Sheffield's Better Care Fund 2016/17

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

DRAFT to the Health and Wellbeing Board, 31 March 2016

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1. Background

In 2013 NHS Sheffield Clinical Commissioning Group (CCG) and Sheffield City Council (SCC) 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) and both organisations jointly set ambitious targets.

The ambition articulated through integrated commissioning of both health and social care was to:

- Ensure service users have a seamless, integrated experience of care, recognising that separate commissioning can be a block to providers establishing integrated services.
- Achieve greater efficiency in the delivery of care by removing duplication in current services.
- 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 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. Of equal emphasis is an ambition to ensure that we commission jointly across health and social care which means using a broader range of skills in the procurement and commissioning process.

Our ambitions have been informed specifically by engagement work led by our Health and Wellbeing Board and by local and national public opinion on integration, and by the learning from our provider-led Right First Time (RFT) programme, which sought to integrate our response to urgent care needs. The Better Care Fund is a pooled budget between the CCG and SCC and to support this commissioners established the Integrated Commissioning Programme to deliver the BCF plans - a sister programme to the RFT programme.

The initial BCF was built on wider local partnerships with our Foundation Trusts who are involved in the work that has led to our plans and are fully supportive of the ambition to reduce non-elective admissions and transform care. However, the transformational change has not yet reached our ambition.

The key learning from this is that whilst integrated commissioning has significant value and a central place in providing a convincing holistic narrative around which providers can align their strategies for future provision, the difficulties with different systems of regulation, of an increasingly challenging financial position and of increasing service pressures across both health and social care have led to a revision to our original thinking. Supporting this revision in thinking was some work carried out by Deloitte in April 2015 which identified that Commissioners needed to provide a clearer vision to the system, an improved governance structure more delivery focused, and a share of the transformation resource across all

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organisations involved in the changes.

A new narrative of whole system working is emerging. The city is currently establishing a Sheffield Strategy which is city centric and focused on working better and closer together across boundaries for commissioning / provision / health / social care and voluntary sector.

We will focus on the delivery of initiatives jointly agreed between providers and commissioners and will include development of decision making and risk sharing arrangements to establish effective shared responsibility and governance of the pooled budget. 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.

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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2. Why we're doing it: the case for change

The initial case for change established a clear rationale for integrating commissioning arrangements for health and social care which would in time extend to the whole of our expenditure. This was based upon:

- 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.

2.1 National programmes

It is important to review this in the light of the developments made around the National Vanguard Programme, the New Models of Care Programme and the recent Pioneer Programme. These programmes of work have looked at innovative ways of establishing new models of care developed in different ways:

- New contracting models establishing new provider organisations where a new mix of skills, resources or core competencies allow for new transformational opportunities based on organizational leadership or changing incentive structures i.e. prime contractor, alliance contracts, primary provider models.
- Emerging Primary care organisations providing an alternative to previous provider organisations.
- Sheffield gaining opportunities through the Primary Care Co Commissioning.

In addition to this the NHS requirement to develop whole system Sustainability and Transformation Plans on a larger footprint together with joined up Local Operating Plans supports the move to a whole system Sheffield approach which benefits our population.

2.2 The Sheffield population

The 580k resident population of Sheffield is both growing and changing and importantly growth has not been even across different neighbourhoods of the city nor between different social and demographic groups. The numbers of young adults (20-29 years old) choosing to live in the city is increasing, reflecting the net outcome of economic migration to Sheffield and a growing university student population. Longer life expectancy in the city has also

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seen an increase in people aged over 75 years old and in the over-85 year old group. The number of births has also increased. Together these three factors have led to the steadily rising population since 2001 at more than twice the rate of the city region. The city has also become more cosmopolitan, with a greater ethnic mix, and over 19% of the local population consisting of people from Black, Asian and other minority ethnic communities

On a neighbourhood level, the seven aspects of the Indices of Deprivation for 2015 demonstrate that although Sheffield has made some small improvements over the last five years however, the polarization of relative deprivation is high across specifically to health indicators. This is significant for the Sheffield Strategy.

The following can be stated about the health and wellbeing of Sheffield people:

- Life expectancy continues to improve. An improvement of 3.5 years for men to 78.8 years and just over 2 years for women to 82.4 years in 2012/14 narrows the gender gap where men now live on average just over 3.5 years less than women in Sheffield. This is similar to the national level.
- Overall, life expectancy in Sheffield is still below the national average and the gap between life expectancy of the least and most deprived women in Sheffield is 6.9 years and for the least and most deprived men 9.8 years. The gap has remained largely unchanged over the last 10 years.
- The causes of differences in life expectancy between most and least deprived men in Sheffield are Cancer (32.1%), Circulatory disease (27.3%) and Respiratory disease (13.5%), and for women are Cancer (35.6%), Respiratory disease (21.5%) and Circulatory disease (19.5%).
- While health life expectancy of men is increasing year-on-year and has improved by two years to 61 years since 2009/11 the trends for women are less favourable with the healthy life expectancy falling from 61 years in 2009-11 to 59 years in 2011-13. This is almost five years less than the national average, placing women in Sheffield in the lowest quartile nationally and of the Core Cities Sheffield has the lowest ranking. This results in women in Sheffield living on average the last 23 years of life in poor health which needs addressing.
- Deprivation is a major determinant of life expectancy, healthy life expectancy and ability to access resources and opportunities that can influence health, wellbeing and prevalence of conditions associated with preventable mortality. The geographic pattern of health deprivation highlights the high levels of deprivation in the East and North of the city
- Mental health has historically featured too little in NHS plans even though 25-30% of all patients admitted to hospital with a physical illness also have a mental health condition that, in most cases, is not actively addressed while the patient is in hospital – this can lead to poorer outcomes of the physical health condition, longer length of stay and for older people an increased risk of discharge to institutional care. In order to reduce demand on secondary care services mental health needs to be addressed alongside physical ill health conditions. It's important to recognise that 78% of mental health service users access hospital services compared with 48% of non-

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mental health service users and that two thirds of NHS beds are occupied by older people. Up to 60% of older people in hospital have, or will develop, a mental disorder during their admission and in the population as a whole 1 in 20 over 65, and 1 in 5 people over 80, has a form of dementia.

