Better Care Fund – Programme Update following on from Internal Audit 2016/17 Review

Governing Body meeting

2 November 2017

L

Author(s)	Nicki Doherty, interim Director of Delivery – Care Outside of Hospital Julia Newton, Director of Finance
Sponsor Director	Nicki Doherty, interim Director of Delivery – Care Outside of Hospital

Purpose of Paper

This paper is being presented to Governing Body at the request of the CCG's Audit and Integrated Governance Committee (AIGC) following its meeting on 10 October 2017.

The purpose of the paper is to provide assurance to Governing Body that actions have been taken to address the issues raised by the CCG's Internal Auditors in their report looking at delivery of the 2016/17 Better Care Fund (BCF) action plan.

Key Issues

Sheffield has an ambitious BCF plan, with a substantial pooled budget. The 2016/17 detailed plan was approved by the Sheffield Health and Wellbeing Board (HWBB) on 31 March 2016.

As part of the CCG's annual Internal Audit plan agreed by AIGC for 2016/17, Internal Audit were asked to undertake work on reviewing the implementation of the BCF plan. Three recommendations emerged from the audit with a high or medium risk rating and an overall assessment of Limited Assurance was given. AIGC consider it important that any audit which results in an opinion of Limited Assurance should be brought to Governing Body's attention and in particular that Governing Body receive assurance that actions are being taken to address the causes of this level of assurance.

It should be noted that the Limited Assurance relates to the level of evidence available to demonstrate measurable delivery against the certain of the plan's objectives and the absence of a systematic reporting framework to HWBB and the Executive Management Group during 2016/17. The audit did not cover the financial management of the BCF Pooled Budget arrangements which were covered as part of the CCG's external audit and no issues were raised.

Is your report for Approval / Consideration / Noting

Consideration

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

1. Note the recommendations of the audit report and the actions and improvements which have been put in place in 2017/18
2. Advise on any further appropriate action that it considers necessary

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?
4. To ensure there is a sustainable affordable healthcare system in Sheffield, **Principal Risks 4.2 and 4.5.**

5. Organisational development to ensure CCG meets organisational health and capability requirements **Principal Risk: 5.4** Inadequate adherence to principles of good governance and legal framework leading to breach of regulations and consequent reputational or financial damage.

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

Additional programme management capacity to support the BCF programme is currently being recruited to.

Have you carried out an Equality Impact Assessment and is it attached?

Please attach if completed. Please explain if not, why not
Not applicable

Have you involved patients, carers and the public in the preparation of the report?

Not applicable

NHS
Sheffield
Clinical Commissioning Group

Better Care Fund – Programme Update following on from Internal Audit 2016/17 Review

Governing Body meeting

2 November 2017

1. Introduction

The Sheffield Better Care Fund (BCF) Plan for 2016/17 was presented to, and approved by the Sheffield Health and Wellbeing Board (HWBB) at its meeting on 31 March 2016. The BCF Plan for 2016/17set out a number of key deliverables that it expected to achieve across the various areas of work within the BCF.

Sheffield CCG's AIGC approved as part of the 2016/17 internal audit plan that audit would undertake work on reviewing the implementation of the BCF plan. This piece of work actually took place in summer of 2017 and the final report was received in October 2017. The purpose of the internal audit review was twofold:

- To select a sample of BCF planned activities and to follow up the progress against the objectives
- To review the governance and monitoring arrangements around the delivery of activity within the BCF.

An overall assessment of Limited Assurance was given. (Limited Assurance means audit identified weaknesses in the design or inconsistent application of controls which put the achievement of the system's objectives at risk in the areas reviewed.) AIGC consider it important that any audit which results in an opinion of Limited Assurance should be brought to Governing Body's attention and in particular that Governing Body receive assurance that actions are being taken to address the causes of this level of assurance.

It should be noted that the Limited Assurance relates to the level of evidence available to demonstrate measurable delivery against the certain of the plan's objectives and the absence of a systematic reporting framework to HWBB and the Executive Management Group during 2016/17. The audit did not cover the financial management of the BCF Pooled Budget arrangements which were covered as part of the CCG's external audit and no issues were raised.

2. Summary of Actions Taken in 2017/18

Attached at **Appendix A** is a table showing the 3 recommendations from the report and the management actions now being taken to address these recommendations. However, it is important to highlight that well in advance of the audit report being received by the CCG management team, a series of actions had already been taken to improve the reporting framework to monitor delivery against the 2017/18 BCF plan and to align this work with the other system wide work being developed through the Accountable Care Partnership (ACP) arrangements.

