Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Active Support and Recovery Update

Governing Body meeting

F

26 May 2015

Author(s)	Idris Griffiths, Director of Health Reform and Transformation

Is your report for Approval / Consideration / Noting

For consideration

Are there any Resource Implications (including Financial, Staffing etc)?

None at this stage

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
1. To improve patient experience and access to care
2. To improve the quality and equality of healthcare in Sheffield
4. To ensure there is a sustainable, affordable healthcare system in Sheffield

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? Not at this stage

If not, why not? Each neighbourhood will establish their own action plan and an equality impact assessment (supported by locality resource and service co-ordinators) will be produced for each individual neighbourhoods.

PPE Activity

The public and representative bodies have been engaged in establishing the key priorities for new care models and will continue to be engaged throughout the process at Neighbourhood and city wide level. An engagement strategy is being produced in association with provider comms teams.

Recommendations

The Governing Body is asked:
1. To note the paper and comment on the contents of the paper and the Neighbourhood model (final version will be circulated following receipt of comments from Governing Body and providers.
2. To consider how Active Support and Recovery fits in with the wider care outside of hospital strategy, which includes urgent care and primary care

ACTIVE SUPORT AND RECOVERY
GOVERNING BODY UPDATE MAY 2016

Overview

The Active Support and Recovery programme aims to improve the quality, efficiency and volume of care provided outside of hospital. It is a response to the growing number of people living with multiple long term conditions, many of whom currently are regularly admitted to hospital. There are five main elements of the programme:

1. Involvement of the public and building on community assets
2. Improving patient outcomes and supporting greater independence
3. Use the Neighbourhood Model as the vehicle for delivering the transformation of services
4. Achieve efficiencies in the service delivery and the transfer of resources from hospital to community
5. Pursue an 'alliance' approach to service redesign, delivery and contracting unless this proves unsuccessful

The Public's Views

During 2015 a public engagement exercise identified the following themes:

People Said:

Everyone will know about it and know how to access it. We will prioritise rapid and assessment of mental and physical health concerns 24/7. We will identify what the person needs and wants and organise additional help and support by giving key professionals responsibility for actions

People Said:

Access to professionals with specialist knowledge that will use people's care plans to try and help stop people from becoming unwell. They will help the person to access the best service or support that they need

People Said:

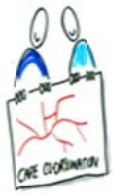
Using resources in the community, friends and family to provide support to the person to help them to stay healthy and continue to live in the community

People Said:

Plan developed in advance and in agreement with the person that describes what will be done, by whom and by when

People Said:

One plan is put in place that is agreed by the person. The plan is written in plain language and is accessible by everyone involved in providing care and support to the person.



People Said:

The coordination of care across all people contributing to a person's care which would involve a common point of access, a nominated care coordinator and a shared care plan

People Said:

One assessment that is done with the person and that can be shared with all the people that provide help and support to the person. It can be changed as the person's needs change

People Said:

Professionals are trained and skilled to provide single assessment and care planning with the person; to help provide the best outcomes for the person

From the outset the CCG set the following essential outcomes:

These are being jointly developed with providers to include specific measures:

- A specified reduction in hospital admissions and readmissions
- Achieving expenditure within the financial envelope
- Reduction in length of stay linked to pro-active care planning and maintaining the community/primary care oversight of the patient's care during admission with an aim to facilitate the earliest appropriate discharge possible.
- An increase in the proportion of people receiving care at home or closer to home
- The proportion of people being provided care holistically, rather than condition or symptom based inclusive of physical and mental health needs
- An increase in the responsiveness of people receiving co-ordinated short term care
- A reduction in new cases of long term care by preventing hospital admissions and maintaining independence for longer

The scoping document identified the potential for savings

These have been subsequently developed using benchmarking data, including RightCare and Intermediate Care National Benchmarking Audit. The three areas for savings are:

1. Efficiency savings across and between providers. The cost of services within the current scope is circa £50m. Conversations through the design workshop phase of the AS&R workstream identified that there is opportunity for efficiencies through reducing non-patient contact time; reduction in duplication of effort across health and social care providers; streamlining of back office and service management approaches; shared workforce resourcing; improved systems and processes including shared care planning; a reduction in administrative time and effort in managing referrals between current providers.

2. Reduce the level of emergency hospital admissions and length of stay for those admitted A fundamental assumption underpinning the AS&R project is that by redesigning/integrating the service provision, this will reduce the number of people requiring an emergency admission to hospital. This includes the number of re-admissions of individuals to hospital within 28 days as this is a cost to the health & social care economy although the commissioners are not responsible for the payment above the contractual basis in this instance.