- Sheffield is on a par with the rest of England in terms of indicators related to preventable healthcare activity and recording of key aspects of preventable ill health, but does less well in terms of reducing preventable premature mortality (deaths in people under the age of 75 years) from cancer, cardiovascular disease (CVD), respiratory disease and liver disease. In addition, there is an aspect of preventable healthcare activity (emergency readmissions to hospital) where further improvement is required:
- Cancer: each year almost 42% of all premature deaths in the city are caused by cancer. This makes it the leading cause of death in people under 75, as is also the case nationally. Moreover, despite a reduction over the last 10-20 years, Sheffield's premature mortality rate from cancer at 159.9 per 100,000 population (2011-2013) remains significantly higher than the national average (144.4 per 100,000 population).
- Cardiovascular disease (CVD): currently CVD accounts for around a quarter of all premature deaths in Sheffield. Although the gap between Sheffield and rest of the country has narrowed, our rate at 89.6 per 100,000 population (2011-2013) remains significantly higher than the average for England (78.2 per 100,000 population).
- Respiratory disease is the third leading cause of premature death in Sheffield (after cancer and cardiovascular disease) and COPD the main cause of respiratory mortality. The premature mortality rate from respiratory disease is reducing in Sheffield and at a faster rate than nationally. In Sheffield, approximately 70 respiratory deaths in people under the age of 75 could be avoided each year if the prevalence of smoking were reduced to among the lowest levels in the country.
- Liver disease is the only major cause of premature death for which the rate is increasing (locally and nationally) although it has recently begun to level off. People are also dying from it at younger ages. Premature mortality from liver disease in Sheffield now accounts for almost 80 deaths per year in people under the age of 75 years. Over 90% of these deaths are considered preventable. The common avoidable causes of liver disease are alcohol consumption and obesity.
- Emergency readmissions to any hospital within 30 days of previous discharge: in Sheffield the percentage of people readmitted to hospital after 30 days following discharge has been increasing year on year for the past 10 years from 10.6% in 2002/2003 to 12.5% in 2011/12. This is now higher than the national average of 11.8%.

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3. Our Vision

3.1 What Sheffield people have said

We have held a number of engagement exercises over the past few months and years. The following statements have been gathered which articulate the distance that required in order to achieve the vision statements outlined below.

- *If things go wrong it's difficult to receive the care I might need quickly enough*
- *I find it hard to find my way around all the variety of services – or even to know if what I need is actually provided by someone*
- *We have to constantly repeat information from one person to another*
- *I have little control over the care I do or don't receive*
- *My psychological needs are not met as part of care for my physical needs*
- *Services often aren't available at night or weekends like they are during the week*
- *Why don't services plan in advance – surely they should know if I get unwell I'll struggle to cope but don't necessarily want or need to go into hospital*
- *Why can't I just have one care plan?*

3.2 Our vision for 2020

Based on the comments above, our hope that the following changes will be delivered by 2020:

- 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.

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- 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.

These changes should mean that:

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

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4. Our future model

In this section we talk about four proposed levels at which services should be established. The starting point is the person, with the aim of establishing services as near to the person as possible whilst recognising that many services must be organised at scale in order to ensure they are efficient, resilient and effective. The needs of the person should drive the services established at neighbourhood level, the neighbourhoods should drive locality level services with the city wide services supporting this work.

4.1 The person: their household, family and friends

Care should be person centred and integrated. Patient assessment should be holistic and there should be single care plans that address a person's health and social care needs. A summary of key features of this approach are:

- Considering the person, the household, family and friends in assessing need and designing care rather than just the disease
- Pro-active targeting through combined risk stratification and people GPs identify as being at risk of escalating need
- Goal setting – move from 'what's the matter with you?' to 'what matters to you?'
- Single assessment, single care plan built around the patient and their carer's, friends, family, neighbours and local community services
- Shared decision making and managing patients expectations to avoid increasing dependence on professionally provided services and to support their autonomy
- Single team looking after the whole person
- Re-enforcing dignity, respect and compassion
- Use of the motivational interviewing and Patient Activation Measure
- Set outcomes being aimed for and not just processes of care and treatment.

4.2 Services at Neighbourhood Level (guideline population size of 30k-50k)

Local communities are often relatively small, perhaps about 5k population. At this scale voluntary groups operate and a there can be a good understanding of the services and support available. Individuals are therefore more likely to be recognised e.g. by the local café, hairdresser etc. It's essential that this 'informal' network and support is understood and utilised. The 'formal' organisational structures will need teams small enough that they know most of their clients and can provide continuity of care, but large enough to be able to cope with holidays of their staff, provision of a range of technical expertise etc. Teams that have the right mix of skills that works to a common goal with the patient at the centre, with flexibility to deliver what the patient needs without a restrictive contract or 'input' service specification. These teams need to support GP practices and are likely to cover a population of circa 30k to 50k:

- Teams and services tailored around a community's particular needs be it language,

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common conditions, age related, homelessness, students etc.