We have introduced a new programme management structure to offer rigour to delivery of our Better Care Fund programmes. This includes:

- An Executive Management Working Group: a sub group of the Executive Management Group (EMG), led by the Director of Delivery Care Outside of Hospital and made up of workstream leads and finance leads
- Programme Management Documentation: this is made up of a strategic summary to describe what each programme aims to delivery along with a summary of overarching key milestones (these shouldn't change much during the course of the programme) and a highlight report that is updated monthly. An example of these as presented to the October 2017 meeting of EMG relating to the Active Support and Recovery Programme is attached at **Appendix B** for information.
- Revised Terms of Reference for EMG and EMG Working Group
- Clear escalation processes
- Governance that connects these programme into other relevant programmes, for example Urgent and Emergency Care Delivery Board

This approach has been well received and has seen improved confidence from the Executive Management Team in delivering the programme of work as well as progress on delivery. It is also worth noting that we have been able to influence the ACP to adopt the same programme management documentation, which will ensure that BCF programmes are able to integrate seamlessly with the ACP programmes as the ACP matures.

Following the decision not to continue with the joint post of Director of Strategy and Integration when the existing secondment arrangements came to an end in October 2017, a revised management structure has been agreed between the CCG and Sheffield City Council to support delivery of the BCF programme and recruitment to 2 new posts is expected to commence shortly. This will be overseen by the Director of Delivery – Care Outside of Hospital. These arrangements are designed to integrate with those in place for the ACP programme.

3. Recommendations

The Governing Body is asked to:

1. Note the recommendations of the audit report and the actions and improvements which have been put in place in 2017/18

2. Advise on any further appropriate action that it considers necessary

Appendix A

Summary of Recommendations and CCG Management Response:

One high impact and two medium impact recommendations were made. These are shown below along with the CCG's response.

No.	Recommendation	Action	Time Frame	Lead
1.	(Medium Impact)Formal monitoring framework to be in existence which receives reports on progress for implementing plans. Health & Wellbeing Board to receive mid and end-of-year reports of progress against formal plans that are identified at the beginning of the year for the BCF.	The BCF plan for 2017/18 was submitted to NHS England in September in line with national deadlines. The draft plan was reviewed by Health & Wellbeing Board in August and signed off in September. A mid-year update will be presented by December 2017 with an end of year report presented in May 2018.	December 2017	N Doherty
2.	(High Impact) Clearly defined and measurable delivery plans containing measurable outputs for 2017/18 and beyond need to be defined for these plans.	As well as developing delivery plans for the 2017/18 BCF plan, executive director sponsors have been agreed for key metrics. The limiting factor in terms of coordination for reporting these metrics has been capacity in the CCG information team. A proposal for monitoring delivery will be considered by EMG in October with a target of November for finalising the proposal.	November 2017	N Doherty
3.	(Medium Impact) Consideration needs to be given to the required structure for the operational monitoring of initiative implementation	An EMG Working Group has been established as a sub group of EMG, with the express purpose of monitoring delivery at an operational level. Reporting will feed into EMG with exception reporting of areas which are not on track being reviewed by EMG.	In Place	N Doherty

Appendix B

Programme	ACTIVE SUPPORT AND RECOVERY
Lead Directors	NICKI DOHERTY
Project Manager	Lorraine Watson
Lead Manager	Sarah Burt

	Last Period	This Period	Forecast
	A	A	G
Impact		A	A

RAG Key
RED - risk or off track, mitigation plan not yet fully agreed with all stakeholders
AMBER at risk, have agreed plan to mitigate
GREEN - on track and not at risk

AIMS AND OBJECTIVES

To develop effective sustainable integrated out of hospital care
To support people to remain at home and prevent avoidable hospital and long term admissions.
To facilitate discharge and minimise hospital stays for those admitted
To maximise peoples recovery , independence and self management via person centred care and support..

