. assumptions about improving flow across the system and in particular 7 day discharging.) will be made due to gaps in information about activity figures ; due to a lack of whole	4	3	12 Moderate	Bring together a quality and outcomes team to support the programme Build on work currently underway with process mapping partners (Impower) Involve both service user and care professional in developing integrated models of care in order to develop a closer understanding of our starting position Develop a robust modelling tool with our academic research partner as part of the quality evaluation work

	system understanding about the way in which people come into contact with the services				Develop the dashboard to confirm that better outcomes (increased independence, enhanced quality of life, reduced readmissions etc.) are attributable. Validate care models with a range of clinical and care professionals Include adequate professional leadership on the programme board i.e. GP with special interest in mental health, chief nurse, adult social care, children's social care, public health
13	There is a risk that the date of the BCF submission on 19th September ahead of the programme's own local timeline for delivery of the detailed case for change will cause provider partners and NHS England to misconceive the level of clarity and robust detail that will appear in our plans as they are not seeing the finished case	4	3	12 Moderate	Hold local communication launch events in October raising awareness of timelines, approach and points of contact Confirm and re-iterate throughout this document the stage the programme is at
14	Risk that primary care capacity will be so strained that its ability to support preventative community work is compromised. For example, the number of people with multiple long term conditions is set to grow from 1.9 in 2008 to 2.9 million in 2018, which is likely to increase the number of consultations.				Co-commissioning

15	Risk that changes to the funding formula will increase inequalities in access to primary care in Sheffield. For a small number of GP practices there is a risk that they may affect their viability and will not be able to afford to continue to exist.				Co-commissioning
16	Risk that the process of changes to the funding formula present challenges to commissioners in terms of keeping practices engaged with the wider commissioning agenda, rather than their seeing it as an increased workload.				Co-commissioning

RED	15+ escalate all red to sponsoring executive
AMBER	>8 or =8, escalate over 12 to Programme Board
YELLOW	>4 or =4
GREEN	<3 or =3

LIKELIHOOD	1 – Very Low 2 – Low 3 – Possible 4 – High 5 – Very High - Almost Certain
IMPACT	1 – Very Low 2 – Low - Some Minor 3 – Moderate 4 – High 5 – Very High

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b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

We acknowledge there is a both a risk with regard to the performance related element of the fund, but also more broadly, there is a risk to both organisations and that is shared risk. We'll be managing the pooled budget on the bottom line, and agreeing risk sharing arrangements that mean that any overspends or underspend are shared, and so we have a shared responsibility for managing that risk.

£3.6m of the minimum CCG contribution is linked to the admissions performance metric and may be considered “at risk” but as the CCG is planning to include this funding in the BCF pooled budget, there is a circular effect – the money, which in other circumstances would have been withheld, will remain in the pooled budget as the pooled budget will be paying for the admissions not avoided.

The CCG plan builds in the best estimate of known cost pressures at this time, taking into account the outcome of contract negotiations, QIPP plans and BCF discussions with the Local Authority. We see the main risks to delivery of our plans in the next 2 years as possible partial non delivery of QIPP particularly in relation to non-elective admissions and if our assumptions on underlying demand are not correct in relation to acute activity including cost per case drugs, prescribing and CHC.

In terms of mitigation of risk the CCGs scope for significant financial reserves over and above the 0.5% general contingency will be limited. The main focus will be on strong programme management of the changes we need to make including with key local partners where appropriate. This is likely to include shared risk management with Sheffield City Council particularly in relation to areas of service which will form part of the Better Care Fund from 2015/16. However, the plan does contain funding for local investment and clearly this will occur in a phased way over the planning period and so some investments will be capable of being deferred or halted if required. At this stage we have not made any assumptions on potential savings from joint procurements with SCC on a range of re-specified integrated services but this should provide additional resilience to our QIPP plans from 2015/16. For some areas of service e.g. some community services we are currently choosing to look for additional activity/improved outcomes rather than impose the 4% cash releasing efficiency – for future years we could choose to impose and hence mitigate risk at the start of the year.

If admissions savings do not materialise this is clearly a risk. We have yet to finalise our risk sharing/management arrangements to be included in our Section 75 agreement but it is expected to include access to contingency funds outside of the BCF Pool. For example, the CCG in its 2015/16 Plan has a £4m QIPP/double running costs contingency reserve which we can commit to supporting urgent care admission pressures if savings are not fully realised. The work which we are doing in themes on keeping well in their communities, intermediate care and independent living solutions is also expected to contribute to reducing inappropriate emergency admissions. Along with the work we

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have been undertaking for the last 2 to 3 years as part of the RFT Programme these might be classed as "pre-emptive" actions.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The boundaries with other programmes will be managed carefully to avoid double counting of benefits and to avoid conflict, parallel working or duplication. We also include a dependency tab on our register that includes an indication of the nature of the dependency and well as mitigating actions and a person responsible for managing it

The fields logged on our dependency log are:
Dependency ID
Description of dependency
Nature of Impact
Level of Impact
Date Identified
By whom
Action Taken to Manage
Priority
Date Last Reviewed
Responsible person

Identifier DXX	Dependency (External item that programme progress is dependent upon)	Nature of Impact	Level of Impact of this dependency upon Programme Outcomes 1-5	Date identified	By whom	Action to Manage this dependency	Priority H/M/L	Date Last Reviewed	Responsible for Managing this Dependency

Table 4: Alignment with other programmes and initiatives

Refining Personalisation	Sponsor is on integrated commissioning programme board
Business Systems & Information Programme	Project Manager is on the Programme
Care Act Implementation	Sponsor in on the Programme Board Project Lead is by default a member of the reviewer group for all business cases
Right First Time Programme	Programme Managers regular meetings Workstream/project leads of the programmes working closely together

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	Shared learning events between the programmes
Ageing Well	One of the lead commissioners for our Active Care project is our link to this initiative
Review & Assessment - Adults	Sponsor is a buddy 1 on our Active Care project
Future Shape Children's Health Programme	Sponsor is on Programme Board
LD Commissioning	Link person TBC
Aging Successfully	Link person is buddy 2 on our Active Care project
Direct payments	Project lead is our commissioning lead on independent living solutions scheme
Reshaping Housing	Link person TBC
Customer Services Digital Insight	Customer Service Manager links to Programme Manager
Lunch clubs review	Lead is on keeping people well cooperative working group
Grants review to VCF	TBC

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

All the schemes in our submission are described in the CCG's commissioning intentions for 2014-16, which includes a section on our integrated commissioning intentions. As part of the refresh of our operational plan to ensure we have sufficiently detailed plans for 2015-16, the CCG will explicitly review and, if necessary, revise the section on integrated commissioning to ensure it reflects the current position. More importantly, the CCGs Governing Body is routinely briefed on BCF developments and is fully supportive of the proposals in our submission.

The CCG led the development of a joint statement of ambition for the Sheffield health and social care economy, which formed part of its Operational Plan, was reflected in the Foundation Trust's Business Plans. This statement includes the aim to reduce hospital admissions.

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c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Our plans for co-commissioning of primary care

The five CCGs within South Yorkshire and Bassetlaw have now submitted to NHS

England, an expression of interest in the co-commissioning of primary care. In entering into a co-commissioning arrangement we intend to have increased influence over and input to the full range of NHSE primary care responsibilities and specifically wish to secure an early joint commissioning arrangement, pooling budgets where it is in the best interest of our patients.

Further guidance is awaited on the expected governance and assurance arrangements that local CCGs need to have in place in order to take on delegated responsibility for commissioning primary care services. However, we anticipate being established in shadow form from Autumn 2014. Sheffield's HWB offered support for this approach at its August 2014 meeting.

A key driver for our interest in co-commissioning is the opportunity that it will provide to fully integrate commissioning of our health and social care system, as primary care, and GP practice in particular, is the cornerstone of our system and the key to supporting people to stay well and reducing demand for hospital and long term care.

Our ambitions for primary care co-commissioning are entirely consistent with our BCF plans and can be broadly outlined as:-

- Patients and professionals alike should have increased confidence in the system delivering care.
- Patients should be treated outside hospital wherever safe and possible to do so.
- The existence of a vibrant primary care sector, supported by a wider integrated primary health and care team, capable of offering a strong model of service delivery to patients.
- Providers across all sectors collaborating to seamlessly deliver that which is best for patients.
- High quality remaining at the heart of all we do, with primary care being in a position of demonstrating key quality improvements.

In particular, we anticipate our plans for primary care aligning most closely with the Commissioning for Independence project of the Programme. As part of the programme of integrated commissioning we have been spending a significant amount of time working with local GPs and GP Practice Associations to integrate care locally, increasing the use of multidisciplinary teams, fostering work with pharmacies, improving information, advice and self-care as well as more broadly looking to establish a network of support workers in local communities based with local GPs.

We also acknowledge the aligned approach to pooling budgets, either between the CCG and SCC in the case of the BCF, or between the CCG and NHSE in the case of primary care co-commissioning, and have a mechanism to share learning and approaches in our project working groups.

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Finally, as we move away from 'input-based' contracting with key providers to 'outcome-based' contracting, in which we are clear of the health, improvement we wish to see delivered. As we start to deliver our ambitions to secure more care out of hospital, it will be necessary for providers to develop integrated responses supported by more integrated commissioning. To that end, we see the promotion and development of such integrated provider models as a legitimate commissioning activity and recognise the importance of GP provider development in the schemes of the programme.

Co-commissioning of primary care and alignment with integrated commissioning will support our management of some of the risks associated with primary care and indicated in the risk log in the above section.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

We will protect social care services in the following ways:

We will maintain current social care eligibility thresholds. This means that it will continue to provide support that meets people's 'unmet critical and substantial' social care needs. We describe critical and substantial needs in plain English on our website.

We will recognise, nurture and encourage informal support from families, friends, neighbours, community organisations and other bodies. This is why we always describe our role as meeting 'unmet' needs.

We have consulted on this position as part of its budget planning last year and we intend to maintain this position into the medium-term.

The BCF plans, by enabling Adult Social Care in Sheffield to continue to work in partnership with health and other partners will play a key role in keeping people safe, well and independent.

The BCF offers a great opportunity to develop Preventative Care and Wellness – a

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critical component for Sheffield to bring down excessive demand by establishing preventative wellness services. .

We will be pooling our resources for people with high support needs we will ensure that people who do require long term care intensive support continue to receive it, whether through comprehensive care packages to maintain people at home or in residential or nursing care where this is needed. We are taking a joint approach to resource allocation across health and social care including joint decision making on continuing health care and jointly funded care packages at our Programme Board.

We will maintain a broad approach to customer contact and the provision of advice, information and signposting. We will broaden our reablement offer to ensure that people with existing long term conditions who would benefit from reablement are able to do so, as well people who have experienced an acute episode. We will commission services from both internal and external providers which have a clear focus on promoting recovery, reablement and independence.

Both the CCG and SCC are committed to maintaining the current level of eligibility making the best use of resources as well as placing a greater emphasis on demand management through information and advice, prevention and investment in equipment and assistive technology.

The rationale for these planned changes is that, through a more holistic approach to meeting the health, social care and wellbeing needs of the people of Sheffield, we will ensure that the money available from the public purse is used to ensure the best possible outcomes in the face of continued budget reductions in local government spending and negligible real terms growth funding for the CCG. Given that the CCG is above its ‘fair shares target’ allocation and expects to receive minimum cash uplift for the foreseeable future.

We will adopt an asset based approach to helping people to help themselves in their local neighbourhood, and communities and will develop services which help informal carers in their caring roles. We will improve value for money by integrating services and avoiding duplication in both assessment and service provision.

We will utilise and invest in the development of the evidence base of all services we commission or deliver, investing in services which can demonstrate improved outcomes in relation to people’s independence, quality of care and cost effectiveness.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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We believe that only by pooling budgets at scale can we protect social care services.

In 2010 SCC published 'Sheffield: a city where every carer matters'. This strategy was developed with carers, carers' organisations and health services. Its stated aim was to "Improve carers' lives, ensuring that they are identified and that their contribution to society is recognised and valued". Eight objectives were identified aimed at delivering the 10-year outcomes described in the national carers strategy:-

- To develop the local infrastructure and improve joint working between partner organisations so that carers are better supported.
- To identify hidden carers and raise awareness of carers and their caring responsibilities within organisations and in the wider community.
- To provide information, advice and advocacy to enable carers to make informed choices.
- To sustain carers in their caring role and prevent carer breakdown.
- To involve carers individually and collectively in shaping, commissioning, monitoring and evaluating services.
- To promote support for employees who have caring responsibilities.
- To ensure that carers have a life of their own outside of their caring role.
- To enable young carers to have the same life chances as other children and young people and prevent them from taking on inappropriate caring roles.

Building on this foundation, Sheffield has not gone down the route of creating a few relatively small BCF integration schemes. We are genuinely aiming to integrate the commissioning of health and social care. This is why we are planning to pool £243m of the CCG and SCC budgets next year, increasing by more than a factor of six the Government's BCF allocation for Sheffield. The size of this pooled budget allows us to plan together and genuinely share risks and opportunities and protect social care – not just at the margins but at scale. This is something we believe we can achieve as a result of the mature partnerships that exist in the city.

All of our BCF schemes are built with preventative care and independence as a key principle. The following two schemes in particular will protect social care services:

- The scheme for Keeping people well in their communities will increase numbers of community support workers
- The scheme for locally commissioned services with GP services will support inclusion of social care in multidisciplinary teams

Our existing health and social care partnerships have helped us deliver successful integration pilots, focused on helping people who are elderly and frail to remain safe, well and independent. We have also already made significant improvements to our intermediate care pathway, helping more people to return home quickly after a stay in hospital and benefiting health services. This work will be continued and intensified as part

of our 'Keeping people well in their communities' and 'Intermediate care and reablement' workstreams.

We are now ready to implement a community based prevention model that we are confident will reduce the pressure on health and social care services significantly over the next 5 years. The model has been developed to improve outcomes for people who are elderly and frail. It is based on some key elements:-

- **Support workers** on the ground doing '**sort and support**' – fixing problems and connecting people to activities and support that support safety, wellbeing and independence.
- '**Life navigators**' to support people who don't have anyone to help them manage their daily life and care.
- **Responsive multi-disciplinary teams** working seamlessly with **support workers** and the **voluntary sector**.

Our pilot work has shown that when these elements are mixed together in the right way for a local community, there are demonstrable benefits for individuals and the wider health and social care system. We have identified £12m of the CCG and SCC investment in this area that we plan to refocus over the next 2 years to deliver this model and we are also leveraging other funding streams to support it.

We are anticipating a continued growth in demographic groups associated with social care demand. However, our preventative and reablement work over recent years has meant that we have held back the full impact of increases in the older population hit social care. However, we have seen significant increases in demand for social care from people with learning disabilities.
A summary of expected demand for social care is included within our Market Position Statement.

The forecast impact of increasing demand is explicitly factored into our joint budget planning process described above.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

In the financial template, we have shown in 2015/16 £188,942k as the funding which supports the protection of social care. This is because as stated above, we have agreed a broad definition of what we mean by 'protecting social care'. Key strategic intentions of

the Programme are to reduce inappropriate emergency admissions and to reduce the number of people requiring long term high cost care, be that NHS CHC funded care or social care, by keeping people well in their communities and providing integrated community services. Thus, we think it is appropriate to class all spend within our BCF with the exception of scheme 7, i.e. spend on inpatient emergency medical admissions as contributing in some way to protecting social care.

We recognise that this may well be a much broader definition than that used by other health and social care communities. If the national assessment process needs more comparable data we can also confirm the following:-

- From within the CCG's minimum contribution of £37.8m we have earmarked £15.5m and a further £2.2m from other CCG budgets for spend on Adult Social Care including long term care, social worker assessment capacity, particularly linked to ensuring prompt flow of patients from hospital and intermediate care beds, and for short term intervention services as part of Active Recovery intermediate care. The £15.5m **includes the local proportion of the £135m for the implications of the new Care Act i.e. £1.4m.**
- In Sheffield we are including the totality of the Adult Social Care budget – purchased services, i.e. long term residential and home based support, together with other social care services commissioned by SCC including the Short Term Intervention Team (STIT) as part of the intermediate care scheme. The CCG has contributed to the costs of these services over a number of years and this investment is being maintained as part of the BCF arrangements.
- SCC is still assessing the full implications of the Care Act and sharing and discussing this information with the CCG. As the totality of the purchased social care budget and the current Carer Support budget are within the BCF by default, any spend requirements emanating from the Care Act will be captured within our BCF.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

We are committed to meeting the duties of the Care Act and stepping up our support for carers as part of overall prevention approach.