- Removal of the silo working between different staff groups and establishing cross-working e.g. between nursing staff: Community nurses working into practices and practice nurses into community to ensure reduced variation of care whether patients are ambulant or housebound
- Based around GP practices with strong joint working, potentially with voluntary APMS or locally contracted services which provide the necessary 'top-up' to the core GP contract
- Supporting the GP as the senior clinical lead for their patients, with the authority to direct services provided by community teams (much as a consultant in hospital works in partnership with ward staff etc.)
- Facilitating changes in roles and skill mix to support care for the 'worried well' and minor illness so that GPs can focus more on complex care, long term conditions and end of life
- Overseeing services within care homes and care plans for end of life care
- Able to integrate support for clients with the local community, voluntary sector, pharmacies, housing support teams etc.
- Care planning is co-ordinated across single multi-disciplinary teams
- Teams following a patient through any step up care or hospital admission to ensure they can be discharged asap with the services in place when they return.

4.3 Services at Locality Level (guideline population size of 100k-150k)

Certain more specialist services (e.g. geriatricians, specialist nurses) must be provided to a greater population than at neighbourhood level. However, retaining a smaller scale than city wide helps to ensure that services remain community based and it is more practical to ensure continuity of care through shared records, certain staff working at neighbourhood and locality level (e.g. through work rotas covering both levels) to ensure a full understanding of the locality teams and the neighbourhoods and the services being delivered to them.

- Provision of services that are only viable at a scale larger than at neighbourhoods
- The potential for utilising on the day appointments across practices and potentially weekend cover arranged for and by Primary Care with access to practice systems
- Teams rotating seven days a week to improve experience of weekend working and ensuring the best professional standards are supported
- Specialist input for rapid advice, potentially through a CASES model
- Community Geriatrician working with neighbourhood teams
- Potentially step up care for patients who require short term treatment or observation, or alternatives to home whilst adaptations are made and/or services are put into place

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- The opportunity to develop local diagnostic services, including investigations and minor procedures

4.4 Services at City Wide Level

Certain services can only be delivered at scale, or there is only a need for one of the services city wide e.g. GP night cover (a number of these services are listed below). In addition, there are certain functions that are best provided city wide e.g. workforce planning. Finally, there are overheads that are far more efficiently provided at scale e.g. governance, human resources, corporate finance etc.:

- Out of hours GP cover, particularly nights
- Workforce planning and training e.g. practice nurses and new training and qualifications such as Urgent Care Practitioners
- Ability to move money around the system seamlessly e.g. from locality to neighbourhood, hospital to community
- Harnessing new technology to better support people to stay in their own homes
- Single urgent primary care centre in front of A&E
- Operational functions including governance, HR, payroll, accountancy, supplies, logistics
- Ensuring strong information governance and shared records
- Carrying out research and development, evaluation
- Making the links to other health and social care economies –Working Together Programme and acute care vanguard
- Leading on OD and culture change
- Ensuring quality and consistency, sharing best practice and reducing variation in services
- Overseeing the overall interface with secondary care
- Ensuring local services are planned and delivered in a wider geographical context, in particular South Yorkshire but also the wider footprint covered by the working together programme.

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5. Our key areas of work in 2016/17

To meet our vision and redesign according to our delivery model, we are focussing on four key areas:

- People Keeping Well
- Active Support and Recovery
- Ongoing Care
- Non-Elective Admissions.

5.1 People Keeping Well

People Keeping Well is a proactive, preventative community-based approach that was initially designed to improve the health and wellbeing outcomes of people identified as being at moderate to high risk of unplanned hospital admission or needing formal social care support. However, it has been developed over time to be equally relevant to improving wellbeing across the population.

This is based around six ingredients (or functions) that, when mixed together in the right way for a particular local community, can deliver demonstrable benefits for individuals and the wider health and social care system. These are described below.

- **Local advice and information** that helps people maintain independence and wellbeing. For example training local hairdressers and shop staff to spot signs of deteriorating health and wellbeing and provide initial advice like who to contact, or where to go for support.
- **Risk stratification**: Utilising the Combined Predictive Modelling tool (CPM) as a starting point, 19,000 people in the city have been identified as falling into the moderate to high risk category.
- **Community assets / activities** tuned to the needs of people at risk.
- **Sort and Support**: The best way to connect people at risk to information and advice, and community activities and other available support is to make this a 'human contact' – people on the ground having conversations. This requires people with the right skills to engage the individual, listen to their story, and then support *them* to take action to improve their health and wellbeing. This could involve making sure people they have a 'winter plan'; encouraging people at risk to access health checks and self-care advice.
- **'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).

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- **Wellness planning'** and self-care is a key component of the framework. It involves people setting goals and coming up with actions to achieve that goal. Wellness planning can be done by individuals themselves or with support. A wellness plan can be as simple as someone having a fridge magnet with a phone number on they can call when they start to struggle with life, or it could be a detailed plan shared between agencies describing the longer term actions someone is taking to manage and live with a long-term condition.

5.2 Active Support and Recovery

Active Support and Recovery (ASR) focuses on creating truly 'person-centered' care, where services are built around the user. It's about working with our partners and providers, service users and carers to create the right model of care.

The main aim of ASR is to keep people well and out of hospital where appropriate. We want to improve the health and wellbeing of people who use health and care support and services in Sheffield. The objectives of this work include:

- Coordinated care with health and social care services
- Services 'built' around the patient
- Personalised response
- 24/7 response
- Seamless care

What do we intend to do?