Progress Since Last Month

Model for Active Recovery process mapped/plans & timescale

Community IVs initiation and complex wound care clinics proposals supported by AS&R Delivery Group

Evaluation/option appraisal for Virtual ward prepared

Neighbourhood Project Support Officer commenced in post

Key Milestones	Target Completion Date	Progress
Neighbourhoods development – maturity	June - October	
Roll out of Virtual ward	June – Octob 17	
Social Prescribing support /PKW	June 2017	
Integrated Active recovery (STIT/CICS)	October 2017	
Community IV - Initiation	October 2017	
Intermediate Care beds review	September 2017	
Care Homes – admission reduction	November 2017	
Service Review – Neuro/EoL/Respiratory	December 2017	

Next Steps

Continue review of Intermediate Care beds with STH linked to DTOC/5Qs and D2A
Clearly identify the impact on community capacity of DTOC and admission avoidance work streams
Identify AS&R social investment schemes /proposals
Confirm components of Neighbourhood maturity index

Ref	Key Risks	Risk Assessment			Mitigation
		I	L	RS	
1	Provision of baseline and performance data to monitor impact	4	3	12	Escalate to SMT/prioritise need for robust timely data from BI team
2	QIPP savings not able to be realised because of changes in HRGs	4	3	12	Monitor & escalate for audit/discussion with STH
3	Capacity of community services/primary care to deliver projects	4	3	12	Work with NBHs and STH re resources/workload – identify additional capacity required in community

Project Interdependencies	Detail	Project Manager
1. IT /Digital Technology / Digital solutions	IT systems interoperability /single care plan / shared care record /links to electronic patient record systems/ACS	Brian Hughes/JS
2. Workforce – skills and capacity	Availability of primary/community care staff with skills /expertise to provide services at scale	Penny Brookes/MP
3.Other key programmes	Links with Urgent Care / Primary Care / Ongoing Care/ Long Term condition /ACS	Various

ACTIVE SUPPORT AND RECOVERY

Strategy 17-18

Vision

To provide accessible , person centred and fully integrated services in the heart of each community in Sheffield, preventing avoidable hospital and long term admissions, and enabling those patients with ongoing complex needs to maximise their independence

Individuals Experience

- Supported to remain at home
- Actively engaged with developing own person centred care plan
- Holistic health and wellbeing needs met

Staff experience

- Increased multi disciplinary team working
- Reduced bureaucracy and duplication
- Skills and expertise to deliver care in most appropriate setting for patients

2 main areas:

- Development of neighbourhoods as a method of delivering care in local communities
- City wide projects to develop integrated Out of Hospital Health and Social Care services to prevent inappropriate admissions to acute and long stay care and reduce length of stay

Key Work streams

Key work streams

01 Targeted Support

Practices / MDTs utilise risk stratification processes to identify those patients with multiple/complex long term conditions at high risk of admissions — May 2017

Commence roll out of Virtual ward to practices in the Central locality — June 2017

Evaluate impact of Virtual Ward on non elective admission rates for Central Locality — September 2017

Develop Business Case for development of Ambulatory complex wound care clinics in the community — September 2017

- Implement Ambulatory complex wound care clinics in three hubs across the city — October to November 2017

02 Promote Self Care

Engage practices with Person Centred Care plan approach – LCS with 64 practices using PAMs approach — July 2017

Pilot use of digital literacy to empower patients to improve management of their long term conditions — August 2017

Dance to Health falls prevention intervention sessions implemented in 3 neighbourhoods — November 2017

03 Co- ordinated Care

Patients have a person centred care plan /Ok to Stay plan where appropriate — April August 2017

Patients have access to Social Prescribing services in local communities — April - /Oct 2017

Providers have access to shared records — TBC

04 Timely access & support

- Fast response services available in community to prevent transfer to Hospita — October 2017
- Integrated Active Recovery Services available to prevent admission and facilitate discharge processes. — October 2017
- Community Initiation of IVs piloted in one Locality for Cellulitis and Frail Elderly — October 2017

05 Asset Based Community Development

- Neighbourhoods develop population focused services that meet the needs of people living there — October March 2018
- GP practice is key co-ordinator of primary health and care needs — October March 2018
- Neighbourhood has developed community nursing, social work and People Keeping Well community partnerships. — October March 2018