3. Reduce the rate that patients need additional care, improve their ability to live more independently from health and social care interventions and reduce the number of people going into long term care, or if they do go in, that their requirements are reduced.

Rather than competition the Scoping Document set out a preference for an alliance approach

The 'alliance' of providers was required to demonstrate that:

1. Patients, the public and staff are engaged throughout
2. Services are designed with the principles of person centred care
    a. Affording People Dignity, compassion and respect
    b. Offering coordinated care, support or treatment
    c. Offering personalised care, support or treatment
    d. Supporting people to recognise and develop their own strengths and abilities to enable them to live and independent and fulfilling life.
3. The service delivery proposals are clinically led and
    a. underpinned by good quality evidence
    b. That GP's are the senior clinical decision makers
    c. There is single managerial overview of service delivery
4. Service development will not be hindered by separate professional boundaries or organisational budgets
5. The voluntary sector is included in the design of delivering services differently
6. Strategic decisions will need to be taken without separate organisation endorsement
7. Primary Care is involved in the Strategic management arrangements
8. Services are developed on a system-wide basis in more innovative, higher quality and sustainable way
9. Commissioners (NHS and LA) have a leading role in the design and development of proposals
10. Effective engagement and involvement with other providers, including independent sectors and YAS

The key method of delivering the principles of AS&R are incorporated into the Neighbourhood Care Model

The remainder of this paper sets out the principles and progress regarding the Neighborhood Model

A neighbourhood is a network of health, social care, voluntary sector and wider public sector teams working together with local people to support them to remain independent, safe and well at home and in their community. Neighbourhoods will cover a population of around 30,000-50,000 with an aim to make the best and most effective use of local services, resources and community assets to support the triple aim of;

1. Improving health outcomes
2. Improving out of hospital care quality and experience
3. Reducing per capita costs of care (particularly through affecting avoidable hospital admissions)

Within the neighbourhood care model, neighbourhood services will be accountable to their local community through defined neighbourhood outcomes, with a commitment to continual improvement of the model. The Neighbourhood care model is the vehicle for delivery of elements of the Sheffield-wide out of hospital approach, including elements of Active Support and Recovery, the Primary Care Strategy and Urgent Care Strategy.

What are the key aspects of the neighbourhood care model?

Neighbourhoods will provide a joined-up, out-of-hospital care model with key aspects of the model as follows. Combined health, social care and voluntary sector teams, with the GP as the clinical lead, will:

- **Proactive/preventative support:** Targeted around people at greatest risk of ill health and admission to hospital. With a single care plan and crisis planning for people identified through their GP. The approach will be to keep people at home wherever possible. It will be delivered by a multi skilled workforce and include the public, independent and voluntary sectors.
- **Crisis/rapid response**:- There will be a timely response to every crisis. For those without a plan, a rapid assessment will take place to make sure admissions to hospital don't occur where services are available at a neighbourhood level.
- **Ongoing management**:- This will make sure there are safe discharge arrangements to help people continue to improve out of hospital even if they can't go straight home and offer support for people to manage long term conditions and remain well.

What are the key principles for neighbourhood development?

The following principles are to be used and developed with learning from initial neighbourhood groups as key principles for neighbourhood working;

- Neighbourhoods should be based around populations of around 30,000-50,0000 for the purposes of delivering an integrated health and care system supporting people to stay independent and out of hospital
- Neighbourhoods should be based around "natural geographies" and primary care practice groups given the centrality of primary care in population care management and co-ordination (such that neighbourhoods are not geographically dispersed and no practice is "left out" within an identified geographical boundary). Alternatively, where this characteristic is not met, there should be a commitment from practice groups to work with each other within such natural neighbourhoods as part of the care model, or look to develop groups into natural geographies in future.
- Within each neighbourhood, there should be evidence of good relationships between primary care staff (including strong clinical leadership) and wider health and social care teams in the neighbourhood, with integrated teams that are aligned to neighbourhoods where possible
- Neighbourhoods should align, as far as possible, to "People Keeping Well" Community Partnerships and similar community groups given the central focus of these on identifying community assets to support health and care outcomes, and commit to working with these groups in defining and delivering the model
- Neighbourhoods should have clear ideas around how they will support the key aims of the "Active Support and Recovery Programme" and other out of hospital programmes such as the primary care strategy and urgent care programme, to develop a clear value proposition
- Neighbourhoods and services within need to work inclusively, inviting all neighbourhood stakeholders into shaping the neighbourhood model
- All those involved in the neighbourhood need to commit to an open approach to development and delivery with collective responsibility for success

What will this mean to patients?