New duties

The Care Act provides a range of new duties for Local Authorities. Those that align most closely to the BCF and the HWB strategy are the duties around:-

- Information and advice.
- Prevention.
- The wellbeing principle.
- The requirements in respect of delivering personal budgets.

- The market-shaping duty.
- The duty to integrate and responsibilities towards carers.

There are a number of new and changed duties in relation to people who fund their own support and in calculating how much people will have to contribute.

Changes that will need to be made
Locally work has been done to review the guidance that supports the legislation and changes will be made to meet the immediate requirements of the Act with the aim of conducting further analysis to understand what additional planned activity is required. Current indications are that more work will be needed to develop a comprehensive information and advice service and embed a preventative approach in the whole of the customer journey.

There will be a real focus on reviewing, amending in light of the Care Act and communicating to staff, the principles and practice that they are required to deliver to, particularly in relation to assessment, support planning and reviewing service users. Included in that, will be an emphasis on what the person can do to meet their own needs and what steps they can take to prevent their needs increasing.

A Care Act Implementation Project has been established that will manage the changes required. The Project Board is chaired by the Director of Care and Support and has engagement from a range of stakeholders from within and outside SCC, including the CCG.

The Integrated Commissioning Programme workstreams “Keeping people well at home” and “Intermediate care and reablement” will contribute significantly to delivering the requirements of the Care Act in terms of prevention. Alongside this the key principles of the Care Act will have to feature clearly in the development of the new model for long term high support.

These interdependencies between the delivery of the requirements of the Care Act and the Better Care Fund have been identified and will be monitored closely. The Project Sponsor for Care Act Implementation Project is a member of the Integrated Commissioning Programme Board.

Responsibility of the Integrated Commissioning Programme
As part of assessing readiness for integration we will carry out a gap analysis which includes a compliance analysis and a statement of readiness for integration. The project lead for the care Act will be a reviewer all business cases of the schemes.
The Programme team will carry out due diligence alongside the Council’s in-house Care Act team to ensure obligations under the Act are captured and met by the solutions and models being put in place. In doing so, we will identify when these requirements will be

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met, by which aspect of the project, by whom and any associated risks. This will provide assurance that the new configurations and integrated models to be commissioned
We will make it explicit in the BCF workstreams that investment carers support services in line with the allocation needs to be demonstrated.

v) Please specify the level of resource that will be dedicated to carer-specific support

Based on local information, we believe that the former PCT was previously expected to identify £1.1m for carer support from its baseline funding (i.e. the PCT's old capitation share of £100m previous announcement.) We can demonstrate that the CCG only inherited c£650k of this original funding as the balance was transferred to SCC as part of the Public Health Grant for a named set of schemes. In creating our local BCF we have included in the BCF the residual £650k which the CCG holds.

In addition, within scheme 1 'Keeping people well in their Communities' SCC have included existing local authority funds for carer support. This figure is stated before factoring in the impact of the Care Act on carer support in 2015/16 which remains work in progress.

Currently SCC has two major contracts for carer specific support that are funded jointly with health

1) Carers Support Services, e.g. information, advice and support
2) Flexible Respite Services for Carers, e.g. sitting services, community respite and respite at home).

Total funding for these contracts is £1,042,000 and the contracts are currently due to run until September 2015.

In addition, SCC spends £4.9m on planned short term residential breaks to provide respite care for carers. This includes a contract for £1.7 million with Sheffield Health and Social Care Trust (SHSCT) and is funded from the purchasing budget.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Funding within Sheffield City Council budget has not been affected.

There has been no impact. We are not changing our planned schemes as a result of the national changes to the performance related element. The £3.6m which is the amount now linked to the delivery of the 3.5% admissions avoided performance target has been

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badged against NHS commissioned services as required i.e. the expansion of Active Recovery which forms part of the intermediate care scheme and a small element of an existing care planning initiative. These actions are part of what is required to reduce emergency admissions and so it does not change how we originally intended to spend the resources.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends.

Strategic background to 7 day services to support discharge
Our JHWS places a central importance on an effective, efficient and innovative health and wellbeing system. It has two outcomes which provide underlying support for the provision of 7 day health and social care services across the local health economy. These are:-

- Outcome 4: People get the help and support they need and feel it is right for them.
- Outcome 5: The health and wellbeing system in Sheffield is innovative, affordable and provides good value for money.

The provision of 7 day services is a question not just of ensuring the best access and best quality services possible for the people of Sheffield but also a way of ensuring the system is more effective and efficient.

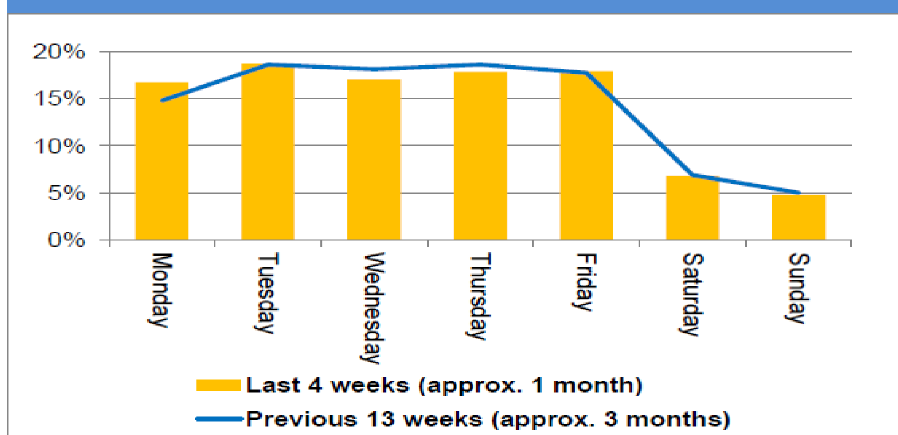

Table 5: Proportion of live discharges by day of the week

Past work to improve 7 day services

As a participant in the Seven Day Services Improvement Programme, Sheffield is committed to ensure that it learns from others and shares the benefits it realises itself. The key ambition is to ensure that the development of 7 day services enhances safety and efficiency, delivering a more sustainable system.

We are engaged in the Action Plan to deliver 7DS in local contracts. that aims to transform how the health and social care system works in the city. Key learning from the RFT programme to date has demonstrated clearly that one of the challenging areas to maintaining whole system flow is the differential between weekday and weekend services for supporting discharge, particularly for patients with complex needs.

The 5 key sponsors of the programme – the CCG, SCC, Sheffield Teaching Hospitals NHS Foundation Trust (STH), Sheffield Health and Social Care Foundation Trust (SHSCT) and Sheffield Children's NHS Foundation Trust (SCH) – are committed to minimising the delay in moving patients across the system. In particular, the programme aims to focus more on levelling out the differential between weekday and weekend discharges.

Some of the key milestones for a whole system 7 day service model are in place:-

- Investment in community nursing services now runs at the same operational levels 7 days a week.
- Health and social care domiciliary intermediate care capacity is the same every day of the week.
- The Single Point of Access (SPA) is currently increasing its overall capacity to cover weekends and evenings. The longer term strategy is to integrate this with social care, simplifying and expanding the capacity of the service model to create an integrated Health and Social Care SPA.

Local partners will continue to work together to ensure that NHS providers meet the milestones for inclusion of the Clinical standards for 7DS

How our changes will impact on admission prevention and discharge

- Reducing the time spent in hospital for all higher risk groups, but particularly people who are elderly and frail who will decompensate very quickly and have a higher risk of needing long term institutional care (NHSOF 2, 3, 5; ASCOF 2).
- Reducing avoidable delays (DTOCs) and in particular aligning hospital and community services more consistently across the whole week.
- Increased availability and responsiveness of health and social care community services to help citizens remain safe, well and independent at home and avoid the need for care to be escalated to a higher level and in particular, hospital admissions.

As part of the BCF plans and to support the understanding for the impact of 7 day

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services we would look to add in the ratio of weekday to weekend discharges onto our dashboard as a key measure of success.

We are confident that, as a system, if we increase the effectiveness of 7 day services to support increased weekend discharge rates, we will be able to measure the impact effectively from a whole system perspective.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All health services intend to use the NHS number as the primary identifier for all clinical correspondence. It is our intention that all our integrated services (including social care elements) will do so from April 2015, though our interpretation of the impact and requirements of the Care Act will determine the solutions and resources needed to do this. This will greatly support good records management.

The programme is defining the brief for the project for the use of the NHS number in order to reduce barriers associated with information and administrative delays that can impact health outcomes

The South Yorkshire Data and Information Sharing Group has been established to support appropriate, safe and secure data-sharing with our partners so that effective services can be delivered. As a matter of course, we will pay due regard to patient confidentiality and will seek suitable assurances from partners in relation to it.

We are currently looking to resource a project that will utilise the Migration Analysis and Cleansing Service to match our social care records with health demographic records and return a match with the NHS number. This matched number will then be uploaded into our ESCR system, CareFirst. This will result in a solution for batch processing.

OLM, our ESCR vendor, have recently communicated that they may be looking to develop a more integrated solution supporting a ‘look up’ facility. Previously the requirement for matching records using the NHS number has been driven by Business Intelligence risk stratification where data sharing issues have been a barrier. Detailed planning in the relevant workstream will identify the most effective means to do this, which will include consideration of whether there is a necessity to utilise the NHS number as part of pathways/processes across health and social care in terms of ensuring a sustainable approach.

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ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The SCC incumbent or 'host' case management system CareFirst v6 has a set of open API's that are been exploiting as part of a mobile working project. These API's are been accessed and routed through the SCC Integration Hub to deliver patient information to worker mobile devices. This same Integration Hub is currently utilised by SCC to exchange transactional messages between SCC and Highways Maintenance delivery partners and represents a capability that could be exploited.

As the information architecture has not been fully developed, the 'host' system for SCC would be CareFirst,

As part of an integrated approach to data, we are committed to investigating the adoption of a uniform information architecture across integrated services; that is, a shared model where each piece of information that supports either the patient/service user's journey on a pathway or underpins the KPIs as part of the Better Care Fund is fully agreed across the integrated service and linked to business processes. This would be a critical building block to inform what changes would be needed to support sharing of data.

Based on the business requirements that support realising the patient/service user's journey, we will review the existing data and system landscape to ensure they are streamlined and optimised in line with requirements. This will involve a mixed model of:

- Exploitation of opportunities to de-duplicate and consolidate Information/systems within participating organisations, reducing the overall number of systems requiring integration.
- Exploitation of opportunities to migrate information processing tasks across organisational boundaries within the integrated service, effectively recognising migrate as an alternative 'means' to integrate where a practical option exists to achieve the same 'end'. Business case here would be balanced against time\complexity to achieve by other 'means' and overall potential savings to the city from consolidation of licensing and infrastructure. And potentially consolidating the teams that gather the information?
- Integration of operational information/systems using APIs where appropriate.
- Appropriate integration of service wide tactical and strategic data to leverage the maximum value from it. Presented to relevant stakeholders as information to support decision making and strategic monitoring of the integrated services KPIs. This will involve adopting an enterprise approach to business intelligence and 'big data' with a future vision to exploit this further in the areas of predictive analysis and forecasting.
- In addition to mapping the system landscape against the patient\service user's journey, we will work backwards from the objectives we need to measure to ensure

the process efficiency, de-duplication and single version of the truth for this stratum of data.

Information systems will support the 'single plan' for a patient\service users across the integrated service, adhering to the following principles:

- The right information available to the right person at the right time, to allow effective care and safeguarding as appropriate.
- Recognise the patient\service user, supporting family members and friends as users of the information systems that support the single plan
- The right transaction functions available to the right person at the right time. Recognition of the wide functional variance between stakeholders. Those providing informal care will have a 'softer' , less structured view and experience of the plan, professionals will require this but also the ability to trigger and manage transactions as part of formal care pathways
- Development of a transactional 'layer' to manage the formal care pathway seamlessly with the narrative plan. Managing the internal workflow, provider engagement and underpinning the monitoring of services used to support requirement around patient budgets
- Availability of timely, accurate information relating to cost of services consumed and position against any budget constraints for each patient\service user. Information should derived from the transactional activity within systems and available without the need for manual collation.
- Security controls, permission levels and supporting governance in place to ensure access only to the appropriate information and transactional services.
- We are working proactively with Leeds City Council as a National Pioneer authority. We will maintain strong ties with Leeds as they start to decide on their architecture, through existing collaborative links with their Head of Public Service Integration.

SCC use CareFirst v6 and this has a range of published API's/Adaptors that we can use to integrate data. However, in terms of the submission I'm not sure of the overall application landscape and availability of API's/use of Open Standards is across the in-scope services across health and social care.

Based on the business requirements that support realising the patient/service user's journey, we will review the existing data and system landscape to ensure they are streamlined and optimised in line with requirements. This will include integration of operational information/systems using APIs where appropriate.

The scope of the programme work will give consideration to the role of GP systems and Mental Health Community Systems as enablers of interoperability and collaborative multidisciplinary team working, conscious of the fact that enabler that are not 'on' become barriers to integrated working.
We are scoping further work necessary to provide the information sharing capability that

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is both fundamental and pre-requisite to multi-disciplinary team working for Primary Care considering information sharing functionality across INSIGHT (MH), EMIS (GP) and the ICE (Integrated Clinical Environment) systems used at STHFT as E-discharge is expanded and linking directly to GP systems

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

SCC, including Public Health, has level 2 re IG Toolkit.

We do have a robust Information Governance Board in place with SIRO (Senior Information Risk Owners) and PIROS (Portfolio Information Risk Owners) as well as other key stakeholders who are at a strategic level within the organisation.
The IG Toolkit reference's the material to support our IG approach.

We are committed to ensuring that the appropriate Information Governance Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2. The CCG and the SWYBCSU have achieved Level 2 against the IG Toolkit.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The target group at high risk of hospital admission for local care planning purposes comprises individuals having a predictive risk score in the range >30 to ≤70. Those with a score greater than 70 are generally more suitable for active case management support. The high risk cohort for targeted support having a risk score >30 comprises 17,637 individuals (3.0%), **16,378** (2.8%) of whom fall within the >30 to ≤70 risk score catchment for care planning.

In Sheffield we use the Combined Predictive Risk model for risk stratifying our population, for which we have **100%** coverage of the GP registered population (n = 580,237 at 5th September 2014).

This ensures the information available to primary care teams for care planning and integrated care MDT purposes is always current

Individual predictive risk scores are updated monthly using 69 predictive variables

extracted from primary care and secondary care records. Primary care teams access their population predictive risk scores through a web based tool that additionally includes information for each individual on:-

- Key GP-recorded LTC diagnoses including mental health conditions.
- Biometric measurements including BMI, blood pressure and cholesterol.
- Lifestyle factors including smoking and alcohol assessments.
- Information about whether housebound, in residential care or having a carer.

The inclusion of GP diagnoses in the dataset enables separate risk stratification to be generated for particular cohorts of interest, including bespoke stratifications for those with mental health conditions; i.e. separate stratifications for those having a diagnosis of serious mental illness, learning disability, depression and for dementia.

During 2013 and 2014 we have had two pilot care planning schemes in operation in the city:-

- A city wide locally commissioned service to deliver 3,500 care plans (target risk scores 30-70) aiming to coordinate care in the community, help individuals manage their long term conditions and enable systematic, holistic multidisciplinary care planning for those who are at high risk of hospital admission, to improve their health and reduce the need for hospitalisation.
- A locally commissioned scheme in one of the four localities (target risk scores 30-50 to deliver an additional 3,000 care plans). 87 out of our 88 practices have signed up to the national admission avoidance DES scheme, aimed at delivering care plans to 2% of the high risk population.