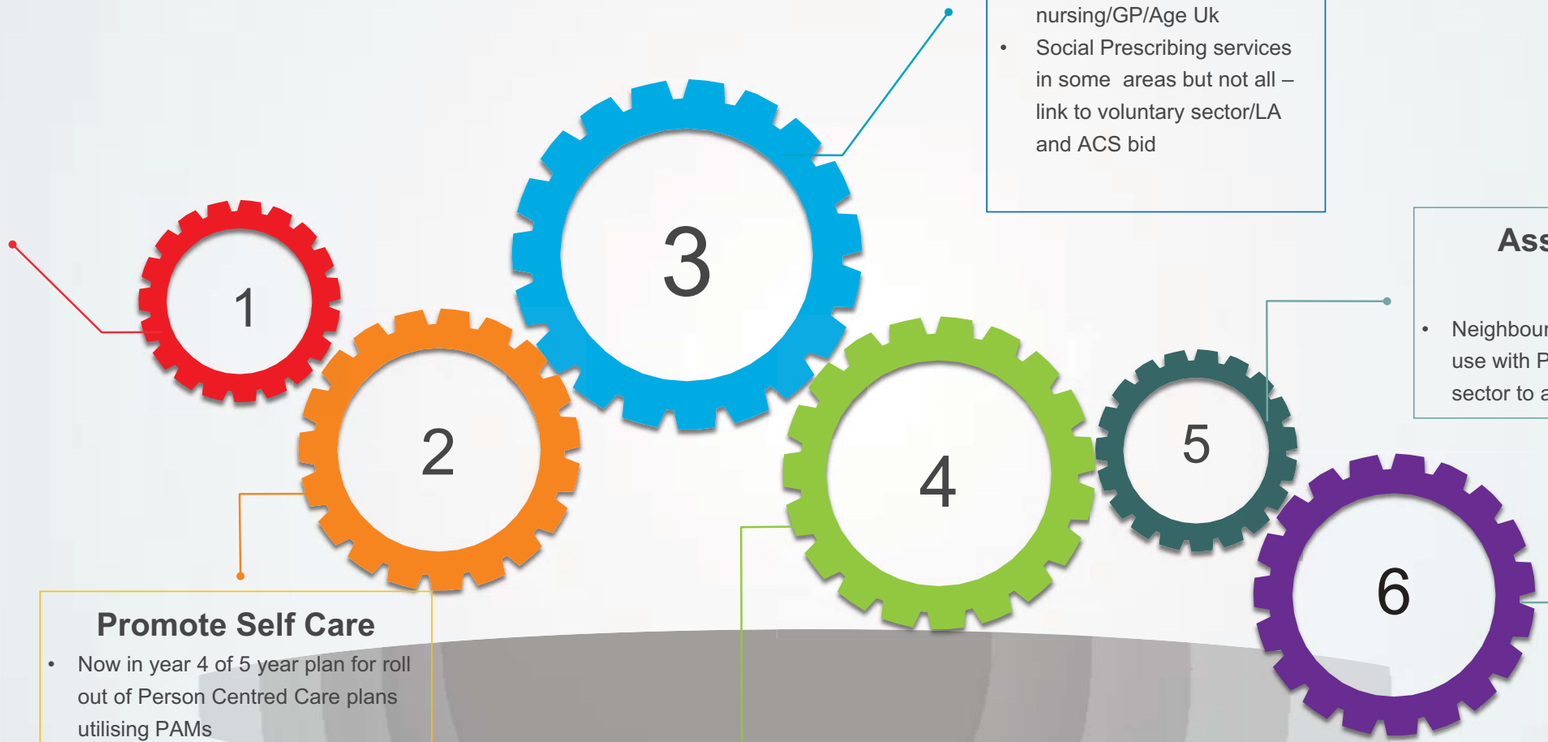
06 Best value

- Reduction in secondary care activity — April - March 2018
- Intermediate Care beds used effectively – review of type/use/capacity — October December 2017
- Shift in resource allocation to support care delivery in the community — Dec- March 2018
- Achievement of efficiency and performance targets — March2018

KEY PROGRESS

Targeted Support

- Risk stratification , frailty index and Long Term condition registers in GP practices
- Virtual Ward pilot commenced and rolled out in Central Locality
- Impact on non elective activity and patient experience to be evaluated
- Engagement and support from GPs in north re pilot of IV initiation in Community. Protocols & procedures being formalised to go through Governance routes.



Co-ordinated Care

- Ok to stay plan being utilised where appropriate in conjunction with community nursing/GP/Age Uk
- Social Prescribing services in some areas but not all – link to voluntary sector/LA and ACS bid

Asset Based Community Development

- Neighbourhood maturity index being developed for use with Primary , Community, Social and Voluntary sector to assess readiness to provide in local areas.

Promote Self Care

- Now in year 4 of 5 year plan for roll out of Person Centred Care plans utilising PAMs
- Pilot for Digital Literacy project launched in two Neighbourhoods with KPI s in terms of numbers of patients using technology.
- Dance to Health sessions due to commence in November in 3 areas with two year roll out in conjunction with AESOP

Timely Access and Support

- Redesigned integrated Active Recovery services due to be relaunched in October 2017 with streamlined service offer.

Best Value

Reductions being achieved in targeted areas for non elective admissions but efficiencies not being released due to increase HRG costs - difficulties in shifting resources to community services will result in capacity issues.