- Support people to stay at home and avoid unnecessary hospital or care home admissions
- Respond quickly when people need additional or different type(s) of support so they stay out of hospital or long term care or their stay is kept to a minimum
- Make sure if people are admitted they are discharged with the right support to help speed up their recovery and increase their level of independence
- The consequential impact of changes on providers has been considered in detail and all plans have been shared with providers. Full agreement can only be confirmed once all provider contracts have been signed. The target date for this is 31/3/2016.

Our aims

- Be accessible and provide timely assessment
- Use care planning, help people access the best support and stop them becoming unwell
- Use friends, family and community resources to support a healthy life

- Plan in advance so everyone knows what to do in a crisis
- One care plan in plain language so everyone can understand and use it
- One assessment with the person which is shared (with consent) with others involved in their care
- Our practitioners are skilled and trained in providing assessments and plans

A fundamental principle is ensuring the needs and aspirations of the citizens of Sheffield were listened to. This was central to ensure creation of a local vision for integrating care, agreeing what outcomes need to be achieved and what the new model of care should look like.

5.3 Ongoing Care

The aim of Ongoing Care is to develop a pooled budget, create a new single organisational culture for shared assessment and move towards a shared approach to assessment, care management and care coordination within the context of access being 'free to NHS services' and 'charged for' LA services.

There has been significant achievement in some areas of this workstream through 2015. There is agreement, though not practical management of, a shared budget. There has been an alignment of the assessment teams (impacted by the in house shift of CHC back into the CCG) and there has been some very effective joint organisational development work.

In the following year we intend to:

- Support an integrated assessment process across health and social care. It is anticipated to be in place by the end of September 2016.
- Hugely simplify the administration of joint packages of care between the Local Authority and the NHS CCG. Discussions are at an advanced stage and should be in place no later than 1st November. This will create a shared agreement on how costs will be apportioned. It is anticipated that this will lead to a culture change within front line staff by avoiding the focus on which side is paying and to instead focus on the most cost effective and appropriate care package for each patient.
- Agree a Transforming Care Partnership Plan. This, and "Building the Right Support", gives us a new opportunity across health, social care, adult and children's commissioning in South Yorkshire and North Lincolnshire to radically review the care that is being delivered in the area. It gives us an opportunity to learn from successes across the region, and establish jointly agreed best practice models of community care to replace outdated hospital care. It gives us an imperative to explore opportunities for more person centred care, including Personal Health Budgets and to look at building a workforce fit for the future across the region, based on approaches such as Positive Behaviour Support as the best alternative to restrictive hospital care. In the next year we will:

- Continue to implement Care and Treatment reviews for all eligible patients and people at risk of admission, and introduce these for children
- Reporting on national Assuring Transformation Tracker of all patients within specialist hospitals
- Developing personalised alternatives to hospital care, including market stimulation for complex needs provision, against the national model
- Reviewing current commissioned provision and potentially giving notice to providers
- Ensure discharges take place as intended against the national trajectory
- Developing plans for decommissioning hospital beds
- Developing plans for alternative provision of community preventative and crisis services
- Continuing to develop plans for improved accommodation with the Local Authority.
- Building on some success this year in aligning assessment teams.

Families and people with learning disability will be at the heart of helping this redesign process aimed at safeguarding the interests of this population.

5.4 Non-Elective Admissions

Non Elective admissions remain one of the largest risks to the financial plan. The detailed work of the Active Support and Recovery and People Keeping Well workstreams are primarily designed around reducing non-elective admissions and form the bulk of the delivery of the QIPP plans.

In addition to the QIPP plans the reduction in the DTOC target and continued focus on the need for daily ward round and discharge management within the acute trust remains a key focus for 2016/17. The joint target for Delayed Transfers of Care (DTOCs) has been agreed. A joint working group to monitor and manage DTOCS is already in place. The detailed action plan to deliver the 16/17 reduction is being finalised.

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6. Our delivery plan

The following actions are proposed:

Theme	Action
1. People Keeping Well/Ongoing Care	1. Reduce numbers and cost of high activity of people with whole-life conditions 2. Agree a single assessment process/reduce assessment 3. Where appropriate redeploy staff duplicated through development of a single team to then deliver a faster assessment at six weeks reducing their level of support required 4. Transforming Care Action Plan 5. Implementation of the second phase of People Keeping Well 6. Voluntary sector to standardise social prescribing offer across all practices 7. Fire service extension of home visits 8. Trial of expanded scope of health check visits to include sight tests and exercise routines etc.
2. Servicing neighbourhoods	1. Identify the current level of staffing, activity and impact of those resources currently within STH Community Services for both generic workforce and specialist resources in parallel with STIT transformation 2. Review both social care and voluntary sector support across the city and map to practices and localities 3. Establish generic roles for the standard delivery of care across key staff groups 4. Develop an impactful two-hour community response from Community Services which will respond to GP or Yorkshire Ambulance Service 5. Align operation of social care staff to neighbourhoods
3. Developing primary care	1. Agree and develop practice groupings phase 2 2. Agree and develop practice groupings phase 3 3. Expand scope of Single Point of Access and rebrand to Central Point of Access and develop service to incorporate neighbourhoods but also wider range of onward referral services
4. Urgent and reactive care	1. Implement estimated date of discharge to ensure planned approach to discharge management 2. Implementation of safer, better, faster throughout urgent care system