The local care planning approach is set out in more detail in response ii) below, and progress with delivery is set out in response iii).

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ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Our vision is that for every person in Sheffield who is in need of support that they will have one care plan, developed with the support of all key health and social care professionals involved in their care. This plan will be owned and understood by the person and will incorporate the individual's own goals for their health, and the actions which they can take to improve or maintain their health.

There is a requirement for GPs (under the national Enhanced Service for reducing unplanned admissions) to establish care plans, and our future plans therefore build on this basis, rather than developing something completely independent of this.

As part of our journey towards this, we are seeking ways in which information within the

NHS patient record including the predictive risk score can be shared with Adult Social Care. A core element of this is to incorporate the NHS number as a person identifier into the adult social care record. This work is continuing under the programme arrangements.

As part of our local city wide care planning scheme we have included the requirement for patients to be discussed at an MDT. The intention was that this would include representation from Adult Social Care. Our evaluation has found that this is not always the case so this work has been brought under the formal oversight of the programme and s part of our plans for the next stage of local care planning we are proposing support from four locality teams, which includes representation from Adult Social Care. The aim is that these teams, as leaders of change, will help to develop methods of including social care assessments in the process, in a way that is effective in terms of time management for both health and social care staff.

The 2014/15 GP contract requires a named GP as the accountable lead professional for over 75s and also specifies that there should be a named co-ordinator for people on a care plan. That person will vary according to the needs of the patient, and whilst for some the most appropriate person will be the GP, for others it may be a community nurse or a practice nurse, or potentially a community support worker. As part of the development of the business case for the programme we are looking at End of Life Care, and we will shortly be piloting some work in the north locality, which gives district nurses a specific role in care co-ordination for patients who are on the palliative care register. This will be evaluated to estimate the benefits and to assess whether it would be appropriate to establish this across the city for this group of patients as part of the programme.

Our proposals for the local care planning scheme, following on from the pilot scheme described above, involve the CCG continuing to invest in a city wide scheme. This will build on the national enhanced service scheme and will include payments to practices to cover the cost of supporting patients to self-care, the use of the Patient Activation Measure (PAM), ensuring the most vulnerable groups are included, the use of MDTs and patient led goals for all plans. This approach will be supported by centrally co-ordinated training on the principles of care planning, the use of the PAM, supporting practices with practical issues together with training on more developmental topics including motivational interviewing. In addition, the CCG aims to fund a support team in each locality that will consist of a GP, practice nurse, practice manager, primary care development nurse, social services staff member, community nurse, pharmacist and IT specialist, who will be able to visit practices to provide support or to be proactive in engaging with practices where they appear to be having difficulties.

Before starting the local city wide scheme we undertook an Equality Impact Assessment and we intend to evaluate how many of the patients with a care plan had a diagnosis of

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learning disability, mental illness or dementia. There was also a requirement within the service specification for the GP care plan to link in with the care plans developed by mental health services. A GP system electronic template has been developed to ensure that patients with mental illness are assessed for physical health problems, and this will be an integral part of the GP care planning template. The Right First Time programme carried out a consultation into improving the physical health of people with mental health problems in October 2013. Anticipated benefits are being assessed as part of the Programme. The evaluation will require practices to review their care plans to identify how many of those include people with mental illness, learning disability or from an ethnic minority relative to the proportions within the practice population, and to develop action plans to redress the balance if it found that these groups are not proportionately represented in the care planning process.

The early findings from patients are that the majority of the people had a positive experience, finding it reassuring and helpful. Just under a third made changes as a result but many found that their physical health was a barrier to change. Not all patients were aware that this was something different from usual GP practice but most felt involved in their own care.

The reports from healthcare professionals show a varying enthusiasm for care planning and a very wide variation in their confidence and skills in undertaking the process. Staff reported that they felt they were learning as they went along and there was a need for more training and guidance.

We look forward to developing our project and benefit plans for care planning as a key part of the programme

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

As at the end of July, **2577** GP-led care plans have been completed for people with a risk score of between 30 and 70 under the pilot city wide locally commissioned scheme that continued until the end of August. The total population at high risk is **16,378.**

We have learned from our experience in the pilot and the early evaluation that in some practices social care workers have been actively involved, but this has not happened throughout the city. In our plans for the new scheme starting in November 2014, we are seeking ways of supporting better engagement with Adult Social Care. We look forward to further defining our plan and milestones for 2015/ 16 following final numbers and report.

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A detailed evaluation of the city wide scheme has begun, which includes a survey of healthcare professionals, focus groups of professionals and a peer-led telephone survey of patients.

Within the pilot in the north locality, a further 2500 care plans have been completed and the evaluation of these is in progress. 3000 in total are anticipated once data collection is complete, making an anticipated city wide total of around 6500 care plans resulting from the two locally commissioned schemes.

Practices are also completing care plans for 2% of their population under the national 'Enhanced Service for Reducing Emergency Admissions' and the numbers for these are reported to NHS England in the first instance. We understand from the NHSE Local Area Team that data will not be available until October.

We look forward to producing our project and benefits plans for care planning as a key part of the Programme for integrated Commissioning

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8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Engagement in Vision & Development of Our Plans
Patients, service users and the public are being engaged in the development of our strategy and will be further involved in the development of our programme and plans. Engagement will commence in October 2014 as soon as the programme is resourced and ready to hold an ongoing stakeholder dialogue.

Sheffield's Health and Wellbeing Board has been engaging closely with Sheffield people and with providers of health, social care and wellbeing services in the city on the topic of integration since its establishment as a shadow and then as a formal Board in April 2013. Through this wide range of engagement activity in the vision over a number of years, we are confident that the vision that we articulate in this plan for an integrated health and care system in Sheffield is widely shared. For example, over 1,500 members of the public, as well as commissioners and providers, helped us to identify our priorities for our Joint Health and Wellbeing Strategy.
Patients, service users and the public have been involved in discussions about our plans for integration as discussed previously in section 1.2. We have a significant amount of information on public opinion and preferences from consultations and engagement

events.

As a component of our approach to communicating in a way that is clear for members of the public and partners to understand, we produced a six-page public information document setting out our plans for integrated commissioning, including the Better Care Fund. This was published in early March 2014, providing the opportunity for those interested to register their interest in being involved in the developmental work in 2014-15. To date, over 200 people and organisations have registered an interest and we will be communicating with them about how they can be involved going forward.

We also attended Healthwatch Sheffield's Interim Governing Body on 17th March 2014 to talk about our specific plans. Healthwatch Sheffield have a key role in representing Sheffield peoples' views and in bringing these together coherently to the city's Health and Wellbeing Board.

Building on a strong record of engagement of Right First Time Programme
We have also been engaging providers and Sheffield people for the last two years on the integrated health and social care services agenda through our RFT Programme and Future Shape Children's Health Programme. It is with this background and experience that we have developed our plans for the Better Care Fund.

We have disseminated the National Involvement Partnership 4PI National Involvement Standards (NSUN 2014) re-launched at the Creating Connections conference in June 2014

Over the past year the RFT programme has been collecting patient / service user experience. We have been asking people to vote for the top 5 questions to ask when measuring success in Right First Time. Early in 2014 a national set of user experience questions were commissioned by the Department of Health. In order to be able to compare results nationally, the reference group voted on which of these aligned the best with their top 5 questions. The result is that the Reference Group have chosen 7 key questions; one of these is locally derived and didn't come up in the national Picker Institute set. Intermediate care, active recovery have agreed to implement the Picker Institute measures of patient / carer / user experience of integrated care, but we don't yet have enough data to report. Importantly, this provides us with a scale for measuring satisfaction that includes asking people whether we met their emotional and psychological needs as well as their physical needs. They rate the degree of involvement to which they themselves and also their family were involved. It also asks users how well coordinated they think our teams are and whether they know who to contact and to rate the attitude of those they come into contact with.

We want to move away from scores like 'satisfied' and 'unsatisfied' which can be meaningless in the context where the service participant is in no position and not equipped to evaluate the service. As part of the development of our programme quality

and outcomes framework we will be developing a single combination metric to understand care service quality as experienced by the participant against these 7 dimensions of service quality. While we appreciate that the tool must be service agnostic it does need development in relation to environmental and setting factors which have a powerful influence over service quality as experienced. We are planning to pilot the same tool for use by those providing the service and assess the degree of correlation between the views and opinions of those providing the service and those receiving it as part of planning for improvement. Research (Parasuraman et al) indicates we should expect a strong correlation and if this holds in our pilot, we may the front-line view may be used as a proxy where it is not practical or possible to carry out a full user analysis. See Part 2 Tab 6 HWB supporting metrics for our baseline and targets for user experience. See Appendix 2.

Lessons for Engagement for the Integrated Commissioning Programme

A critical success factor for the Programme is to build on what we have learned about engagement from RFT:

- To effectively measure service user experience in integrated care, there is a need for services to use consistent data in their questionnaires. (See OPM evaluation for Transitional Care). The 7 killer questions are a robust basis, based on the DH Picker Institute questions and tested with Sheffield citizens at Healthwatch events and RFT reference group.
- Roadshows/events are only so effective; citizens would like to be and have shown to be more successful when they are involved more holistically in a project. This can vary in terms of involvement from members of focus groups, to board members to user representatives on working groups. See evidence from Communities got talent event, attached documentation from RFT representatives.
- Citizens need to be involved from the beginning of a project when it involves service redesign. If involved when designs and principles are already decided it limits the power of change for the user.

We have organised a range of engagement opportunities for members of the public and providers to influence our vision and strategy. This has included:-

- A number of engagement events that have brought together a range of individuals and organisations, including our key providers.
- Specific work with a wide-ranging group of citizens, providers and other organisations.
- Work by Healthwatch Sheffield with members of the public and Health and Wellbeing Board members.
- Consistent communication with members of the public and providers through publishing presentations and papers online, and sending out our monthly e-bulletin, as well as using other communications tools such as our popular Twitter feed.
- Engagement work done as part of our RFT Programme, which has a well-supported Citizens Reference Group, the learning from which, as with the RFT Programme generally, has informed our integrated commissioning plans.

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Feedback related to Specific Initiatives
In addition to the body of feedback and case studies regarding individual experiences, we have also established projects that have helped us to learn what integration means on the frontline for providers and customers in relation to particular projects and initiatives. One example of this is the Lowedges, Batemoor and Jordanthorpe Project. We have been careful to learn from this as we further develop our plans for integration.

Best Practice in Engagement
The programme will also aim to engage people in line with best practice, and we are using our understanding of Community Engagement for Reduction of Health Inequalities (CERI), and in particular the Marmot Review of Health Inequality 'Fair Society, Healthy Lives' which identifies factors which modify health risk such as smoking, alcohol abuse, substance abuse, obesity. We aim to build in best practice theory about the effectiveness of engagement models using the principles of Lay-delivery of messages, involvement in design and empowerment. Before starting the local city wide scheme we undertook an Equality Impact Assessment and we intend to evaluate how many of the patients with a care plan had a diagnosis of learning disability, mental illness or dementia. We will be carrying out EIAs for all schemes. We are aiming for 'values-based' commissioning; the views and experiences of people who use services have equal weight to the scientific and research evidence. We aim to make decisions based on values (people's views and experiences), as well as facts. In practice this means we will aim to involve people who use services at every stage of the commissioning cycle – not just at the end when it's too late to have real influence. See http://www.jcpmh.info/resource/guidance-values-based-commissioning-mental-health/

People will also be involved in the development of our own programme's own quality and outcomes framework to ensure it takes account of individuals with high needs and those from disadvantaged groups and areas of the City, addressing health inequalities through increasingly personalised services. The programme will measure as part of its quality framework the perception of users and public in rating the effectiveness of the proposed new integrated services in improving access, experience and outcomes for individuals and groups from business case development to benefits realisation.

Diverse Forums & Groups
Adult social care has an engagement programme that includes facilitating/supporting a range of groups that focus on adult social care. Some but not all focus exclusively on adult social care issues. These include:

- Learning Disabilities Partnership Board and reference groups
- Mental Health Partnership Board and reference groups
- service users and statutory reps.)
- Service Improvement Forum (physical disability and sensory impairment service user forum. Chaired and led by service users of adult social care. (all except LD))

- Carers & Young Carers Board and reference group
- Right First Time Citizen Reference Group

Adult social care also engages with a range of other organisations and groups which have an interest in adult social care e.g. Partners for Inclusion (board for physical, sensory and cognitive impairment), Disability Sheffield and 50+ and Be network (user led organisations) Links are initiated and maintained with a wide range of groups with particular emphasis on seldom heard groups e.g. member of the SAVE network.

There is also an Equality Hub Network (new local authority network that reaches groups protected under the Equality Act, including older people, people from BME communities, LGBT groups and other disabled groups (e.g. people on the autistic spectrum) not otherwise reached

Seldom heard groups have been a particular priority, with significant work undertaken e.g. :

- Serious mental illness consultation – in depth interviews recording preferences for service design and recording barriers to physical health for those diagnosed with serious mental illness.
- Survey of parents of under 5's from the geographical areas most over represented in attendance at A&E.

More widely the Programme is looking forward to building on a strong track record of involvement covering a range of forums, meetings and groups :

- Active citizens reference group formed with 50+ members to help with culture change and shaping of Right First Time and oversee involvement work
- 50 people engaged in a consultation looking at the relationship between physical health and activities for people with serious mental illness
- Deaf community consultation on the overall principles for Right First Time- report fed to RFT senior teams
- 6 focus groups held with reference group members to guide individual involvement projects, design surveys and plan meetings.
- 3 volunteers trained and carrying out surveys with GP patients who have received a new holistic care planning session. 49 surveys completed. Interim results available soon.
- Over 160 parents consulted as part of the Urgent Care Review for Sheffield Children's Hospital
- Two citizens reference group members elected and involved in RFT project 4 (physical health and serious mental illness).
- Consulted widely on the metrics for service user satisfaction – to be used in the evaluation and analysis of Right First Time
- Collected experience stories from a wide range of people through postcard distribution to help feed into project's analysis and to assist with design templates

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- Citizens commented on GP templates, letter invitations, results template and Common Childhood Conditions information in focus and readers group.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

- A clear description of who the main providers are across
    - NHS Trusts and FTs
    - Primary care providers
    - Social care and the voluntary and community sector
- A description of how the organisations have been engaged in the development of the plan and how they will be engaged on an ongoing basis, mentioning specific meetings, forums and representative groups
- Confirmation that the implications of the BCF delivery have been reflected in their operational plans

i) NHS Foundation Trusts and NHS Trusts

There are three Foundation Trusts in Sheffield – Sheffield Teaching Hospitals (STH) provides most physical care in hospital and community settings, Sheffield Health and Social Care (SHSC) provides mental health and learning disability services and some community physical health services, and Sheffield Children's Hospital (SCH) provides children's hospital and community services.

Service users, carers, clinicians, allied health and care professionals and social workers and families will be involved in programme decisions about the development of integrated models.
We understand clearly that user involvement needs to be designed into the programme from the beginning in order to be successful. We know users want to work with managers and clinicians as equal partners (as the recent NSUN report shows http://www.nsun.org.uk/about-us/our-work/commissioning/values-based-commissioning/)
Our aim has been to reflect that engagement in both the way the programme is organised (outlined in section 4) and though its activities and values.

Research concludes that pathways designed by professionals have been between 200% and 300% more effective than those centrally derived by central government or imported from another organisation (Bandolier, 2004 Effectiveness of Care Pathways)

After we have drafted our business cases and submitted our plan to NHS England we are scheduled to produce our stakeholder strategy and communications plan and run our Programme Vision Event where we introduce all stakeholders to the programme, its

objectives and their role in making change happen. After the design workshops we will produce the programme stakeholder map indicating people's current levels of interest Vs their influence and we will produce a stakeholder engagement plan outlining the differing actions we need to take to engage those who we need to be participating fully Vs. those we want to be actively coproducing Vs those we want to be consulting Vs those we need to keep informed.

