# Integrated Commissioning Programme

NHS
Sheffield
Clinical Commissioning Group

Sheffield
City Council

# Active Support and Recovery

- Active Support and Recovery (ASR) is part of the Integrated Commissioning Programme (ICP).

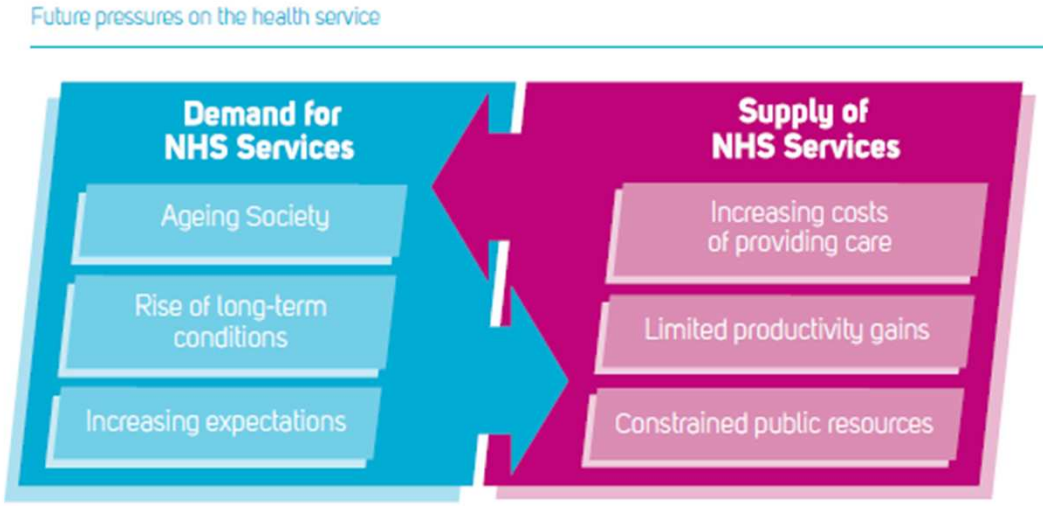
The main aim of ASR is to keep people well and out of hospital where appropriate.

The objectives of this work include:

- Coordinated care
- Services 'built' around the patient
- Personalised response
- 24/7 response
- Seamless care

Its about working with our partners, citizens and providers to create the right model of care.

# Future pressures on the services




- More than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days. (15)
- Health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.(18)
- By 2021, the number of Dementia sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year
- Over 15 million people in England have an Long term condition. They use 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England. (6)

# People told us what would make it better – we've called these the Service Principles

- The right response to a persons needs at anytime of the day or night


- A service that listens and considers all aspects of a persons health and wellbeing


- People have control over the outcomes that are important to them.
- Services and organisations that talk to each other


- Support that helps people to stay independent and well
- A way of identifying those people who need support and help them to get it quickly

# People told us ways to make it better – we've called these the "components"

- Be accessible, provide timely assessment and give key practitioners responsibility
- Use care planning, help people access the best support and stop them becoming unwell


- Use community resources and friends and family to support a healthy life
- Plan in advance so if a crisis happens everyone knows what to do
- There is one care plan in plain language which the person agrees and everyone uses
- Care and support is coordinated, with a shared plan and a single access point
- There is only one assessment with the person which is shared (with consent) with others involved in the care
- Practitioners are skilled and trained in providing single coordinated assessments and plans

# How will we measure success ?

- People get a more coordinated response from health and social care
- People get care based on what they need
- People receive care that supports the whole person including their health and wellbeing
- People have more control over their life and health
- People have more choice about their treatment
- A reduction in hospital admissions and in people being readmitted to hospital
- People will only be in hospital for as long as they need to be
- More people receiving care closer to their home
- A reduction in the numbers of people receiving long term care
- Fewer crisis situations. But when people are in crisis they will not have to wait for support

# How do we intend to do this?

- Existing providers are working together including organisations in the voluntary and independent sector

- We are working in collaboration with providers, citizens to co-design services which:-
  - Include the principles and components and focuses on achieving outcomes
  - Makes sure people are at the centre of their care
  - Meets the savings targets (currently 24m over 5 years)

- We will ensure that patients, the public and staff are engaged in and able to influence the discussion.

- This is the start of an ambitious five year programme

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