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	3. STIT reorganisation 4. Home First introduction supporting A&E/ambulance turnarounds 5. Fire service volunteer night sitting service to reduce admissions 6. Fire service pre-discharge house check on admission for unheralded falls patients
5. Effective care/planned care	1. Implement CASES and LTC programme 2. Ensure that pathways are supported at appropriate specialist community support and link capacity 3. Implement follow-up reduction 4. Implementation of BADs settings 5. Develop high priority pathways between primary and secondary care
6. Mental health	1. Procurement of psychiatric liaison service 2. Implementation of community model of delivery for community psychiatry 3. Prevention workstream
7. IT/Information Governance	1. Whole-system approach to risk stratification to increase coverage and efficiency 2. Deliver the Test Bed action plan
8. Estates	1. Develop a clear position statement about the whole-system estates opportunities 2. Understand potential changes to estates use through new models of neighbourhood service delivery 3. Deliver 50% reduction in CCG void costs
9. Workforce/OD	1. Whole-system workforce planning strategy 2. Dual training programme for flexible working within a community model 3. Scope workstreams on future models of care to understand gaps and potential for new roles across the health and social care system
10. Research and evaluation	1. Development of a whole-system dashboard illustrating the key shifts in activity, resources and outcomes 2. Coordinate range of externally commissioned evaluation programmes by initiative 3. Align evaluation resource and budget to key workstreams for delivery boards

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7. Our financial plan

7.1 Overview

The Sheffield Better Care Fund Pooled Budget was £277m in 2015/16 and the proposed budget for 2016/17 is £282m. The respective contributions of Sheffield NHS CCG and Sheffield City Council are shown below. These figures are taken from the Better Care Fund 2nd Planning Submission made to NHS England on 21st March 2016 and are also consistent with the CCG financial planning submission made on 2nd March 2016. The Executive Management Group also considered the 15/16 budget on the 2nd March 2016. **It should be noted that the Sheffield CCG budgets may still be the subject of change, given that the budgets presented here are part of an overall financial plan which at present do not meet the financial planning requirements set out by NHS England.**

The table below shows a reduction between the forecast outturn in 2015/16 and the proposed budget in 2016/17. However this is misleading since the 2015/16 outturn includes £5m of non-recurrent expenditure that has not been included in the 2016/17 budget which is predominantly only a recurrent position.

The contributions made to the Better Care Fund Pooled budget represent approximately one quarter of each organisations total budget. The proposed BCF budget for Sheffield for 2016/17 considerably exceeds the minimum contributions required.

The local authority BCF budget includes the Disabled Facilities Grant and agreed plans for carer specific support and carer breaks. The budget set aside for reablement activity both within the Council and the CCG is also specifically identified.

7.2 Protection of Social Care Services

One of the eight national conditions of the BCF in 2016/17 is to maintain provision of social care services.

The table below shows the change in combined BCF expenditure on different service areas. The total investment in social care increases by £1.4m in 2016/17. NHS out of hospital services are a key focus for 2016/17. The total spend has fallen in this area but this is as a result of efficiency measures.

Comparison of year on year spend	**Budget**	**Outturn**	
Area of Spend	**16/17**	**15/16**	**inc / (dec)**
Acute	57,398	59,052	(1,654)
Community Health	49,364	50,931	(1,566)
Continuing Care	51,740	50,870	870
Mental Health	445	440	5
Primary Care	1,408	1,230	178
Social Care	122,097	120,724	1,373
Grand Total	**282,452**	**283,246**	**(794)**

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The amount allocated to social care from the CCG mandatory amount has also been protected as evidenced by the table below.

CCG Mandated Minimum contribution	16/17 Budget £'000	15/16 Outturn £'000	Change £'000
Community services Total	20,477	21,005	(528)
Primary Care services	1,408	1,230	178
Social Care	3,160	3,150	10
Mandated transfer from baseline	**25,044**	**25,384**	**(340)**
Additional BCF Allocation	12,613	12,399	214
Total Mandated minimum contribution	**37,657**	**37,783**	**(126)**

7.3 Allocation of Resources

The Sheffield BCF is structured around the key areas (themes) of activity.

Sheffield Better Care Fund Budget	2015/16 Budget £'000	2015/16 Forecast Outturn £'000 (M10)	2015/16 Overspend / (Underspend) £'000	2016/17 Draft Budget £'000
Theme 1 Total - People Keeping Well in their Local Community	8,780	8,380	(400)	8,754
Theme 2 Total - Active Support & Recovery	53,296	53,598	302	49,939
Theme 3 Total - Independent Living Solutions	3,772	4,336	564	3,879
Theme 4 Total - Ongoing Care	154,229	155,880	1,651	157,467
Theme 5 Total - Adult Inpatient Medical Emergency Admissions	53,713	59,052	5,339	57,398
Theme 6 Total - Capital Grants	3,506	2,000	(1,506)	5015
Total	**277,296**	**283,246**	**5,950**	**282,452**

The 2016/17 financial position has been constructed based on joint planning between the CCG and Local Authority. Joint working formed part of the budget setting process of both organisations and was led through discussions at the Executive Management Group. In this way the impact of changes was considered across the whole health and social care system.

Planning Submission funding sources	16/17 Budget £'000	15/16 Outturn £'000	Change £'000
Sheffield Local Authority	104,670	104,285	385
Sheffield Local Authority (DFG)	3,509	1,950	1,559
Sheffield Local Authority (Other Capital)	1,506	50	1,456
	109,685	**106,285**	**3,400**
NHS Sheffield CCG - min contribution	37,657	37,783	(126)
NHS Sheffield CCG - additional contribution	135,110	139,178	(4,068)
	172,767	**176,961**	**(4,194)**
	282,452	**283,246**	**(794)**

7.4 Management of the Pooled Budget

Work has started to draft the S75 agreement for 2016/17 which must be signed before 30th June 2016.