- Avoiding having to go to hospital unless you really need to
- Seamless care – the right out of hospital care to be in place so you can be cared for as close to home as possible
- Improving your quality of life with better support enabling you to take control of your own health and wellbeing, live independently and stay healthy for longer
- Care closer to your home where possible
- Not having to repeat yourself to many healthcare professionals as you will have a unified record

What will the neighbourhoods do?

The neighbourhood model will be developed iteratively over time and dependent on each local neighbourhood's needs. However, it is expected that neighbourhood activity will include;

- Population and risk profiling; Identifying neighbourhood health needs and supporting those at risk of high care utilisation (through risk stratification), particularly focussing on reducing avoidable hospital admissions and affecting unwarranted variation (supported by population profiling and data analysis)
- Developing a co-ordinated, integrated and multidisciplinary care team that works together to support the needs of the neighbourhood population and wrap services around the individual within a single care plan
- Using evidence-based continual improvement to adapt the model; A "menu of services" for each integrated multi-disciplinary neighbourhood team to support people e.g. **Social prescribing,** rapid response, regular neighbourhood MDT care planning for those most at risk, single care plan accessible across services, long term conditions management clinics, post-discharge follow-up, interventions affecting psychosocial circumstances and social isolation etc.
- The approach of People Keeping Well and the associated Community Partnerships will be aligned, bringing AS&R and PKW into a single integrated programme
- Influencing all determinants of health such as biopsychosocial and environmental factors (e.g. lifestyle, education, housing, employment etc.), not just health*care*. Neighbourhoods will have services to respond to these wider determinants and critically utilise people keeping well partnerships and sign-posting as part of the integrated care model
- Neighbourhood services will help people to prevent ill health, manage their own health and conditions, empower people to make choices about their care, ensure the right services are available to all, and ensure joined up care for people, especially those who are vulnerable or have complex needs.

Neighbourhoods will be supported to develop their model through city-wide resources and the governance framework for neighbourhood development.