We will ensure that all are jointly engaged in the design of the model of integrated care to be delivered. Users and front-line staff are co-producers of the service experience. As such they are the key holders in unlocking ways of improving the experience. Front line staff are well placed to understand people's perceptions of the service as well as how the service could be different, to better meet their needs. Service-user and carer knowledge, and front-line staff knowledge will be key to organisation understanding how best to integrate the service. Redesign of care processes, together with the knowledge transfer will take place in the cooperative project working groups

Our programme has established formalised structures 'cooperative working groups' for projects and workstreams that promote the active participation of professional staff in the development of the models to be commissioned. The programme structure gives us a means to provide a formalised method of engaging a range of stakeholder but with assured oversight over who how and when

The main provider to be affected by the BCF proposals is Sheffield Teaching Hospital NHS FT, which is both the main provider of acute adult services and community services for Sheffield. We have had meetings at Chair/CEO level and then with their Director of Finance and Director of Planning/Operations in August and September including on specific issues such as the 3.5% planned reduction in non-elective admissions. As noted in Annex 2, STH shares our ambition to reduce non-elective admissions and is confident it can manage the consequences of that reduction, but is not yet assuming it will happen.

The FTs have been part of Sheffield's planning for integrated care since the inception of the RFT Programme in 2011, which was based upon a series of clinical conversations led by the then PCT's clinical directors and the medical directors at the Foundation Trusts. The RFT Programme involves the Chief Executives of five partners at its Programme Board, its Operational Group and in the Project Groups. There has therefore been significant provider involvement in all aspects of RFT, which in turn has developed the principles, particularly on keeping people well in their communities and on intermediate care, that inform our integrated commissioning plans.

The project working groups of the programme are hubs where products are co-produced and members review, validate and decide on key outputs. Our model is not one where models and solutions are created up by commissioners in isolation and then consulted on, but a cooperative one from start to finish where involvement is threaded in all the way

through from ambition to business case to delivery benefits review.

This allow a range of professional staff to review pertinent issues relating to care practice and safety and compliance and remain involved

Our aim is to ensure nursing and allied health professional input to these groups so that we ensure integrated models are not just flexible and deliverable but are in line with the high standards of clinical quality.

Our Integrated Commissioning plans are currently focussed primarily on older people and therefore STH and SHSC have been more closely involved than SCH.

ii) Primary Care providers

Most of the initiatives in our schemes covering such areas as care planning, Active Recovery and other intermediate care services, are initiatives which have been progressed through the city wide RFT Programme. GP practices in the city have been supported to come together in GP Associations and have formed a provider assembly. Through this they have been involved in the RFT Programme and hence have been briefed and party to discussions on the key initiatives which are now being taken forward via the BCF.

Our stakeholder engagement plans will include practice forums and the LMC and each project working group of the programme will have a locality manager, GP and nurse on it, and there is GP as a member on our programme board. We have held meetings with practices and local voluntary organisations in each of the CCG's localities, focussing on the 'Keeping people well in their communities' workstream, which have been well attended.

iii) Social care and providers from the voluntary and community sector

Health and social care providers were involved in all of the ways outlined in the section above, but we have also discussed the plan's ambitions and content with:-

- A select but roughly representative group of providers at a special Health and Wellbeing Board meeting on 30th January 2014 (providers are not formal members of the Health and Wellbeing Board).
- Our Integration Advisory Group, a mix and cross-section of providers (as well as members of the public and representatives from non-provider organisations), on 10th January and 12th February 2014.
- Providers that have expertise in delivering services that we want to develop as part of our wider integration work.
- Local VCF organisations as part of the meeting with practices described above.

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In addition, ad hoc and informal discussions with providers have been taking place through the duration of our planning for the Fund, not least as part of regular update meetings between the Chief Executives of Sheffield's Foundation Trusts, the CCG and SCC.

As planning for the Fund develops in 2014-15, we anticipate holding several events and co-production sessions with our providers. We see it as vitally important that we work with and develop the supplier market effectively to help us deliver our shared ambitions for Sheffield.

Work planned for 2014-15
We plan on doing further more focussed work, including with Healthwatch Sheffield, in 2014-15 to ensure that our plans and service specifications reflect the views of Sheffield people, service users and their carers.

The first stage in this focussed work has been to produce a public-facing information document which summarises the information set out in the original Better Care Fund submission. We plan to update this as new information becomes available. We have also introduced an online form where people can register their interest in being involved in the different elements of our plans over 2014-15. Once we have a good idea of how and where people want to be involved, we will produce an engagement plan.

We are also working with Think Local Act Personal to establish genuine and active engagement with Sheffield's communities as we develop our proposals. This may incorporate the following themes:-

- Integrating around people, especially those with two or more long-term conditions; valuing and further developing people's own skills and life experience alongside the expertise of practitioners; changing the expectations of both people and practitioners to enable this to happen.
- Building, using and contributing to community capacity, so that people can more effectively support one another but also benefit from contributing to their local communities.
- Engaging with small community organisations and encouraging providers to adopt a localised consortium approach so that small community organisations can play an active and creative part in an integrated health and care system.
- Influencing as well as directly commissioning, recognising that some services such as buses and shops are vitally important but are not directly commissioned by either the NHS or the local authority.

Sheffield's Health and Wellbeing Board is also considering creating a wider provider forum (alongside its existing engagement events) which we expect would also consider such issues.

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c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

In relation to determining the reduction in emergency admissions performance target for 2015/16, the finance and information teams at the CCG first reviewed the pre-populated activity information within the BCF template. We have taken some time to reconcile this information back to our operational plan submission and importantly to the information we have previously provided to our main acute provider (STH FT) in relation to our non-elective admissions QIPP plan for 2015/16. We can supply this detailed reconciliation if required. This formed the basis of our discussion with the Trust in relation to activity impact contained in Annex 2.

We have been able to demonstrate that the 3.5% reduction we have included for the BCF is compatible with the QIPP reduction within our contract arrangements for the financial year 2015/16. Clearly it does not agree exactly because the 3.5% uses Q4 of 14/15 and first 3 quarters of 2015/16 and not a full financial year and is on a resident not registered population.

We believe using 3.5% for 2015/16 is reasonable because it reflects our existing operational plans. It is part of a 5 year plan which the CCG has already put forward designed to save 20% of adult emergency admissions over the 5 years. We have reviewed the trend data produced by NHSE and issued with the assessment guidance but believe it is not particularly useful as for example it has not isolated out specialised services.

The way Sheffield has constructed the BCF is to include spend on emergency admissions within the BCF, so the budget shown for emergency admissions in the BCF is net of relevant QIPP savings. (These are a sub set of the £3.6m – element relating to emergency medical admissions only.) We can confirm there is no double counting of savings.

Because the BCF also includes the investment intended to support delivery of these savings, e.g. the expansion of Active Recovery and the maintenance of other budgets, the savings are effectively recycled within the overall BCF budget.

Joint modelling with STH FT (i.e. P Harriman model used by Right First Time programme to determine Active Recovery numbers and hospital flow) has been undertaken on what might happen in terms of acute bed requirements if patient flow within the health and social care services in the city is optimised. Thus we are looking not just at emergency admission reductions, but also reductions in length of stay and reductions in numbers requiring long term care.

STH FT have indicated in Annex 2 that they recognise that the impact of the planned reduction in admissions (after allowing for demographic growth factors) could be 1 to 2 wards if these occur. They have been clear that this is not yet within their operational plans as they remain unconvinced that a net reduction in admissions will emerge for the reasons they set out. However, it is important to point out that £3.6m is only a very small (less than 0.5%) of total income of this very large tertiary provider and should this income loss emerge it would not be destabilising to the trust. The trust would in any case be able to mitigate the income loss by removal of direct costs (as indicated in Annex 2). The level of staff turnover within the trust of this size should allow for 1 to 2 wards to be closed within normal turnover. We have already seen significant expansion of community services over the last 3 years and this has included redeployment of both SCC and STH staff into the expanded community services.

In addition it is important to point out that a substantial proportion of the investment agreed through the RFT programme has been with the intention of reducing delayed discharges and length of stay in the hospital as this can be demonstrated to bring financial benefits to both commissioners and STH FT, as well of course as being better for patients. We have shown the anticipated financial benefits as far as we are able to quantify at this stage into tab 4. We have seen improvements over the last 2 years and expect this trend to continue. This is a key priority for the Trust and we understand that financial benefits from achieving reductions are factored into their CIP /operational plans, but we are not in a position currently to include in our benefits assessment on tab 4. The BCF scheme 4 in particular includes investment to allow initiatives such as the expansion of the Active Recovery service to be maintained to support reduction in length of stay. This gives the trust potential financial savings against PbR tariff income where reductions in bed nights are before trim point, fewer outliers and cancelled operations.

As part of completing the re-specification of other services (schemes 1 to 4) we will be considering the implications for providers and level of market maturity to respond.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

Investment – applies to all schemes Figures for both costs and benefits are currently being established for all schemes. For 2014/15 Sheffield City Council and Sheffield City Council have both put aside funding for business case development and implementation planning. The working assumption is funding of £200,000 per quarter from July 2014. This is for project and programme resource beyond the substantive staff identified within both organisations to be involved. The CCG has identified its share from within its Running Cost Allowance. The two partners envisage that for each of the large commissioning themes further non recurrent resource will be required in 2015/16 and have set aside an initial budget of £500k.

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Scheme Ref No. 1

Keeping People well in their Communities - Community based services

What is the strategic objective of this scheme?

Increase the wellbeing of people at greatest risk of declining health and loss of independence – reducing demand and dependency on the formal health and social care system.

This strategic objective clearly aligns with our overall health and wellbeing strategy and in particular our aim to '*establish more preventative and targeted approaches to help people stay healthier for longer and avoid hospital and long-term care*'.

Overview of the scheme

The Model
A co-produced and flexible outcome-based prevention model delivered in local communities that will reduce the pressure on health and care services by an estimated £4.9m over 10 years.

The model is based on the powerful ingredients described below, which our pilot work, and the national evidence base has shown that when mixed together in the right way for a local community, can deliver demonstrable benefits for individuals and the wider health and social care system.

The Ingredients

- **Identifying people at risk of declining health and wellbeing (Risk Stratification).** The city's 88 GP practices already operate a city-wide risk stratification model, which we plan to expand to include social as well as health factors. Our workers in pilot areas also collect intelligence on people at risk from frontline staff (including housing officers, shop workers, district nurses).

- **Local advice and information** to help people maintain independence and wellbeing – including innovative models of delivery. For example, our pilots have trained local hairdressers and shop staff to spot signs of deteriorating health and wellbeing and provide initial advice on who people should contact.

- **Community assets / activities tuned to the needs of people at risk.** Our model relies on not only developing community assets and activities – but making sure

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they are focused on, and reached by, people at risk of declining health and wellbeing. This relies on smart local needs assessment, strong local partnerships, and the effective local management of the whole model. Our work in this area builds on the learning from the Think Local Act Personal (TLAP) Partnership's Building Community Capacity workstream[1].

- **Support workers on the ground doing 'sort and support'** – connecting people at risk to community activities / support that helps them to be independent and well; making sure people have a 'winter plan'; encouraging people at risk to access health checks and self-care advice; arranging one-off fixes such as ensuring glasses prescriptions are up to date, finding a cleaner, de-cluttering, matching to transport options, arranging handy-persons and tele-care support

- **'Life navigators'** to provide more intensive support for people who are at high risk of declining health and wellbeing, have no family or friends to support them and do not access social care. Support includes: helping people as they return home after a stay in hospital (this will link to other work in the city regarding shortening the length of stay in hospital); (re)connecting people to local activities and social networks; supporting people during the life events that can easily derail people (such as a bereavement, a fall, a period of ill-health); helping people manage everyday problems often associated with ageing (such as managing appointments, correspondence, shopping and household and health management)

- **'Wellness plans'** for people that set goals and what the individual and others will do to help

- **Responsive multi-disciplinary teams** working seamlessly with support workers and the voluntary sector

Who Will Receive the service? - Patient Cohorts
The CCG uses a combined predictive model to give each patient a score of between 1 and 100 as an indication of likelihood of hospital admission in the next 12 months. The Keeping People Well project uses this as the starting point for its risk stratification and focusses on patients with a score of between 25 and 60. This list is then further refined using Social Care, housing and other data to produce a list of patients where proactive engagement begins. In addition there is a more general referral process that enables anyone in the community (with the persons permission) to refer someone they may have concerns about. There are approximately 18,000 people in this cohort across the city.

[1]TLAP, Building community capacity website http://www.thinklocalactpersonal.org.uk/BCC/

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Where and when will the service be delivered?

Phase One – 2015/16
We plan to implement the above model in 2 out of 4 GP localities (covering half the population of Sheffield) targeting approximately 9,000 people. The areas covered will depend on the readiness of the provider partnerships in different areas of the city – something we are currently assessing. We envisage the market will require a great deal of support to deliver this model in the first year; however, once the approach is established and the right mix of ingredients is in place, delivery will be increasingly commissioned on an outcomes-basis (potentially with hard incentives based on reduced health and care demand) from local consortia of providers made up (most probably) of GP practices, VCF organisations and the private sector.

Running in parallel to this will be a programme of work to prepare the provider market in the remaining two localities for phase two.

Phase Two - 2016/17
Applying the learning and building on the preparatory work done in phase one, we aim to roll out the model to the remaining two localities, targeting the remaining (approximately) 9,000 people estimated to be at risk.

The delivery chain

The delivery chain
Using learning from local and national projects we have worked with patients and providers to develop an outcomes framework for the overall model. The headline outcomes are shown in the blue hexagons in the diagram below. We are currently asking the provider market to assess their readiness to deliver these outcomes.

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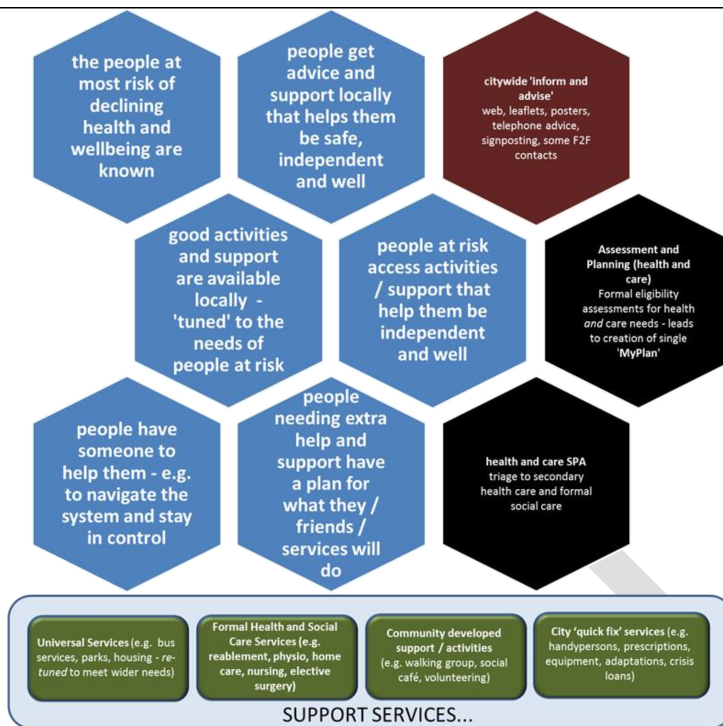

Diagram 8: Blue hexagons show target outcomes

The service for phase one will be commissioned jointly by the City Council and CCG. No one provider could deliver all of the ingredients necessary for the delivery of the outcomes framework. Therefore we anticipate the providers to be GPs, Sheffield Teaching Hospitals Community Services, Adult Social Care, private sector health and wellbeing providers and voluntary community and faith groups.

We will work with the potential provider market to re-shape activities in line with the outcomes framework and facilitate the development of consortia to commission and deliver locally in further phases.

The evidence base

Sheffield has used the feedback and input from local people, a range of practitioners and where it is available national evidence to refine the approach.