At present there is no agreement to implement a risk share arrangement in 2016/17. Both the council and the CCG are creating contingency plans to ensure that the expenditure in out of hospital services can be protected if the reduction in non-elective admissions, or other QIPP plans or efficiency savings cannot be met.

The majority of expenditure lines within the S75 agreement are solely managed or jointly managed schemes that are funded by solely by the partner responsible for that scheme, and it is this partner who is responsible for all operational issues. The exception to this is Theme 3 the Community Equipment Service which is a jointly managed scheme with a risk share arrangement for any over or underspends.

The Section 75 agreement clearly sets out the process for dealing with over and underspends from all scheme types, and has worked well during 2015/16. Work will continue in year to explore whether there are more services which would benefit from alternative mechanisms for the organisations to share risk.

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8. The governance around our plans

In addition to the statutory Governance functions within the system, the following settings will be instrumental to the delivery of the 2016/17 Better Care Fund ambition.

8.1 Health and Wellbeing Board

The long established Health and Wellbeing Board is currently reviewing its remit and focus. It is expected that the Health and Wellbeing Board will take a holistic view of Sheffield and rather than provide an assurance role. In the light of the significant changes Sheffield will face under the public sector reform agenda the Board may challenge itself to ask "how does its Health and Social Care model support the changes the city will see in the next 5/10 years?". This will be revised and agreed in time for the final submission of this narrative.

8.2 Executive Management Group

Fortnightly, the Executive teams of both Sheffield City Council and Sheffield Clinical Commissioning Group meet to manage jointly the delivery of the BCF, the shared budgets and to progress the commissioning vision. This is known as Executive Management Group (EMG)

There are a number of changes proposed to EMG based on the outcomes of work from this year and the recognition that this is now becoming an operational way of managing whole system metrics against a plan. It is useful to note that EMG in its first year has seen the development of close working relationships whilst gaining a much more thorough understanding of each organisations method of working.

- More prominent management of the Better Care Fund metrics. Whilst there has been some good progress specifically through DTOCs, other areas have not performed as well. It has been reflected that a tighter grip via EMG would have enabled earlier interventions which could have delivered better outcomes.
- An delegation of budgets to responsible commissioners. Throughout 2015/16 issues surrounding budgets have been resolved through finance teams and with non recurrent solutions. In order to continue the drive towards better integration of the commissioning functions then these financial issues are better and more sustainably addressed by commissioners reviewing their services and making recurrent interventions.
- Improvements in the servicing of this meeting using a shared Business Intelligence report which clearly demonstrates a range of KPIs including those of the BCF indicators so that EMG can have a clearer understanding of the flows of patient activity and long term service use on a more regular basis.
- Following the establishment of the Transforming Sheffield Programme Board, EMG will become the commissioning function to take a view on the pace and impact of Transformation through TSPB.

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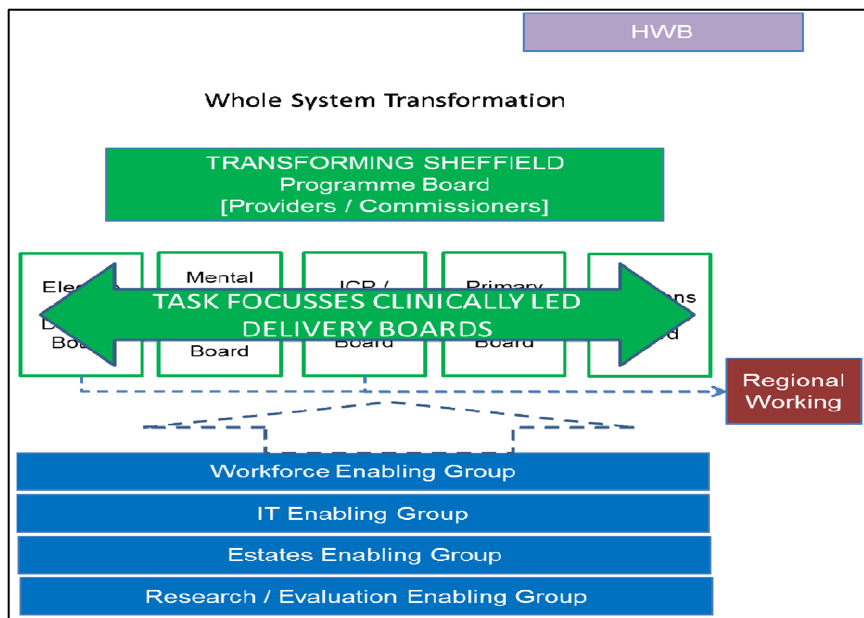
8.3 Delivery of our Ambition: Transforming Sheffield Programme

Whilst the RFT Programme has now stood down, its replacement function is based upon a better and closer commissioner-provider relationship and will ensure the supportive strategic relationships between us continue but that there is a much more focused emphasis on delivery of transformational change across the whole of Sheffield. This new function is the **Transforming Sheffield Programme**.



This revised structure consists of three tiers. The Transforming Sheffield Programme Board, a range of Delivery Groups and a number of whole system Enabling Groups. The purpose of this proposal is to encourage a whole system approach to service transformation which enables commissioners and providers to deliver the benefits of a truly patient centred integrated health and social care system. Delivery of the BCF objectives will be via this revised structure. The Figure above illustrates this structure.

It is important to appreciate that this new structure separates out the business of Service Transformation from both maintaining operational grip on the system, via System Resilience Groups and also from expediting contracts via Contract Management Boards.

This structure incorporates Providers as commissioners and the key focus is on delivery rather than another strategic forum. impact is measured in the extent to which providers change their service offer. The Transforming Sheffield Board will ensure that the delivery functions beneath are delivering whole system change.