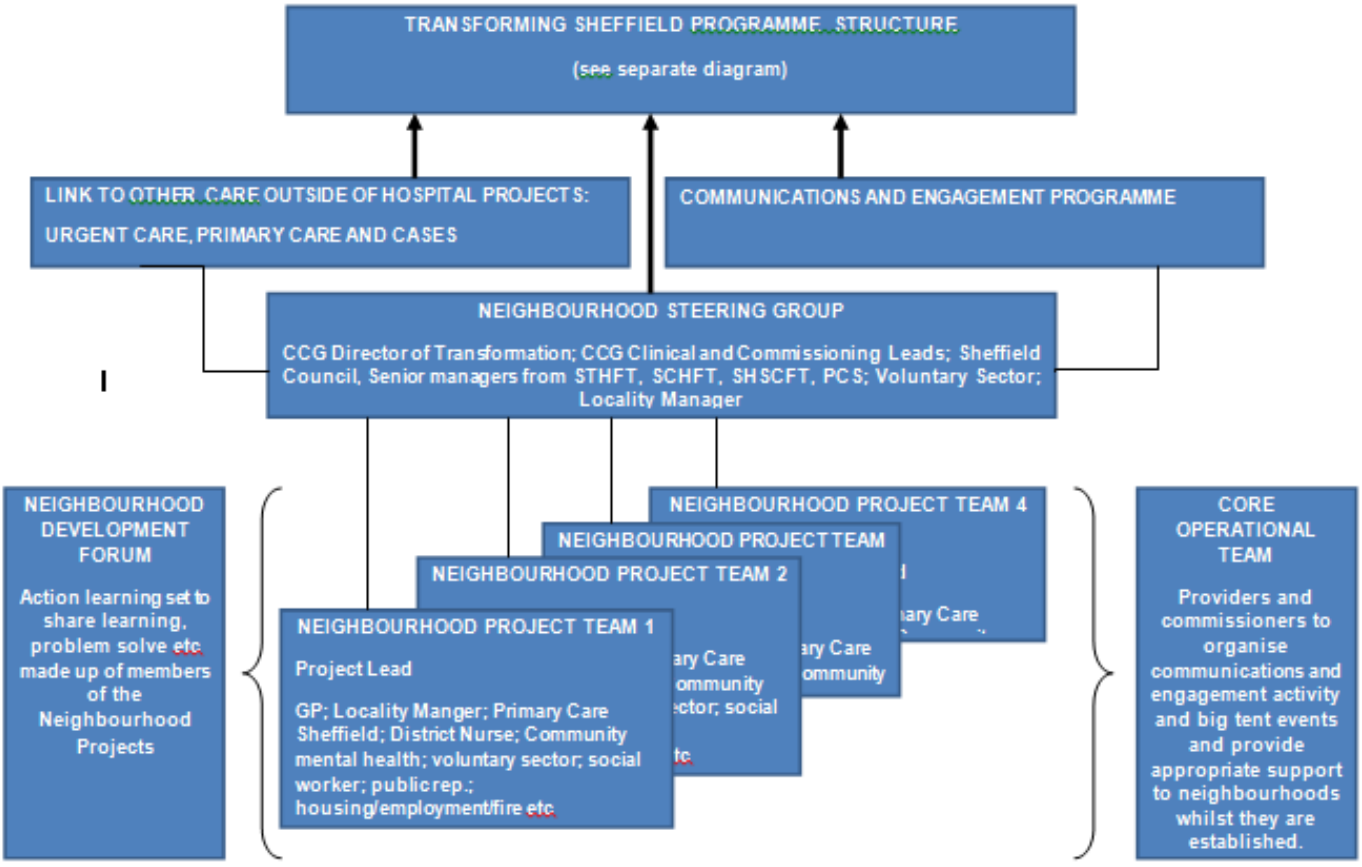
Governance

The Joint (commissioner and provider) Active Support and Recovery (AS&R) Group will oversee the delivery of the neighbourhood model and the efficiency savings (agreement confirmed at joint meeting on 10th May 2016). This group has Director Level

representation from all providers and commissioners. It was also agreed that detailed plans and timescales would be reviewed at every meeting. Each scheme would have a named facilitator who would be supported by relevant individuals from other organisations across the system. Operationally issues would be addressed at the weekly provider meeting or raised with commissioners where relevant. The intention is to establish growing devolved leadership to the Neighbourhoods themselves. The Joint AS&R Group will:

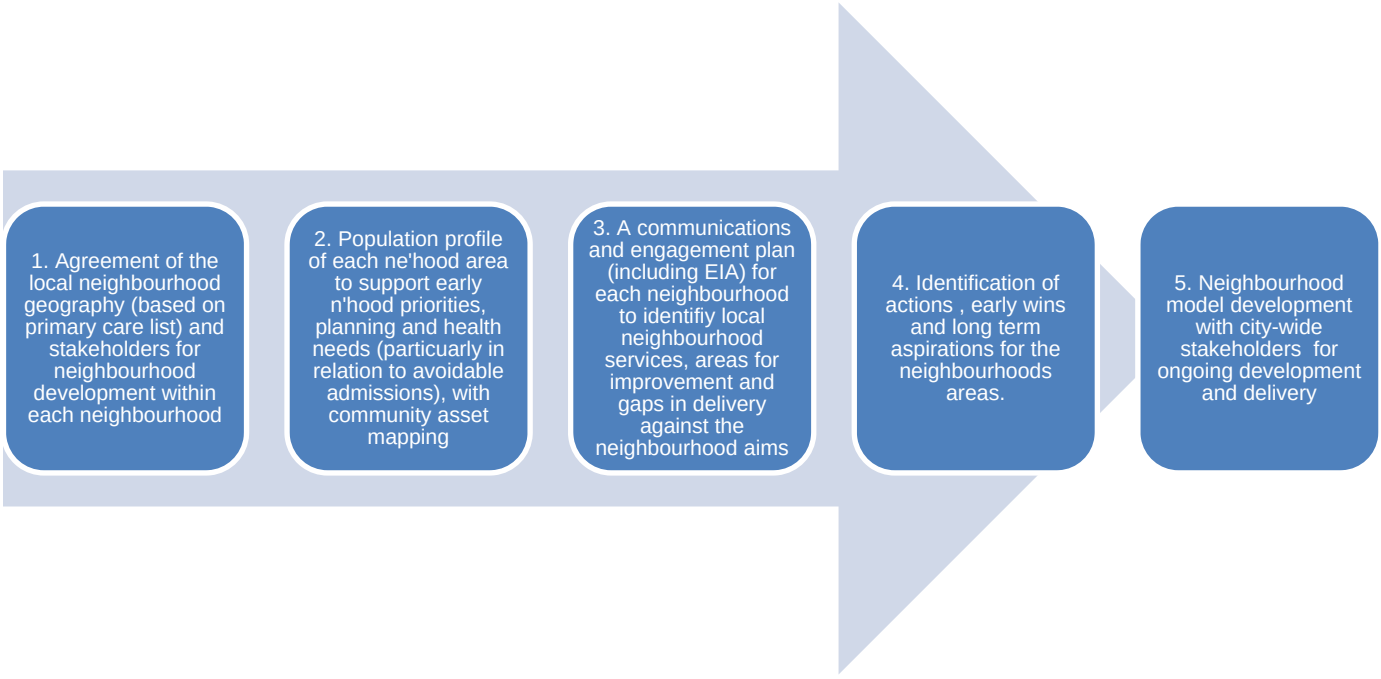
- Own the model and ensure it is widely understood and adopted
- Ensure direction is maintained and work remains on track
- Ensure pace is maintained alongside an inclusive approach
- Monitor benefits realisation (quality, experience, outcomes and savings)
- Consideration of requests for approval and act as point of escalation (as part of an MoU to be agreed with CEOs)
- The Joint AS&R Group will also oversee delivery of efficiency savings as part of the wider AS&R activity and QIPP.
- The Joint AS&R Group will also set up task and finish workstreams e.g. agreeing outcome measures, carrying out 'big tent' events, and similar.