The learning from local pilots was evaluated externally and the findings compared with national evidence and found the following:-

- A Kings Fund report identified factors that needed to be in place to ensure integrated care and prevention work were successful. These factors align well with the findings from the pilot evaluation. (Ham, C., et al, 2013, Making Integrated care happen at scale and pace, King's Fund, pp.3-7).
- Sheffield City Council Public Health team recently conducted a wide ranging national and international literature review of national and international evidence of successful prevention and early intervention work. The review showed that Sheffield's approach

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concurs with the evidence that is available – particularly regarding optimum patch size and the partnership between communities and practitioners to keep people well

- The development of our approach has been supported by Think Local Act Personal to ensure that it builds on what has been learned nationally
- The qualitative evidence from the pilot evaluation shows that the intervention was well received by clients and professionals alike, and there was a shared perception that the intervention had a positive impact on the quality of people's lives.
- The quantitative pilot evidence is not on its own entirely conclusive due to the scale of the pilot and the length of time that the data has been tracked. However, early indications are that it is making a difference locally to the use of health and social care services as well as improving quality of life. We need to test the approach at a larger scale and for longer to build up our evidence base to further inform the Keep People Well in their Local Community approach

We feel confident that taking information from local people about what they have told us they need to stay well, combining this with the national evidence that is available and practitioner input we are pursuing the right course of action.

Investment requirements for Scheme 1

Keeping People Well in their Communities

See Part 2, Tab 3, HWB Expenditure Plan row 9, row11, row 12
2015/16

£560,000 (CCG)
£3,379,000 (SCC)
£4,232,000 (Charity/ Voluntary Sector)

Impact of Scheme No. 1

This scheme will have a major effect on reducing non-elective admission activity target of (2,018) or £3.6m for 2015/16. The benefit from this scheme will deliver over the medium/ long term. The benefits plan will indicate what portion of benefit can be delivered in 2015/16. Full benefits profile of the scheme and assumptions to be worked up
It will also have an impact on the reduction in the reduction in permanent residential admissions activity – target (25) £650,000

Risk stratification
The people at most risk of declining health and wellbeing are known
Local inform & advise: People get advice and support locally that helps them to stay safe and well
Sort & Support: People at risk are connected to community activities / support that helps them to be independent and well

Community Asset Development: Good activities and support are available locally
People are Supported to live healthy lifestyles
Care Planning: People needing extra help and support have an agreed plan for what they, friends, family and services will do
Life Navigation: People have someone to help them navigate the system and stay in control

The combination of the above will:

- increase quality of life
- contribute towards reducing usage of secondary and primary care
- reduce the number and level of social care packages
- Lead in the medium-term to the release of resources to meet financial targets and / or be reinvested in further developing community based prevention and early intervention work

- Describe the **feedback loop** in place to understand where services are working well

Sheffield has developed a systematic approach to collating anonymised health data from primary and secondary care into a data warehouse on a monthly basis. This is supported by robust information governance arrangements including data sharing agreements. This data warehouse contains detailed primary and secondary care information relating to 580,000 individuals (the whole registered Sheffield population). The dataset includes information about diagnosed conditions and biometric measurements at the individual level in a format suitable for use by integrated care teams. This can be linked at the individual level to data on secondary care utilisation and expenditure, enabling any of these population attributes to be risk stratified using predictive risk scores. We plan to include social care data in the warehouse in 2015 when we have completed work to include the NHS number within all social care records.

This dataset will allow us to monitor at an area level the impact of our rollout of Keeping People Well in their Communities– providing a direct feedback loop to inform the further development and refinement of the approach.

We are developing specific performance measures in line with our outcomes framework and the strategic context we are working within. These measures are subject to negotiation with providers and co-production with a range of stakeholders. However, they are likely to include:

- Hospital admission rates amongst the target population (those with a risk score of between 25 and 60) in the areas covered by the new approach (including related costs)
- Demand for and cost of social care in the geographic areas and population groups covered by the new approach
- Overall wellbeing data for the target population

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Much of the hard health and care cost and usage data exists and will be collated in our data warehouse. However, we still have some work to do on the wellbeing measures, which will require new or adjusted surveys including:

- Customer / patient satisfaction surveys
- The Sheffield loneliness index (developed by South Yorkshire Housing Association who lead on our ‘Ageing Better’ partnership)
- Measures of community provision activity, capacity and its ability to meet the needs of people at risk of declining health and wellbeing
- Health and care practitioner views

What are the key success factors for implementation of this scheme?

The scheme is based on the logic that IF the ingredients described earlier are delivered *in the right way* within communities they will achieve the outcomes described in the outcomes framework diagram earlier. The evidence base gives us confidence that if we can achieve these outcomes together across a community we can achieve our overall strategic outcome of increasing the independence and wellbeing of the at-risk population, thus achieving a reduction in dependence on and usage of the health and care system in Sheffield.

We are confident that ‘what’ we are proposing is aligned with our strategies and based on solid local and national evidence. However, we are also aware that our success depends equally on ‘how’ these ingredients are mixed together and delivered. This is the focus of our preparation: getting the ingredients of the model right whilst recognising the interdependencies between each ingredient and the need to be adaptable to the needs and infrastructure of different communities.

The text below describes the key success factors for each ‘ingredient’ of the approach, and how we will ensure delivery.

Risk stratification

Our risk stratification approach is universally used across primary care and correlates very strongly with use of secondary care (as measured by cost of hospital usage – see graph below). However, we need to include other social factors within the risk score to enable us to target our interventions more intelligently. Getting this expanded approach to risk stratification in place will be a key success factor – in particularly if we are going to support people to improve their individual independence and wellbeing. If we cannot expand risk stratification, we will use more informal methods for the identification of people at risk as we have done in our pilot areas (e.g. referrals and intelligence from local people, calls to our contact centre etc.). This *may* compromise the delivery of the full potential benefits of this scheme and this will be closely monitored during phase 1.

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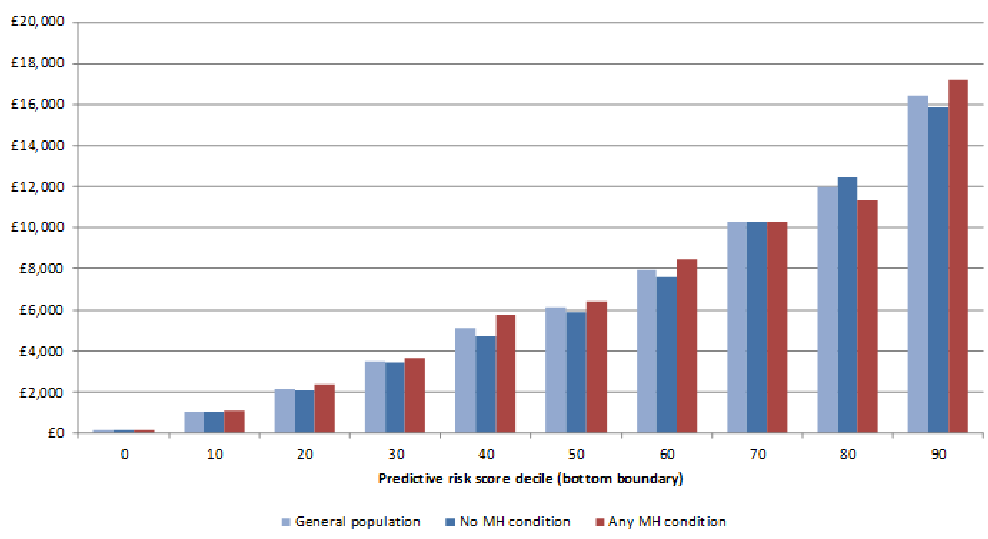

Diagram 9: Graph showing 2013/14 expenditure on all secondary care activity by risk decile (excluding maternity)

Local inform & advise

Our pilots have demonstrated the importance of information and advice being available locally. Critically, the pilots have also shown that networks of knowledgeable local people and practitioners are highly effective at providing the vital information that connects people at risk of declining health and wellbeing to the support available to help them to increase their wellbeing and independence. Getting these 'knowledge networks' in place is a critical success factor; however, the pilots have shown that these networks take time and energy to develop. Our plan is to make sure that the people delivering the 'sort and support' role spend a proportion of their time (a) nurturing local networks so that they can provide information and advice; and, (b) creating and contributing to better reference material on local activities and support so that local people and practitioners can quickly identify and access support.

Community assets / activities tuned to the needs of people at risk

Our model relies on not only developing community assets and activities – but making sure they are focused on, and reached by, people at risk of declining health and wellbeing. Critical success factors will include strong local needs assessment (based on the intelligence gathered by 'sort and support' workers and other practitioners), strong local partnerships, and the effective *local* management of the whole model (the mix of ingredients).

Our approach to making sure these success factors are in place will be to encourage, develop, and support local provider networks to work *together* to deliver against the outcomes described previously. This should enable a staged devolvement of central budgets to community level consortia (e.g. current lunch club funding, voluntary sector

grants) – leading to a phased move from output-based smaller contracts to more outcomes-based commissioning (whilst maintaining and increasing the diversity of local service provision). Over time a proportion of the savings to the overall health and care system achieved as a result of community-level activity will be re-invested in increased development and delivery of community activities – allowing us to deliver further savings as provider networks learn from and refine their approaches to achieving outcomes.

Support workers - 'sort and support'

We have successfully piloted 'sort and support' workers in communities in Sheffield. The role involves people proactively speaking to people identified at risk (using risk stratification approach described above) and helping them over the short-term to achieve greater independence and wellbeing. This will typically involve some short-term interventions such as housing repairs, re-connecting people with estranged family members, introductions to local community activities, encouraging people to access health checks and self-care advice, ensuring glasses prescriptions are up-to-date and so on.

The critical success factor here is the skills and knowledge of the support worker – and particularly their ability to help someone to achieve greater independence (without ongoing dependence on the support worker). Our experience from the pilots has given us the confidence that we can recruit and train enough people with the right skills and knowledge to perform this role.

'Life navigators'

The life navigator role provides more intensive, often medium-term support for people who are at high risk of declining health and wellbeing, have no family or friends to support them, and perhaps do not access social care. Support includes: helping people as they return home after a stay in hospital (this will link to other work in the city regarding shortening the length of stay in hospital); (re)connecting people to local activities and social networks; supporting people during the life events that can easily derail people (such as a bereavement, a fall, a period of ill-health); helping people manage everyday problems often associated with ageing (such as managing appointments, correspondence, shopping and household and health management).

The critical success factors for this role are again the skills and knowledge of the life navigators and their ability to work in partnership to help people them achieve greater independence and wellbeing. Our experience, and that of key partners such as Shelter, Age UK, and local housing associations, is that the success of this role depends on life navigators being prepared to be persistent and assertive with their support. Again, we are confident given our previous experience that we can expand this role across the city.

'Wellness plans'

We recognise the importance of people being able to set goals for their independence

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and wellbeing, which can then be used to shape the support offered by provider services (and friends and family). A single and shared 'wellness' plan for people at risk of declining health and wellbeing will therefore be a key part of our overall approach to keeping people well in their communities. A critical success factor for the 'wellness plans' will be the currency they are given by professional services – we need the plans to be the point of reference for different services to that people do not have to continually re-state their preferences or have to do the 'joining-up' of services themselves. We intend to achieve this by building the use and development of the plans into a range of service specifications (we are currently trialling this with 'care planning' in primary care).

Responsive multi-disciplinary teams
Our pilots have shown the importance of multi-disciplinary teams – e.g. creating the capacity to 'case conference' more complex cases, ensure that lead professionals are assigned, sharing of intelligence, and so on. The critical success factor for these teams will, in our view, be the relationships and trust between the members of the team, and the interface between formal services (e.g. social care, community nurses), and the less formal support workers, life navigators and other voluntary sector workers working on the ground. We intend to put resources into the development of these teams and define clear standards and incentives for people to achieve the level of joint working required (e.g. by working with teams to define shared outcome targets that align with the 'keeping people well in their communities' workstream

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Scheme Ref No. 2

Keeping people well in their communities – locally commissioned services with GP services

What is the strategic objective of this scheme?

- Have a clearly articulated **strategic objective** that links to and cross references both the Vision for health and care services and the case for change
    - How does this scheme help to achieve the vision for health and care services and how does it respond to the case for change?

Through GP led care planning and support for self-care, patients at medium to high risk of admission to hospital will be better motivated and supported to self-care, and will have improved health and reduced reliance on health and social care services.

Patient centred care planning with supported self-care is the way patients are treated in general practice and community nursing and from there throughout the health and care system.

Residents of care homes will receive high quality, person centred care which will result in improved health and quality of life, and fewer admissions to hospital.

Overview of the scheme

These are two existing CCG commissioned services and which we are bringing into the BCF from 2015/16 as they have strong synergy with theme 'Keeping people well in their communities'.

For the Care Homes Locally Commissioned Service, the aim is to improve access to NHS services by funding services over and above core GMS to residential and nursing homes in Sheffield where populations of the most vulnerable and medically complex housebound residents are concentrated. 2015/16 will be the second year of the current 2 year contract with GP Practices. The updated specification and KPIs have been introduced part way through 2014/15 once the CCG had clarity on the national DES re care planning to prevent inappropriate overlap.

The objectives are:-

- To provide a 1 GP: 1 Home care model as the best way to provide high quality care.
- Larger homes of more than 40 beds can be shared by providing 1 GP:1 floor or wing.
- Pro-active management of residents is essential to ensure that robust and personalised care plans are developed for every resident and that home staff and other NHS staff work to these.

The majority of homes for frail and elderly patients in Sheffield are covered by the

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scheme.

The CCG commissions GP practices to provide care over and above the GMS/PMS care which they provide under the contract with NHS England. One GP is designated by the practice to be the link, and makes a minimum of 46 weekly visits a year. The GP should also arrange for specialists to periodically join these visits to review care across the home population as clinically appropriate, erg. Community Psycho- geriatricians.
All residents should be initially assessed by the GP as soon as possible following admission to the home, and an initial care plan developed within two weeks, and a full care plan following discussion with the patient / carers/ staff within 8 weeks.

Guidance is given on what should be included within the initial and full care plan, and how this should be shared with care homes staff.
After each admission the GP must review the care plan in partnership with staff at the home to assess what changes need to be made, and must record the review and any agreed action plan on the care plan.
.An End of Life Care Plan and DNACPR should be discussed with each resident, unless the resident specifically refuses to do so, or is unable to do so. Where there is cognitive impairment, the EOLC plan and DNACPR should be discussed with the family. The five priorities referenced in 'One Chance to get it Right' should be followed.

Training is provided to participating GPs and monitoring takes the form of self reporting, submissions of reports, and peer review. Training is also given to care home staff to enable them to work with the GP practice as a team.

The scheme has been shown to have an impact in reducing admissions.

For the care Planning /Supported Self-care scheme

The purpose of this service is to improve co-ordinated care in the community underpinned by optimising patients' long term conditions management and enabling patient informed multidisciplinary care planning for those who are at emerging and high risk of hospital admission. At the same time it is to enable a personalised approach that empowers and equips individuals to self-manage. It is a continuous process through which information is shared, needs are identified, and anticipated, collaborative goals and actions are set focused on outcomes that people want for themselves, informed by professional knowledge.

The cohort or patients which are initially being targeted is the 2% of patients who are being supported by care plans under the national GP Enhanced Scheme for reducing Emergency Admissions. Care planning therefore spans across the Better Care Programme and potentially covers all the stages from keeping people well at home, planning intermediate care and eventually potential long term care. We aim to add greater quality and patient engagement to the national scheme.

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Following the pilot carried out from September 13 to August 14 a number of lessons have been learned, and the intention is for a new incentive scheme for general practice, starting in November 2014, whereby practices will be rewarded for their progress on a journey of culture change of supporting patients to self-care, rather than on the number of care plans they complete. The evaluation of the pilot demonstrated a much stronger need for training and support and there will therefore be a comprehensive programme both CCG wide and in localities for joint training of primary care staff and community nursing teams. We will also establish four locality support teams with representation from primary care, community nursing, medicines management, IT and social care who will work with practices on whatever aspect of care planning they are finding difficult.

As part of the pilot practices in one GP Association have been using the Patient Activation Model, and this has proved to be very useful in determining whereabouts patients are in their motivation for self-support. It is therefore intended to roll this out, with associated training.