This strategy needs to be patient focussed and have gains and incentives in it for each organisation to ensure that they come to the table with an intent to deliver.

A range of delivery groups, which will be service oriented in the first year, will deliver annual objectives working towards a longer term vision of increased community interventions and reduced acute interventions:

- Delivery boards / groups / functions to have a dual role of applying the overarching system strategy to their service area and also of ensuring effective delivery of plans once set.
- Delivery functions would operate effectively to deliver through providers and other stakeholders ta number of key priorities each year holding itself to account for this in a challenging but professional manner.
- Encourage the active clinical leadership of delivery groups both chairing these sessions or co-chairing and in leading and delivering initiatives within these to support wider transformational work
- To extend the capacity of those involved in directly leading service change it is expected that a greater range of accountable managers and clinicians will lead and deliver work through commissioning funding sessions of clinical time within providers to enable this and remove blockers.

A delivery board is:

- A place for robust open and frank discussion about the rigorous delivery and implementation of agreed transformation initiatives.
- Focussed Delivering 4-6 Key Clinically led / managerially supported initiatives over a 12 month timetable.
- Representatives from professional groups / clinicians and managers associated with delivering the changes identified by in that programme.
- Owning of associated performance measures and functions.
- Effective Programme Management Support
- Credible and jointly agreed plans with accountable owners / dependencies and timescales made very explicit
- Well served by a dashboard of both outcome indicators and process indicators which demonstrate progress of initiatives and also the initiatives impact on the overall aims / objectives.
- Clinically leadership of the Delivery Board potentially devolved to organisations across the system to ensure
- Devolved clinically leadership of initiatives spread across all organisations with clearly identified managerial support
- Clinicians funded to lead these through primary / secondary care plus other professional groups
- Standardised approaches to problem solving and issue resolution will be adopted: Root Cause Analysis / Practical Problem Solving etc.
- Highlight reports and exception reports submitted to Transforming Sheffield Board on a monthly basis.

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- Highlight reports shared with other Delivery Boards to ensure effective cross working where programmes interface and also to share best practice.
- Annually these boards will agree the future years high level initiatives in accordance with the Whole System Strategy.

Supporting these Delivery boards are four whole system Enabling Boards. These will cover IT, Estates, Workforce and Organisational Development and finally Research and Evaluation.

These enabling groups:

- Are Whole System groups organised by cross cutting themes which will prioritise and delivery a range of supporting initiatives enabling the delivery boards to have maximum impact.
- Make clear expert opportunities to Delivery Boards where appropriate.
- Treat the Delivery Boards as customers these boards will focus on priorities and needs which the delivery boards clearly articulate.
- Represent all partner organisations and work will be led by best placed organisations / people on behalf of the whole system.
- Ensure that effective programme management will underpin delivery
- Utilise exception reporting up to Transforming Sheffield Board and clear communication to delivery boards.
- Have clear links with region working to support Working Together Programme.

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9. Meeting the national conditions

In 2016-17, NHS England will set eight conditions, which local areas will need to meet through the planning process in order to access the funding. The conditions require:

9.1 That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs.

The Executive Management Group of the BCF approved the draft budget on 2nd March 2016. The Health and Well Being Board meet on the 31st March 2016 to review the BCF plan and budget.

9.2 A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.

This is covered in the financial commentary. Investment in Social Care is planned to rise in 2016/17 both in total and within the CCG mandatory investment.

9.3 Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge.

Plans have been developed to improve the delivery of 7 day services however further work is required to ensure comprehensive 7 day services in line with the 5 year forward view.

9.4 Better data sharing between health and social care, based on the NHS number.

Considerable progress has been made in adding the NHS number into the Local Authorities Social Care System. The work has been completed and is now subject to testing.

9.5 A joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.

Plans are being developed to support an integrated assessment process across health and social care. It is anticipated to be in place by the end of September 2016.

9.6 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans.

The consequential impact of changes on providers has been considered in detail and all plans have been shared with providers. Full agreement can only be confirmed once all provider contracts have been signed. The target date for this is 31/3/2016.

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An important consideration and principle for the Transforming Sheffield Programme Board is to ensure that problems are not passed around the system but rather treated at source. What this means in practice is that should there be a specific piece of work which provides an organisation with a financial challenge then this will be offset with gains from elsewhere. For example, the investment in Sheffield Teaching Hospital into Community services would be supported through a shift of staffing made available through a reduction in non elective admissions. The detail of this is still to be modeled through but will be confirmed in the final submission.

9.7 That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement.

The Sheffield BCF includes £49m of expenditure on out of Hospital Community Services. Both the local authority and CCG are creating contingency plans to ensure that the expenditure in out of hospital services can be protected if the reduction in non-elective admissions, or other QIPP plans or efficiency savings cannot be met.

9.8 Agreement on a local action plan to reduce delayed transfers of care.

The joint target has been agreed. A joint working group to monitor and manage DTOCS is in place. The detailed action plan to deliver the 16/17 reduction is being finalised.

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10. The Better Care Fund's Targets for 2016/17

10.1 Non Elective Admissions

Non Elective	Resident Population	Registered Population
Non Elective Admissions 15/16 Outturn (corrected)	55,543	55,755
Non Elective Admissions 16/17 Revised Target	53,742	53,947
	-3%	-3%

Non Elective admissions are measured using two different bases based on registered or resident populations.

The activity plan submitted by the CCG as part of 2016/17 planning is due to be revised in the next submission to 53,742 admissions which represents a 3% decrease from 2015/16. The QIPP reduction in non-elective admissions is 2750.