The Joint Active Support & Recovery Group will in future report into the Transforming Sheffield programme structure as below:



Stages for Neighbourhood Development

The neighbourhood care model development will occur in line with the following key stages with indicative timescales (where each neighbourhood may progress at a different rate depending on local context)



Stage 1: May 2016

Stage 2: Within one month (end June) following stage 1 and ongoing

Stage 3: Within one month (end June) following stage 1

Stage 4: Within two months (end July) following stage 1

Stage 5: Within three months (end August) following stage 1

Key Considerations for Neighbourhood Model Development

Neighbourhoods will need to be responsive to the strategic aims and objectives of the Sheffield-wide transformation and out-of-hospital agenda, with the model to be developed in line with the following key considerations;

- Neighbourhoods need to define a core-model which is consistent across the city through the neighbourhood governance framework
- In addition to the core-model there may be services to address needs specific to the neighbourhood
- The aims and objectives of the neighbourhood need to deliver efficiencies which need to be made in the system

Communications and Engagement

As part of a “constant” public and patient engagement (PPE) approach to the neighbourhood development and delivery, the following considerations and activities will be utilised working with and supported by Equality and Diversity, Communications and Engagement Teams;

- A general approach to PPE based on the Gunning Principles
- Equality Impact Assessment Screening to be used in conjunction with public health neighbourhood data profiling and analysis
- A “PPE” offer from PPE teams to support neighbourhood development that may include; Utilisation of existing community events to support continual public engagement and involvement as the model evolves (e.g. summer festivals), profiling “what we know” at neighbourhood level to support neighbourhood development, PPE support to neighbourhood plans, meetings and groups, provision of any existing/accessible/relevant evidence base to support neighbourhood development, support for engagement and involvement events at neighbourhood level (e.g. big tent events/focus groups), and others. Such activities will need to be agreed with the PPE team and utilise available PPE capacity and expertise effectively which may include support across different organisations.
- Ongoing public communications in relation to the progress of the programme of work
- Measurement and evaluation using PPE data (qualitative and quantitative) as part of the model development, performance analysis and delivery e.g. Assessing the impact of the model against ”Speaking with confidence” data, patient experience data and similar. Feedback collected to be shared with partners to ensure a cohesive and shared learning approach across the city
- Activities that ensure the model develops in line with relevant legislation e.g. due process for consultation and similar where relevant

Who is involved in this work?

- NHS Sheffield Clinical Commissioning Group (CCG)
- Sheffield City Council
- Sheffield Teaching Hospital
- Primary Care Sheffield
- Sheffield Health and Social Care Trust
- Sheffield Cubed (A consortia of voluntary sector organisations).
- South Yorkshire Housing Association (A registered social landlord providing both social housing and extra care services etc.).
- Local voluntary sector organisations and Community Partnerships as part of Keeping People Well
- Wider public sector organisations

Appendix; Neighbourhood areas and facilitators

One representative from each neighbourhood will report to the Joint ASR Commissioner/Provider Group to update on progress, to be determined by the neighbourhood. However, the facilitators for each neighbourhood are listed below to support early development.

Neighbourhood	Description (practices within may change and require consideration in line with commissioner and provider feedback)	Neighbourhood Facilitator
1	GPA1	Paul Wike/ Michelle Wilde
2	The Foundry Alliance (and others)	Simon Kirby/ Nicky Normington
3	Townships	Gordon Osbourne
4	W4 GPA	Rachel Dillon/ Kate Carr
5	Darnall	PCS/SHSC
6	Carrfield	PCS/SHSC
7	Jordanthorpe	PCS/SHSC
8	City Centre Practices	Meeting 8/6/16 to discuss
9	SWAC	Paul Wike/ Michelle Wilde
10	SAPA	Simon Kirby/ Nicky Normington