The CCG is also aware that care planning has the capacity to increase health inequalities if people from more deprived communities or those with learning disabilities, from ethnic minorities or with serious mental health problems are not included, As part of the quality incentive we will therefore be asking practices to review their population with care plans against the whole practice population and if there are serious discrepancies, to develop action plans to increase the proportions.

Whilst a range of patient information materials were developed, the feedback form the evaluation showed that patient communication and information needs to be improved and we will therefore review the letters and leaflets, and carry out some publicity with relevant patient groups.

We also recognise that because of general pressures on time, it has not been possible for social care staff to be as involved as both health and social care would like and we will therefore explore ways of improving the MDT meetings which are an essential part of the scheme to make them as time effective as possible for the partner organisations.

There will be ongoing evaluation of the scheme, and whilst the focus is on primary, community and social care, in the longer term we hope to work with all partners to encourage a culture of supported self-help.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

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For Care Planning, NHS England via the Area Teams commissions the national Enhanced Service for reducing Emergency Admissions from Primary Care. The CCG commissions the enhancement to this scheme from primary care. The CCG commissions the contribution of community nursing from Sheffield Teaching Hospitals NHS Foundation Trust. The CCG commissions the training from a range of providers, and intends to commission the contribution from a range of professions to the locality support teams including primary care, community nursing, and Social Services. The voluntary and community sector activity commissioned under Keeping People Well in the Community have a vital role to play in supporting the implementation of care plans. This can be through assisting patients in self-support, providing signposting to appropriate services, and by providing additional social support to patients.

For additional support to Care Homes, for those patients who are included within the practice 2%, NHS England commissions a form of care planning. The CCG commissions practices to provide regular visits develop care plans in partnership with the patient, family and care home staff and undertake regular reviews.

The evidence base

The following documents have been used to guide and shape the thinking and assumptions on the local care planning scheme:-

- Angela Moulter, Sue Roberts, Anna Dixon: Delivering better services for people with long term conditions - Building the house of care. Kings Fund 2013
- Nigel Mathers, Sue Roberts, Isabel Hodkinson, Brian Karet Clinical Innovation and Research Centre 2011 Care Planning, Improving the Lives of People with Long Term Conditions RCGP
- DH Our Health Our Care Our Say", January 2006
- Derek Wanless – Securing good health for the Whole Population 2004

Investment requirements for Scheme No. 2

Keeping People Well in their Communities - Locally Commissioned Services with GP services

See Part 2, Tab 3. HWB Expenditure Plan row10

£1,408,000 (CCG minimum contribution)

Impact of Scheme No. 2

See in Part 2, Tab 4. HWB Benefits Plan, row 119

Primary Impact is the schemes contribution to the reduction in non-elective admission

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activity by (2,018) £3.6m. Full benefits profile of the scheme and assumptions to be worked up in its business case
Feedback loop

Care Homes Locally Commissioned Service
The CCG monitors the numbers of admissions from care homes, and the reasons for admission. The CCG also monitors the numbers of care home residents who die following admissions, rather than dying in the care homes.

The participating practices are required to report on the outputs in terms of numbers of care plans, numbers of visits, and also to return reports on emergency admissions and how care can be improved to prevent future admissions, on how far the One Chance to Get it Right priorities have been followed when death has occurred within the home, and to undertake peer review of the care plans

Care Planning/Supported Self-help Service

The CCG is currently consulting the health and social care staff on the key quality standards for the new scheme which is due to start in November.

The current proposals are:-

- Practices will need to have signed up for the national emergency admissions ES and to be achieving the standards within it in order to be eligible for the local scheme.
- For each practice minimum numbers of key staff within each practice attend training.
- All the care plans are done on the local combined template.
- The Patient Activation Measure is used for minimum 80% of all patients on the national ES.
- A minimum of 80% of patients who have a care plan are given the opportunity to participate in the patient survey.
- Either as part of the national ES monthly meeting, or if practices prefer, as a separate meeting, patients are discussed at an MDT which includes at least community nurses in addition to practice staff and brings in social care and other key staff depending on patient need.
- Practices submit a quarterly report showing of their 2% on the national scheme, how many
  a. Have a SMI.
  b. Have a learning disability.
  c. Have dementia.
  d. Are on the palliative care register.
  e. People who are recorded in GP records as having an ethnicity that is not White British

Where the proportion of people within these cohorts is not proportionate to the practice population, practices are asked to submit an action plan on how they intend to move

towards a more proportionate cohort.

Peer review of a sample of care plans

In addition to the measures for general practice, the CCG has a CQUIN as part of its contract with the STH community nursing service covering their contribution to care planning.

It is also planned to monitor emergency admissions, to continue with an evaluation of attitudes and approaches, and to use the feedback from patients.

What are the key success factors for implementation of this scheme?

For the Care Homes Locally Commissioned Scheme, the key factors are as follows:-

- GP practices able and willing to participate.
- GPs having the necessary skills.
- Care Homes understanding the role of the scheme and the GP,
- The establishment of good working relationships between GPs and Care Homes.
- Effective measures for early intervention if there are problems in the relationship, in the car provided by the home, and in the care provided by the GP.

For the Care Planning/supported self-care scheme the key factors are:-

- Patients to understand what the process is and how it can help them.
- All the health and social care professionals involved, particularly - all the members of the primary care team GPs, practices nurses, practice administration staff, community nurses including both district nurses and specialist nurses, mental health t staff, social care staff, staff working in relevant community and voluntary sector organisations, to understand the principles and be prepared for the cult rye change this involves.
- Staff listed above to have the knowledge and skills to undertake and support the process.
- Staff listed above to have support in dealing with issues, problems which may occur in the process.
- Tools and processes e.g. templates, IT, patient materials to be in place to support care planning.
- Staff listed above to understand how different patients may react and respond to the process, and to have the skills to adapt their approach to differing levels of motivation.
- Staff listed above to have the time and capacity to invest in this process.
- A health and social care system which can respond to the potentially changing needs and demands that widespread adoption of care planning will bring.
- The service is provided equitably to all people in need so that it does not increase health.

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Scheme Ref No. 3

Independent living solutions

What is the strategic objective of this scheme?

- Have a clearly articulated **strategic objective** that links to and cross references both the Vision for health and care services and the case for change
  - How does this scheme help to achieve the vision for health and care services and how does it respond to the case for change?

To develop and promote the provision of independent living solutions in Sheffield so that more people can maintain and build their wellbeing and independence.

Overview of the scheme

This scheme is focussed on solutions which support independent living for children, young people and adults in Sheffield. It is at the centre of our vision for a health and care system in Sheffield which supports people locally in their communities to live independent lives and also has significant connections to the vision set out in the Care Act and Children and Families Act.

At its heart, we are looking at what independent living in Sheffield means and in particular:-

- How we support children, young people and adults to live safely, keep well and independent at home.
- How we ensure that we have a coherent offer that covers equipment, minor and major adaptations, tele-health, tele-care, and assistive technology.
- How we can do better at exploiting the opportunities that different technologies offer to help people live independently or, in the case of children and young people, to grow up to be increasingly safe, well, independent and resilient.

Therefore, this scheme as two parts to it:-

1) The commissioning of a community equipment service, which needs to be complete by 1 July 2015 (the end date of the current contract with Sheffield Health and Social Care NHS Foundation Trust). This commissioning activity will ensure that children, young people and adults have timely access to the equipment they need to enable them to live well at home, including specialist chairs, hoists, commodes, grab rails, etc. as well as bespoke equipment to meet more complex needs.

   Just over 19,000 people received some equipment in 2013/14 from the current service. 32,185 items of equipment were issued which had a cost attached to them, amounting to £2.7m. We expect the new service to deal with this level of volume and potentially more as we develop our offer to support independence at home.

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We expect to significantly improve on the service that is currently offered and realise substantial benefits through:-

- Increasing the efficiency of the provision of this service.
- Encouraging and supporting appropriate assessment and review of such equipment use.
- Exploring new models of how it can be delivered into Sheffield's communities.
- Increasing independence and thereby reducing the need for formal care and support services.
- Enabling speedy hospital discharge.
- Creating a pooled budget and ensuring there is no longer an unhelpful division between health, social care, and educational needs.
- Ensuring children's equipment moves with them into adulthood where required.
- Improving the information and advice that we offer people to help them to make choices for themselves around independence at home.

We have already done a range of consultations focussed on this area, including most recently, telephone calls, focus groups and online surveys. We are working directly with a range of practitioners in our Foundation Trusts (both children's and adults) to ensure we understand their needs.

Developing our understanding around independent living

More broadly, our work needs to bring together a vision for supporting independent living, which encompasses the Disabled Facilities Grant, larger adaptations in people's homes, tele-health, tele-care, and assistive technology. While there is money attached to these areas, our initial focus in this part of the scheme will be on connecting these areas together and ensuring that these independence solutions are coherently provided and promoted across the city.

The delivery chain

Under the banner of the Programme for Integrated Commissioning, the scheme is sponsored by Joe Fowler, Director of Commissioning at Sheffield City Council, on behalf of the local authority and NHS Sheffield Clinical Commissioning Group.

The lead commissioners are Andy Hare and Louisa Willoughby from Sheffield City Council, supported by the CCG and a team from NHS, SCC and VCF organisations.

At this stage of the commissioning and procurement process we are unable to say who will provide the service that provides the equipment. However, the contract and budget will be jointly held between the CCG and SCC. We will also ensure that people in Sheffield can directly access the advice, information and products offered by the provider(s), e.g. self-funders looking to get advice independent living solutions.

In addition, a range of providers will have connections to the new service as assessors of

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independent living solutions, such as GPs, occupational therapists, physiotherapists and nurses. We have carried out consultation with these assessors including two workshops and an online survey, as well as some one-to-one meetings. We will continue to work with them through the tendering process and as we transition to a new service to ensure the new service works for them.

The evidence base

National evidence

The business case for investing in independent living solutions and, more specifically, equipment, is well documented. For an example, see http://blogs.lse.ac.uk/healthandsocialcare/2012/07/13/building-a-business-case-for-investing-in-adaptive-technologies-in-england and the accompanying report.

Local evidence

In the past few years, there has been some additional investment into equipment services in Sheffield as part of the RFT Programme. This programme is currently being evaluated but anecdotally the additional investment to ensure the responsiveness of the equipment service has been valuable in increasing the speed of hospital discharge. This, along with significant feedback from Sheffield people and practitioners detailed above as well as the nationally recognised evidence base, helps us to be confident that investing in this way is important and valuable.

Investment requirements for Scheme 3

Independent Living Solutions 2015/16

See Part 2, Tab 3. HWB Expenditure Plan row 13, row 14, row 15

£1,675,000 (CCG additional contribution, provider NHS Mental Health)
£770,000 (City Council Social Services, provider NHS Mental Health)
£995,000 (City Council Social Services, provider Local Authority)

As part of this work we will also clarify whether and how the Disabled Facilities Grant could be allocated more effectively than at present.

Impact of Scheme No. 3

See in Part 2, Tab 4. HWB Benefits Plan

This schemes contributes to the reduction in non-elective admission activity by (2,018) £3.6m. Full benefits profile of the scheme and assumptions to be worked up in its business case

This scheme contributes to the reduction in permanent residential admissions by (25) £650,000. Full benefits profile of the scheme and assumptions to be worked up in its

business case

This scheme will carry a significant target for driving up customer experience outcomes

See below.

Feedback loop

We will:-

- Require the new provider to work with us in our wider work to support independent living. As such, we will connect with tele-health, tele-care and assistive technology work to consider how we can develop the provision offered to support independent living.
- Carefully select the Key Performance Indicators for our contract and ensure that, through clear contract management, the new provider is delivering a high quality service which is constantly improving and developing to meet people's needs.
- Require the new provider to have a service user group and practitioner group to ensure that what is provided meets the need appropriately. The project team that we have been working with to commission the new service has a number of expert practitioners on it, and they will continue to be involved.
- Require the new provider, as part of the contract, to provide us with clear, accessible, accurate and up-to-date information about the service they are delivering, including numbers and volumes. This, along with the service user and practitioner groups' feedback, will enable us to have around-the-clock feedback, rather than requiring regular new surveys/data collection.
- Work closely with other schemes as part of Sheffield's Better Care Fund submission to understand joint implications of our work and ensure the scheme is part of programme-wide measures of outcomes.

We are just establishing some of our measures/KPIs, but these may be:-

- Reduction in use of health and social care services as a result of equipment provision.
- Reduction in delays in system caused by lack of equipment (e.g. hospital discharge).
- Reduction in time from assessment to equipment provision.
- Reduction in use of health and social care services as a result of the expansion in choice of alternative support solutions.
- Reduction in delays in system caused by lack of alternative support solutions.
- Increase in patient/service user satisfaction (however, we do not currently have a baseline for this).
- Establishment of a clear policy around independent living in Sheffield.
- Establishment of relevant working groups supporting independent living, constantly aiming to improve the offer for Sheffield people.
- Coordinated assessment teams who work well with providers.

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What are the key success factors for implementation of this scheme?
We are dependent on:- • Local partnership with the CCG and SCC under the auspices of the HWB. • Local partnership with our NHS, independent and VCF providers. Through working with a multidisciplinary and multi-organisational project team, we hope to ensure that this scheme is successful in a number of ways for different organisations and disciplines. • Good quality data from the new provider about demand, volumes, and types of equipment ordered. We will build the requirement to provide this data into the contract. • Practitioners, who assess for equipment, assessing in an appropriate way so that Sheffield people receive the equipment they need. Currently, over 1,100 people in Sheffield carry out this role so we are dependent on their expertise. As we develop a coherent approach to independent living in Sheffield which includes tele-health, tele-care and assistive technology, these practitioners will be crucial for the success of the scheme. • Learning from other local areas. We have already carried out a benchmarking exercise and have visited one area and plan to visit one more. We are confident that these elements are already in place in Sheffield and that we can build on them for the success of this scheme.

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Scheme Ref No. 4

Intermediate care – Active Recovery and bed based services

What is the strategic objective of this scheme?

To commission person centred and outcome focussed intermediate care within an overarching active care model which is closer to people's homes and provides the best value for Sheffield citizens.

Which will ensure:-

- Hospital admissions are prevented where possible.
- The bridges between home and hospital work effectively.
- The length of stay in hospital is further reduced and in intermediate care provision is focussed on people's own homes reduced to support more people returning home faster.
- People reach their optimum independence as soon as possible.
- An explicit focus on providing for people's mental health as well as physical health needs.
- Any service builds on and further develops people's self-care capacity and draws on appropriate informal community support.

Focussing on person centred outcomes will be a priority in line with the Sheffield April submission, success within the intermediate care workstream will be measured through its contribution to the programme outcomes and specifically by the achievement of the following:-

Person centred outcomes. (NB these are draft and subject to consultation)

- People will have fewer crisis situations through earlier intervention and joint working; including access to specialist services which is timely and appropriate. Where a crisis or emergency.
- People receiving care at home or closer to home.
- People receiving short term care which is timely and co-ordinated.
- People enabled to live independently.
- People having control over their lives; involvement in their care and choice over their treatment.

These do not detract from also commissioning affordable health and social care but currently providing an evidence base for financial savings is not without its challenges. "Altogether Now Making integration happen (August 14) -" states that "Although there is much evidence to show that greater integration and personalisation improves outcomes, the evidence that it delivers financial savings is still in its early stages and there is currently a lack of empirical evidence to show it will be more cost effective".

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Overview of the scheme

The aim is to bring together nearly £30m of existing CCG and SCC contracted services into jointly commissioned and specified integrated intermediate care provision. To maximise benefits consideration will be given to expanding the scope to include other community services and if so the budgets for these services would then be brought into the BCF arrangements.

The CCG funded Community Intermediate Care Service CICS has previously been commissioned through a procurement exercise and is currently delivered by STH FT. The contract is due for renewal but can be extended into 2015/16. During the term of the contract the service has been significantly expanded in response to RFT agreed priorities and is now aligned with the Short Term Intervention Team (the jointly funded SCC service) and known as Active Recovery. The latest expansion of 69 new packages per week will be in place by November 2014.