Non Elective Target and Spend	Outturn 15/16	Budget 16/17
Non Elective Spend £m	£106.3	£104.3
Non Elective Admissions	55,543	53,742

The table above shoes the trend of non-elective spend and admissions.

10.2 Residential Admissions

Residential Admissions		Actual 14/15	Planned 15/16	Forecast 15/16	Plan 2016/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	731.2	754.7	927.4	820.6
	Numerator	666	695	854	763
	Denominator	91,084	92,084	92,084	92,981

The national measure has changed. Benchmarking has identified inconsistences among authorities as a result of the change. Our approach for the year end submission in 15/16 will be to include all admissions within the data returns so that this measure captures all admissions again rather than only those which were the initial planned sequel to a review as required in the new framework. Using a consistent local measure, performance in 2015/16 deteriorated by around 13% rather than the 27% suggested here. The 14/15 figure under this basis would have been 748 admissions with a rate of 821 per 100,000 population. The 16/17 target is improve to 14/15 levels.

Sheffield seems to perform worse than the national average on this measure, but changes to the definition of the target in 2015/16 has created widespread regional variation in the way this is reported making a like for like comparison to other Cities difficult.

10.3 Reablement

Reablement		Actual 14/15	Planned 15/16	Forecast 15/16	Plan 2016/17
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	76.6%	85.3%	85.4%	85.1%
	Numerator	555	512	818	808
	Denominator	725	600	958	950

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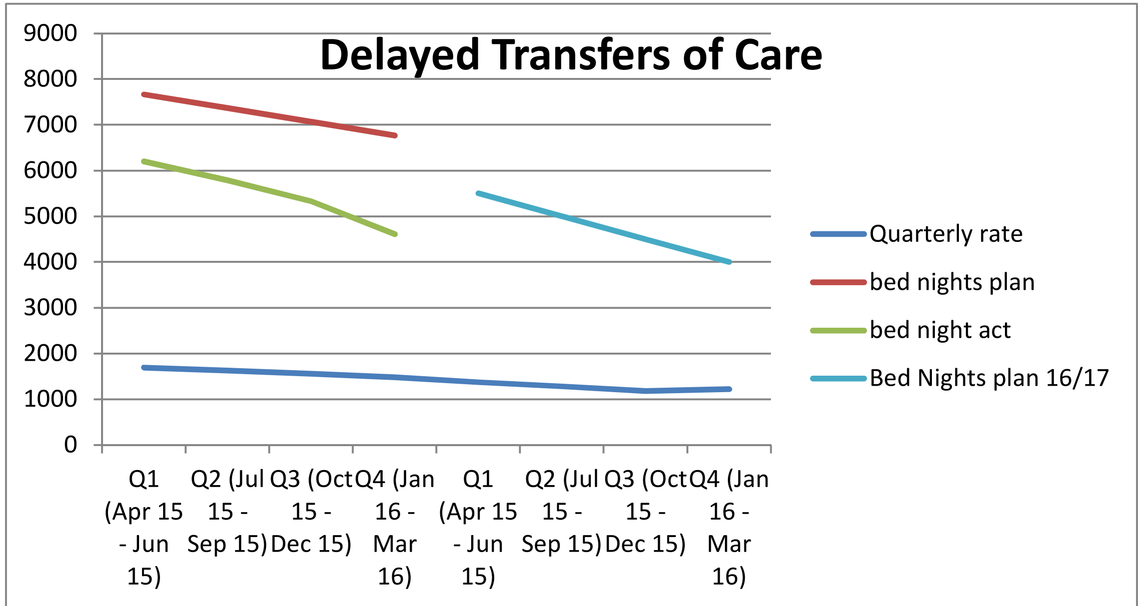
Sheffield performs better than the national average on this measure.

10.4 Delayed Transfers of Care

This is a new measure for the BCF for 2016/17.

In terms of a quarterly rate per 100,000 of population the target for Q4 2016/17 is 875 compared to 1,372 in Q1 2015/16 – a 36% reduction.

It is easier to review the trend by looking at the total number of delayed bed nights per quarter.



The forecast for Q4 2015/16 is affected by the extrapolation of a data issue which is why the plan for 2016/17 seems to start at a higher baseline level. The target for 2016/17 has been set based on the recently seen trend of improvement in 2015/16.

	Actual/Forecast				Options for 2016/17			
	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Historic Trend	6199	5787	5325	4,612	4,183	3,754	3,330	2,911
Target 16/17	6199	5787	5325	4,612	5,500	5,000	4,500	4,000

10.5 Ambulatory Care Sensitive Bed days (locally agreed metric)

Ambulatory care sensitive conditions have been identified as a cohort where there is greatest potential in reducing admissions.

Locally Agreed Metric - To reduce number of hospital bed nights due to emergency admissions for Ambulatory Care Sensitive (ACS) conditions.				
		Baseline 13/14	**Actual 15/16 Annualised**	**Planned 2016/17**
ACS Bed Nights		151,608	127,669	102,135
Year on year change			-16%	-20%

The plan for 2016/17 is a 20% reduction.

10.6 Stranded Patient Measure (locally agreed metric)

It is proposed to replace the health related quality of life measure with a stranded patient measure.

Locally agreed metric 1 2016/17 - Stranded Patient				Forecast 15/16	Plan 2016/17
Average no. of beds occupied by patients over 65 for more than 7 days				202	172

This seeks to measure the number of beds occupied by patients over 65 who have a length of stay over 7 days. It is seen as a simple measure to monitor the speed of discharge. The baseline data is based on the average for 2015/16 during the period April 2015 to December 2015.

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