A model for Active Recovery has been consulted upon through RFT with key providers working together in central teams to provide rehabilitation and reablement.

The CCG and SCC have committed to a significant expansion (60%) in the number of new packages a week as part of the city's Active Recovery home based intermediate care service, which is building up to full capacity by November 2014. This was agreed by all key stakeholders in the city as part of our existing urgent care programme (RFT), to be the number one priority for investment in 2014/15. The HWB are aware of this. In the current financial year this is a 'test of change' and we will be evaluating impact over the winter with a view to confirming whether to maintain this expansion in service. The full year cost in 2015/16 to pool would be c£3.3m. Thus, this investment is probably the most appropriate of our range of investments to 'badge' as being funded from the performance element of the BCF minimum funding. However, in the context of the scale of the BCF commitment in Sheffield it is something of an artificial 'badge'. Assuming we decide to continue with the investment in 2015/16 before the whole of a re-specified intermediate care service is procured during 2015/16, the funding will be fully committed from the start of the year. Phasing in year is not applicable.

At the moment Active Recovery is the term used for the service delivered to support clients in their own homes. This is both a "step up" and "step down" service with patients transferred into the service from both acute and intermediate care beds if appropriate.

In addition Sheffield has 156 intermediate care beds. The beds are in a range of nursing homes in the city with medical and other reablement wrap around services provided via a contract with STH FT. RFT has agreed protocols for admission and discharge. However, the commissioner view is that the current huge focus on "step down" (only 2

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beds used for “step up”) needs to change as part of the work on the re-specification of intermediate care services – we believe that a greater focus on “step up” will support our ambitions on reducing hospital admissions.

The current vision for Health and Social Care Active Recovery is;
To improve people experience and quality of life by accelerating their recovery through responsive rehabilitation/ reablement. To maximise peoples independence and resilience and avoid unnecessary hospital admissions and long term care services. To ensure an appropriate plan is in place for those who need it when leaving Active Recovery.
The right response, at the right time by the right person.
A comprehensive service delivered by Health and Social Care working in partnership.

The RFT developments of the core teams forming Active Recovery and its effectiveness will be reviewed and built upon to develop options for a future jointly commissioned service with a single specification. To identify where the “intermediate care” outcomes of recovery, rehabilitation and reablement are best provided as part of the continuum care pathway which will be the basis for the overarching Active Care model. Learning from other RFT projects such as Virtual Ward and Integrated Nursing Teams will be incorporated into developing a future model.

Potentially a new model could move intermediate care into the mainstream delivery of community health and social care as a function rather than a number of specific services, to this end additional community services such as Community Nursing, Allied Health Professionals and Community Support Services will be considered in an options appraisal.

Which patient cohorts are being targeted?
Adults- Frail Older People and People with long term complex needs especially Housebound patients and those identified using the risk stratification score of between 30 and 70.

The delivery chain

Commissioners
Sheffield CCG
Providers
Sheffield Teaching Hospital NHS Foundation Trust- CICs, Integrated Community Nursing, AHP’s
General Practice- NHSE
Sheffield Health and Social Care- OT’s and Dementia and Mental Health Services.
Independent providers of care services- Intermediate Care beds

Commissioners
Sheffield City Council

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Providers
Adult Social Care -Sheffield City Council
Independent providers of care services- Community Services.
Voluntary organisations- sccc

The evidence base

Nationally the drive is to improve integration of Health and Social Care a number of the Integrated Care Pioneer schemes are centred on Intermediate Care and/ or Neighbourhood Teams, learning from the programme to date has and will be incorporated into the developments in Sheffield.

- National Intermediate Care Audit 2013
- Prof John Young's presentation at NAIC conference- Intermediate Care as a platform for integration.

-The Kings Fund January 2014 published key messages for Integration which includes;

- There is no single organisational model or approach that best supports integrated care.
- The starting point should be a clinical/service model designed to improve care for people, not an organisational model with a pre-determined design. .

- Numerous national historical documents
- Keeping People Well in the Community – Review of evidence for the CCG and SCC August 2014
- RFT partnership Transition Care and Flow Group documents

JSNA Demography
Pop. 552,700. High Older People esp. 85+
Increase in LLC, disability & LD
Neuro- Nationally rising.
Dementia circa 6,400 expected to rise to 7,300 by 20,20 85+ BIGGEST INCREASE
Care Home accommodation predicted to rise by 55% additional pressure on LA funding, CHC and acute services.
COPD slightly lower than Nat aver 2.4% people diagnosed.
Alcohol- focussed on 18-65 years- no info provided 65+
Public Consultations for H&WB S For example, NHS Sheffield's Intermediate Care Consultation in 2008 saw concerns expressed about the fragmented nature of intermediate care. There was widespread support for the proposed model of 'care in your own bed'

to drive assumptions about impact and outcomes
STH report 11/12 showed 49% of 75+ could have had an alternative – JSNA event agreed people needed to reduce reliance on hospital services- p.62
Increase in numbers of non- elective admissions to STH
RFT time modelling shows need for community alternative in order to ultimately close acute beds.

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Keeping People Well in the Community – Review of evidence for the CCG and SCC August 2014- indicates that increased **care co-ordination** around people at home will have greater benefits.
High number of intermediate Care Hospital Discharge beds and low number of preventative intermediate care alternatives to own home (156 of which 2 are preventative)

Investment requirements for Scheme 4

Active Recovery & Bed-Based Services

See Part 2, Tab 3. HWB Expenditure Plan row 16, 17,18, 19, 33

2015/16

£20,831,000 (CCG minimum contribution, NHS Community provider)
£273,000 (Additional CCG contribution, NHS Community provider)
£3,083,000 (CCG minimum, local authority provider, 2m is ex-NHSE)
£5,361,000 (City Council STIT and ICAT, local authority provider)

2014/15

£2,000,000 (CCG minimum, local authority provider)

Pooling the budgets for the teams/services identified plus potential for wider community services to be incorporated.

Impact of Scheme No. 4

See Part 2 Tab 4, HWB Benefits Plan, row 122

This schemes is the main vehicle for producing the change in reducing delayed transfers of care activity by (1,500) £300,000. Full benefits profile of the scheme and assumptions to be worked up in its business case

It will also have an impact on the reduction in the reduction in permanent residential admissions activity (25) £650,000 and drive up the increased effectiveness of reablement

This will lead to significant benefits including:-

- Increased independence.
- Reduced hospital length of stay.
- Reduced – and prevented – hospital and care home admissions.
- Better mental and physical health.

Reduction in number of teams,” hand offs” and duplication to lead to well-co-ordinated Streamlined and less fragmented services.

Reduction in cost of services- -potential to reduce non-elective hospital admissions-(though lacks evidence well planned and co-ordinated care supports people to be well at home also providing preventative beds will reduce non- elective admissions)
Feedback loop
Outcomes when agreed will be embedded into the provider contract and monitored through this route- this will include reported patient experience measures and achievement of individual outcomes. Finance- Meeting targets- reduction in contract value. Citizens reference groups- for developing the outcomes and generic feedback Primary Care - support in developing the model.
What are the key success factors for implementation of this scheme?
• Key Factors Maintain the impetus of the RFT Programme and the level of commitment to developing responsive intermediate care • Partners through RFT have visited other areas e.g. Leeds bed base and are willing to discuss moving teams to support proactive care and admission avoidance, developing integrated teams in the localities GPA's. • Commitment from all partners to the next step of integration and joined up workforce will only happen once the procurement issues are resolved following an options appraisal. • The first steps for implementation will be - agreeing a new model and what resources it will require -Procurement options, including for the bed base. -Discussions with Trade Unions/ Governance arrangements -Timescales of the Finance project to move to pooled budgets - developing a single specification and commissioning plan- up to at least Mid-2016.

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Scheme Ref No. 5

Proactive hospital admissions and flow management

What is the strategic objective of this scheme?

To commission focussed management of emergency admissions (other than via A&E) and discharge to reduce un-necessary admissions and reduce excess length of stay for patients fit for discharge.

Please refer to scheme 4 for further rationale.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:-

What is the model of care and support?

The Sheffield Teaching Hospital NHS Foundation Trust (STH) in partnership with Sheffield City Council Adult Social has developed a Single Point of Access.(SPA) for hospital discharges, bed bureau, admission avoidance etc. In addition a number of teams are funded by the CCG in the hospital to ensure flow.

The purpose of this scheme is to ensure that the current teams are reviewed and a streamlined response to admission and flow through acute and intermediate care beds, an integrated model developed with outcomes that could be included and monitored in future contracting arrangement with STHFT.

Excellent communication flow will be an essential factor of success in getting Right Care, Right Time, Right Place

A draft pathway has been devised but requires consultation on.

In addition to seeking a revised model, procurement options will also be considered by Commissioners.

The current services to be included in remodelling ;

SPA- STH (with ASC)

Length of Stay and Discharge Teams (includes STH & ASC funded by the CCG)

Which patient cohorts are being targeted?

All Adults in community plus- Frail Older People and People with long term complex needs in hospital settings

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The delivery chain
Commissioners Sheffield CCG **Providers** Sheffield Teaching Hospital NHS Foundation Trust **Commissioners** Sheffield City Council **Providers** Adult Social Care -Sheffield City Council
The evidence base
Please see Scheme 4.
Investment requirements for Scheme 5 **Proactive Admissions & Flow** See Part 2, Tab 3. HWB Expenditure Plan row 20, 21, 22,23 £436,000 Additional CCG contribution, dementia discharge NHS Mental Health Provider £2,646,000 Additional CCG contribution, SPA, Discharge liaison NHS Acute Provider £1,057,000 Additional CCG contribution, social work assessors, Local Authority Provider £1,040,000 Local Authority, social work assessors, Local Authority Provider Pooling the budgets for the teams/services identified plus potential for wider community services to be incorporated.
Impact of Scheme No. 5 See Part 2 Tab 4, HWB Benefits Plan, row 119,120,121 This schemes contributes to the reduction in non-elective admission activity by (2,018) £3.6m. Full benefits profile of the scheme and assumptions to be worked up in its business case It will also have an impact on the reduction in the reduction in permanent residential admissions activity (25) £650,000 and drive up the increased effectiveness of reablement

This schemes is the main vehicle for producing the change in reducing delayed transfers of care activity by (1,500) £300,000. Full benefits profile of the scheme and assumptions to be worked up in its business case
This will lead to significant benefits including:- • Increased independence. • Reduced hospital length of stay. • Reduced – and prevented – hospital and care home admissions. • Better mental and physical health. Reduction in number of teams," hand offs" and duplication to lead to well-co-ordinated Streamlined and less fragmented services. Reduction in cost of services- -potential to reduce non-elective hospital admissions-(though lacks evidence well planned and co-ordinated care supports people to be well at home also providing preventative beds will reduce non- elective admissions)
Feedback loop
What are the key success factors for implementation of this scheme?

• Demonstrate an understanding of the **key success factors** for the scheme that you are proposing. E.g. expertise, staff, demographics, history of partnership working?
  ○ Do these also exist within your area?
  ○ If not - what action is required to put them in place?
  ○ Or what impact will the absence of those supporting factors have on the outcomes that can be achieved?
  ○ Outline a stepped approach to implementation which draws on i) learning from either local evaluation or other areas where this has been implemented, and ii) engagement with partners about the deliverability of the proposal
• Faster, coordinated assessment and decision-making.
• Better contracting and quality assurance.
• Focus on the person rather than the care system.
• Removal of tension and scope for shifting the cost between health and social care – freeing up staff time for more productive activity
• Better market management and support.
Providing care and support across the life-course, reducing silo planning and delivery between children's and adult's services

Scheme Ref No. 6

Long term high support care

What is the strategic objective of this scheme?

The Overall objectives of this scheme is to:-

- Design and implement an integrated care model across health and social care for long term high support which will include a single:-
- Developing a single vision and shared culture
- Approach to assessment, care management, care co-ordination and placing people with robust providers.
- Management of the flow of people into the right support at the right time, flexing accordingly up and down levels of support when needed.
- Planned approach to inherent conflicts around access to 'free NHS services as opposed to 'charged-for LA services.
- Organisational culture that prioritises system benefits over individual budget efficiencies with single managed behaviours around implementation.
- Integrate Budgets, with integrated transactional functions to support delivery associated with Assessment & Care Management, Continuing Health Care and Section 117
- Design and deliver on a single integrated commissioning specifications that provide a framework for:-
    - Achieving standard outcomes, based on evidence based service delivery model
    - Delivering outcomes for both assessed health and social care needs
    - Market shaping and development
    - Market management (availability/quality standards/value for money and price)
    - Delivering efficiencies

Monitoring, achieving quality and value for money

Overview of the scheme

At this stage we have defined Long Term High Support to include:-

- NHS Continuing Health Care (including fast track palliative care).
- NHS Funded Nursing Care.
- LA Authority purchased Social Care for adults (inclusion of children's remains subject to discussion).
- Section 117.

We have not at this stage included the cost of social worker and CHC nurse assessor teams. This remains subject to further review and discussion.

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The ambition is to combine these budgets to have a single budget for long term care, although always recognising that patients eligible for NHS CHC will be entitled to free (non means tested) care. By having a single budget we aim to remove the current various perverse incentives to “cost shift” between commissioners and to focus on what is most appropriate for patients. We will take on board the implications of the Care Act and the personalised budgets agenda for both the CCG and SCC.

Clearly combining these budgets will form a very large budget (c£138m). Whilst we will aim to ensure access to care for those eligible (taking into account the eligibility criteria set nationally), the combined budget for 2015/16 will be less than that for 2014/15 primarily due to the significant overall pressures faced by SCC and so we will be deploying a number of efficiency schemes to deliver the net reduction, which could be in region of £15m. The rational of our integrated commissioning is to look to support the people of Sheffield to live independently without the need for high cost long term support and high cost hospital admissions as much as is possible and so even after taking account of demographic pressures we will be aiming to reduce spend on these two major spend areas.

This scheme will cover where:-

- Care is delivered in people’s own homes, in supported living accommodation and tenancy support and through residential, nursing and non-acute specialist hospital care, both in the city and out of city.
- Care or predicated cost to the health, social care and specialist housing economy is for 6 months or more duration and/or is high cost (excluding palliative care).

The scheme will cover clients in need of long term health, social and specialist housing care needs or lifelong conditions who may require long term/on-going health and social care support and includes:-

- People with learning disability/physical disability/mental health issues/personality disorder/ autism/ dementia/ older people/head injury/brain injury/people with multiple complex needs.
- People at risk of avoidable out of city placement and already placed out of city inappropriately.
- Children and young people with complex support needs as per SEN reforms, particularly looking at those young people in transition up to the age of 25. (70% of adults in on high cost out of city service were placed as children) may be included subject to further discussion.

Work is currently being undertaken to develop a robust integrated care model for long term high support, which includes :-

- Options appraisal, including understanding the benefits and dis-benefits for each option.

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- Benchmarking and understanding best practice within the city and elsewhere.
- Lessons Learnt from previous work undertaken.
- Understanding the challenges / risks in putting in place an integrated care model.
- Value for money and potential efficiencies to be gained in proposed models.

The delivery chain

As this scheme is at early stage of design, stakeholders from both CCG and SCC have been engaged to gather intelligence on current contracts including value and volumes of people supported.

This work will brings together a coherent picture of potential areas for commissioning and contracting new integrated models of care and support the work to develop the market. It is envisaged that providers will be engaged in the design and potential delivery of potential future integrated care models.

In terms of designing and putting together an integrated team for long term high support and as part of supporting the work for cultural change, a blended group of both commissioners and front line staff have been brought together from the CCG and SCC (both adults and children) to actively design the future model for an integrated team and then manage implementation. This blended group currently consists of:-

- CCG Commissioning
- CCG Head of Clinical Services
- Senior Finance Lead
- LA (Adults) Strategic Commissioning
- LA Head of Service – Care & Support / Long Term Case Management
- LA (Adults) Interim Head of Service
- LA (Adults) – Finance Lead
- LA (Children's) – Director of Business Strategy
- LA (Children's) – Strategic Commissioning

As each objective of the scheme is being developed, the membership of the blended group will change and bring in key stakeholders that can actively contribute and support the design and implementation of that element. Through wider engagement, other commissioners, providers and front-line staff from both the CCG and SCC will be engaged in shaping of this work.

Through existing infrastructure the following will be engaged:-

- Leads for LD, LTC, MH, PD, Dementia, Housing, GPA,
- Children's Services
- Finance
- Elected members
- User engagement through existing fora
- Primary, secondary care and relevant specialist clinicians
- Support Providers

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The evidence base

- Describe the **evidence base** used to identify the scheme and model future impact
    - What research and evidence did you consult as part of your decision to implement this scheme?
    - Have you done any local evaluation to support/ inform this?
    - Articulate where the evidence base may be relatively weak in support of the scheme
    - NB - If you are not able to articulate an evidence base in support of each individual scheme, please articulate what evidence you have consulted to plan your approach to integrated care overall

This scheme is at early design and options appraisal stage and as part of this work a range of intelligence is being gathered to support the preferred way forward for Sheffield City. This intelligence includes:-

- Benchmarking and understanding best practice within the city and elsewhere
- Lessons Learnt from previous work undertaken
- Analysis on the potential financial impact on the options identified
- Analysis of potential delivery of value of money for each option

Impact analysis on both service users and the services currently offered

Investment requirements for Scheme 6:

Long Term High Support Care

2015/16

Please see Part 2, Tab 3. HWB Expenditure Plan, row 24, 25, 26, 27, 28, 29, 32

£53,561,000
Additional CCG contribution, CHC incl. palliative, Private Sector Provider

£10,399,000
Additional CCG contribution, Ex-NHSE, Private Sector Provider

£1,412,000
CCG minimum, Local Authority Provider

£588,000
Additional CCG contribution, Learning Disabilities specific, Local Authority Provider

£650,000
CCG Minimum, Carer Support Respite, NHS Mental Health Provider

£71,150,000
Local Authority, Purchased social care budgets, Private Sector Provider

2014/15

£10,399,000
(CCG Minimum contribution, Local Authority Provider)

Impact of Scheme No. 6

The main anticipated benefit will be impact of this scheme will be to drive the reduction in the reduction in permanent residential admissions activity (25) £650,000

In terms of providers the following benefits would

- **Inclusion** in a life equal to that of other citizens, within affordable support
- **Tertiary prevention.** Reducing dependency on specialist services through personal development/ recovery/ enablement.
- **A whole system approach to people with long term care and support needs.** Council and CCG integrate internally and across the emerging ITF.
- **A clearly and jointly defined "offer"** for personalised approaches as defined in Putting People First including the emerging rights to personalised budgets.
- **A well-developed market** of skilled providers, operating within an integrated health, social care and specialist housing economy.
- **Flexible services** that work across boundaries of care, through integrated commissioning, pooled resources, and a holistic approach to individual need.
- **Clear joint specifications** that drive up quality, value for money, delivering "Duty of Care", enabling access to health promotion, health screening, promoting well-being, preventing physical, mental and social deterioration
- **Savings** in reducing avoidable costs through prevention of avoidable dependency; premature morbidity and mortality.
- **Efficiency gains** from an integrated approach to provider VFM.

For Commissioning

- **A single vision for outcomes in long term/high support** based on a whole system/integrated approach geared towards reducing dependency on specialist services.
- **Opportunity for joint assessments** based on shared outcomes, with improved customer experience and potential for increased efficiency
- **A single specification** providing increased clarity of expectation for service users and providers.
- **People receive the right support at the right time,** which flexes as needed within an integrated stepped model of care aimed at prevention and recovery
- **SCC and CCG energy and resources focus on solutions**, removing conflicts of interest and achieving value for money for "the Sheffield £".
- **Joint application of legislation** that leads to greater benefit to individuals.
- **Joint market shaping and management**.
- **Joint management of savings, pressures and opportunities**, rebalancing the health and care economy through integrated resources.
- **A culture that prioritises whole system benefits** over individual budget efficiencies.

Feedback loop

The work to develop the integrated model for care will include building in performance and quality measure in the effectiveness of the integrated model for care.

Also robust performance/contract monitoring through commissioning and contracting

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frameworks.

Outcomes when agreed will be embedded into the provider contract and monitored through this route- this will include reported patient experience measures and achievement of individual outcomes.
Finance- Meeting targets- reduction in contract value.

Citizens reference groups- for generic feedback

Primary Care / Secondary Care feedback

What are the key success factors for implementation of this scheme?

- Key Factors
  Maintain the impetus of the RFT Programme and the level of commitment to developing responsive intermediate care and flow services
- Partners through RFT have visited other areas e.g. Leeds SPUR and have increased activity and breadth of service.
- Commitment is required from all partners to the next step of integration and joined up workforce will only happen once the procurement issues are resolved following an options appraisal.
- The first steps for implementation will be
  - agreeing a new model and what resources it will require
  -Procurement options,
  -Discussions with Trade Unions/ Governance arrangements
  -Timescales of the Finance project to move to pooled budgets
  - developing a single specification and commissioning plan

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Scheme Ref No. 7

Hospital Adult Inpatient Urgent Care Medical Admissions

Scheme name

What is the strategic objective of this scheme?

This is not a scheme per se as envisaged by the BCF guidance. Sheffield LA and CCG have agreed as part of our integrated commissioning arrangements that given that we have included the vast majority of our budgets for our joint investment on initiatives to keep people well out of hospital (including intermediate care & independent living solutions), it is appropriate to include the two large budgets where we are jointly looking to reduce spend - long term care (social care and NHS CHC funded) by keeping people independent and well for longer and hospital emergency admissions.

Thus this “scheme” is in effect is the element of the contract with our main acute provider for emergency medical admissions. The related contract activity plan incorporates our QIPP targets for 2015/16. It is important to recognise that these have been reconciled to the activity information which is included in the BCF performance template but are not identical because the QIPP target is purely for our main provider, uses financial years (not a hybrid as per performance target) and is on a registered not resident population basis.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The budget which we have included for urgent care admissions relates purely to our main acute provider for adult emergency care – ie Sheffield Teaching Hospitals NHS FT. We have not at this stage included our separate budget for Children’s admissions at Sheffield Children’s NHS FT as the integrated commissioning schemes we are including in the BCF at the moment are wholly focussed on adults.

We are aware that the Statutory Instrument which governs what a CCG is legally entitled to include in a Pooled Budget does not allow us to include the urgent admissions element of our contract with STH in full which was our original intention – the SI does not allow the inclusion of budgets for commissioning surgery and endoscopies for example. Thus we have reviewed the inpatient urgent care contract with STH FT and determined a value which as

far as practical excludes these elements. This leads to a somewhat frustrating and arbitrary split of the total emergency inpatient contract budget for inclusion in the BCF and leads to a split of the QIPP savings requirements which will be formally incorporated into the Pool, as some relate to medical and others to surgical specialities. ***We have raised a query with NHSE as to the rationale behind the SI exclusions.***

Notwithstanding this "legal technicality" we plan to monitor delivery of savings on admissions in total and build this into our Pooled Budget risk framework – This fits more comfortably with the national admissions avoided performance target which covers both medical and surgical specialties

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

As above this "scheme" is an element of the NHS Contract which will be held in 2015/16 between the CCG and STH FT.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

N/A

Investment requirements

See Part 2, Tab 3. HWB Expenditure Plan, row 30

£54,013,000 (Additional CCG contribution, NHS Acute Provider)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What is happening on emergency admissions including excess bed nights is fully embedded

in CCG contract monitoring and also forms part of national BCF performance target monitoring. If reductions in admissions do not occur as planned we will need to evaluate whether changes are required to the specifications for integrated community care – i.e. our other schemes.

What are the key success factors for implementation of this scheme?

Reduction in emergency admissions (and excess bed nights) in line with or in excess of plan.

Scheme Ref No. 8

Capital Grants

What is the strategic objective of this scheme?

The scheme will enable people to remain in their own homes and live independent lives reducing their need for organised care.

Overview of the scheme

The scheme will deliver physical changes to the homes of people requiring supported care to enable them to continue to live in their existing homes without the need to move. Delivery will be through accredited contractors who will submit a competitive tender to ensure best value for money.

Anyone who needs support to make their home more accessible and meets the defined criteria set at the time of application. The scheme will be delivered throughout the year. It is relatively simple to administer requiring a needs assessment, then engagement of contractors to deliver the adaptation.

The delivery chain

The Council has set in place a number of contracts for specific modules e.g. stairlifts.

The evidence base

The Adaptations scheme has already run for several years so considerable evidence has already been built up. Prior year's completions have been between 600 and 950 adaptations per year. Typical average unit costs are between £2,450 to £2,650 per adaptation.

Investment requirements for Scheme 8:

See Part 2, Tab 3. HWB Expenditure Plan, row 31

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2015/16 £3,456,000 (Local Authority, Local Authority Provider)
Impact of Scheme No. 8: Full benefits profile of the scheme and assumptions to be worked up in the business case for this scheme
Very large impact on customer experience / net promoter score
Feedback loop
What are the key success factors for implementation of this scheme?
Key success factors are: - Communication of the scheme to those in need so they know that help is available; - Clear rules to assess and rank individual needs - Value for money contracts which enable us to deliver the maximum number of interventions for any given sum

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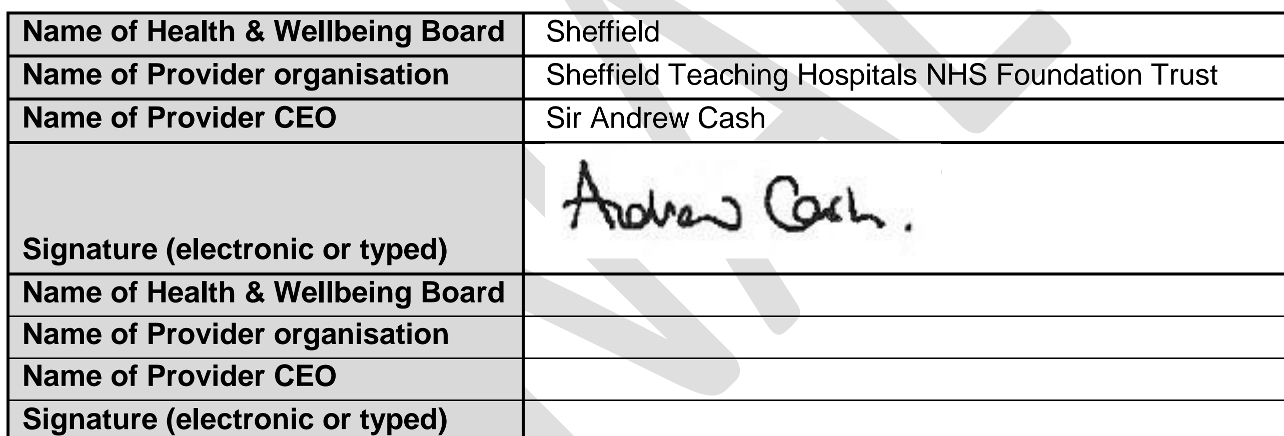
ANNEX 2 – Provider commentary

One of the key changes is that we are asking all areas to ensure they have shared their planned non-elective activity reductions with their relevant providers. In particular, we are looking for acute providers to submit commentary explicitly stating whether they recognise the emergency admissions activity reductions and agree with them. We do not expect providers to sign-off BCF plans, but we do expect to see evidence of provider engagement. A template is provided in annex 2 which should be shared with acute providers for commentary and should be submitted alongside the BCF plans in September.

Although we only require explicit written commentary from acute providers to be submitted alongside the BCF plans, you may wish to conduct a similar exercise with out-of-hospital providers to ensure they are prepared for any impact of planned emergency admissions reductions.



Name of Health & Wellbeing Board	Sheffield
Name of Provider organisation	Sheffield Teaching Hospitals NHS Foundation Trust
Name of Provider CEO	Sir Andrew Cash
Signature (electronic or typed)	Andrew Cash.
Name of Health & Wellbeing Board	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

Total number of non-elective FFCEs in general	**2013/14 Outturn**	58,422 (46,348 relates to STHFT)
	2014/15 Plan	57,158 (45,276 relates to STHFT)
	2015/16 Plan	55,567 (43,918 relates to STHFT)

& acute*	**14/15 Change compared to 13/14 outturn**	-1,264 (-1,072 relates to STHFT = 2.4%)
	15/16 Change compared to planned 14/15 outturn	-1,591 (-1,358 relates to STHFT = 3.0%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0 – BCF is not operative in 14/15 other than support to social care, it will become live on 1st April 2015. Many of the schemes that will operate in 2015/16 are already in place.
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-1,591 (-1,358 relates to STHFT) In terms of the presentation of information for the performance measure, the planned reduction (Q4 14/15, Q1-3 15-16 compared to Q4 13/14, Q1-3 14/15) is -2,018 (-1,585 relates to STHFT at a an estimated financial value of £2.85m)*

*figures are not directly comparable to contract targets which include all specialties and which are presented in spells and on a registered population basis. Neither are they directly comparable to the performance target information shared separately, which is presented in individual quarters and not on a financial year basis.

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	STH is aware of the planned reduction in non-elective admissions, has discussed the issue in 2014/15 contract negotiations and supports the general ambition. The Trust is a full and active partner in the City's Right First Time Programme and has been fully engaged in developing plans and agreeing investment priorities. However, the Trust currently has no expectation that there will be a reduction in non-elective admissions in 2014/15 or 2015/16 and is not planning on this basis in its operational or strategic plans.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	There is currently no evidence that the historic trend of growth in non-elective admissions can be reversed. Demographic change, healthcare developments and cuts in social care funding would all suggest a further growth in demand. However, the Trust will continue to support the Right First Time Programme work to secure the best treatment for patients and to ensure that all non-elective admissions are necessary.

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Given that the Trust is not currently expecting a reduction in non-elective admissions, consideration of the implications of such a reduction have been very limited. The proposed reduction would require the closure of one to two wards which would enable direct costs to be reduced. However, there would be difficulties in respect of indirect and overhead costs unless the capacity could be redeployed to elective activity requirements.

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Appendix 1
Sheffield Right First Time Dashboard September 2014

RFT_Dashboard_20140909.pdf

RFT dashboard overview Sep14.docx

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APPENDIX 2

The '*Seven Dimensions*' Service Experience Tool

We are currently developing an indicator (made up of a combination of ratings against these seven dimensions of the quality of the service experience. Our tool is based on the DH survey questionnaire plus one locally defined question.

Measuring the Quality of Service Experience

Over the past year, we have been asking people to vote for the top 5 questions to ask when measuring success in Right First Time. Early in 2014 a national set of user experience questioned were commissioned by the Department of Health. In order to be able to compare results nationally, the reference group voted on which of these aligned the best with their top 5 questions. The result is that the Reference Group has chosen 7 key questions as one of them didn't come up in the national set.

The 6 key questions to be asked in user experience surveys are: -

Questions	Answers
1. Were all of your physical needs assessed?	a. All of my needs have been assessed b. Some of my needs have been assessed c. None of my needs have been assessed d. Don't know/can't remember
2. Were all of your psychological/emotional needs assessed?	a. All of my needs have been assessed b. Some of my needs have been assessed c. None of my needs have been assessed d. Don't know/can't remember
3. Were you involved as much as you wanted to be in decisions about your care and support?	a. Yes definitely b. Yes to some extent c. No
4. Were your family or carer involved in decisions about your care and support as much as you wanted them to be?	a. Yes definitely b. Yes to some extent c. No d. There were no family or carers available to be involved e. I didn't want my family or carers to be involved f. Don't know/can't remember
5. Do you know who to contact if you need to ask questions about your condition or treatment?	a. Yes definitely b. Yes to some extent c. No d. Don't know/can't remember
Potential to add additional question here about out of hours contact.	
6. Do all of the different people treating and caring for you work well together to give you the best possible care and support?	a. Yes all of them work well together b. Most of them work well together c. Some of them work well together d. No they do not work well together e. Don't know/not sure
7. Do the staff who treat and care for you have a caring attitude?	a. Yes definitely b. Yes to some extent c. No

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