Sheffield's Better Care Fund 2017/18 and 2018/19

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

DRAFT

Contents

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. 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.

This year's plan

This Better Care Fund plan for 2017/18 and 2018/19 knits together more recent work on the Sustainability Transformation Plan for South Yorkshire and Bassetlaw, Sheffield's own Place-Based Plan, and the CCG's operational plans. It has an expanded number of areas for us to work jointly on. 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 existing transformation programmes.

As part of our BCF Plan, we will focus on the delivery of initiatives jointly agreed between providers and commissioners and will develop joint 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.

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.

2. Our vision and challenge

Our vision, as set out in our Place-Based Plan, is:

To be recognised nationally and internationally as a person-centred city that has created a culture which drives population health and wellbeing, equality, and access to care and health interventions that are high quality and sustainable for future generations.

We will have a reputation for working in partnership to co-produce, improve outcomes, experience and inclusion and to influence national policy and regulation; this will be visible in our success.

Crucially:

- We believe that integrated commissioning is essential to the development of integrated services. 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 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.
- There is also a huge benefit in working with wider cross-city partners through our Sheffield City Region Public Sector Transformation network.

Why do it?

We've set out our need to change in four challenge areas:[1]

The health and wellbeing challenge

Over the last 10 years, Sheffield's position relative to the rest of the country has remained virtually unchanged for most health and wellbeing indicators.

Sheffield continues to lag behind the England average on most outcomes including life expectancy, healthy life expectancy, educational attainment, unemployment and housing.

The gap in healthy life expectancy in Sheffield is substantial: over 20 years between the most and least deprived men; 25 years for women; and up to 20 years for people with serious mental illness or learning disability. The cost of inequalities is £30bn to the NHS (the financial challenge is £20bn).

[1] These are outlined in more detail in our Place-Based Plan Sheffield Place Based Plan and in our JSNA which is regularly being updated.

The care and quality challenge

Demand

•Increased diagnosis of long term conditions as well as co-morbidity
•Increased patient expectation
•With more people working longer those able to care for their relatives are reducing
•Increasing number of children with complex health needs
•Significantly high number of delayed transfers of care
•Variation in rates of cancer mortality across the city
•We have more long-term admissions to care homes per 100,000 population
•We have fewer people at home 91 days after leaving hospital
•People experiencing a crisis in their mental health need access to community based treatment 24/7

Value

•The Better Care Better Value Tool identifies areas where there is an opportunity for us to redesign services to reduce hospital based activity that is either better provided in another setting or not at all:
•Reducing length of stay
•Reducing emergency readmission within 14 days
•Managing the number of follow-up; appointments
•Patients not attending appointments
•The Right Care tool identifies procedures that offer limited clinical value; these need review

Access

•Access to adult services, against national targets, is challenged
•Access to children's services meets or exceeds national thresholds
•The proportion of people receiving IAPT moving into recovery is a new measure and plans are in place to improve
•Cancer Screening coverage for the Sheffield population is above national average for all programmes
•Increase access to evidence based treatments for a range of mental health needs including psychological therapies (IAPT), perinatal, eating disorders, crisis care

Experience

•Poor experience can happen when multiple agencies are involved
•Complaints feedback indicates themes including communication and values and behaviours.
•The Annual HealthWatch report also identifies themes including:
•Waiting too long for a service, or not getting help early enough
•Physical and mental needs treated separately

The finance and efficiency challenge

By 2020-21 the combined health and care budget for Sheffield will be £1,390m. Whilst significant we have modelled that it could be £232m less than we will need if we don't change the way that we work or how services are provided. We want to provide Sheffield residents with the services that they need and this means that we need to ensure that we

get value (that delivers quality and benefit) for the Sheffield pound.
The culture and leadership challenge We often don't fully understand the pre-conditions needed in order to really make change happen • By not defining causal links and behavioural drivers we often don't see the full benefit or impact of planned changes and therefore in spite of can feel like successful implementation of a transformational project we still face the same problem. • Often the timeframes we set ourselves for designing and implementing change are challenging and taking time to understanding the theory behind it is compromised. • We need to be clearer on how we get from where we are to where we plan to be.

Addressing specific community needs and health inequalities

The city has a Health Inequalities Action plan, which was signed off by Health and Wellbeing Board in 2014. We are looking to do a refresh in December 2017.

We had a substantial discussion around this priority in May 2016 and reaffirmed the commitment to the principles agreed in the 2014 plan including:

- Continued commitment to an asset based community development based approach to Health and Wellbeing.
- Continued investment in and commitment to primary care and within this General Practice, especially in the most disadvantaged parts of the city.
- Continued commitment to the principle of implementing effort and change where greatest need is identified.
- Refocused effort on the link between employment and health
- Making the health choice the easiest and default choice.

We are currently in discussion how we will build commitment to interventions to address Health Inequalities more deeply into the totality of it's resource commitments, at both political and officer level. This will not be an easy task.

Our agenda around Health inequalities in our wider programme includes work on inclusive growth, fairness commission, and the city work on poverty.

The city is increasingly clear that the ongoing commitment to the policy of austerity is almost certainly making inequalities worse not better

Examples of our commitment to engagement and health inequalities include:

The CCG and the local authority public health team have supported a development programme called the “Alliance of the Willing” that brings together GPs working in disadvantaged communities and their sister voluntary organisations who are also working in those communities. The programme builds on the experience of the Glasgow Deep End group - a network of GPs in Scotland who work in neighbourhoods with very high health inequalities. The Alliance of the Willing aims to capture good practice and influence key health strategies in the city.

On a wider scale, our new neighbourhoods which cover the whole city have the opportunity to work with local groups and the communities to identify what the needs are for their neighbourhood and how as neighbourhoods covering statutory and non-statutory organisations they can meet those needs and fill gaps. This could range from opportunities to bring more specific services and different access than what the city normally would offer to ensure services can be accessed by their communities to develop local plans to provide specific low level support to reduce social isolation.

We are committed to meeting our statutory obligations in relation to patient and public involvement. Our plans are continually being shaped by our citizens. In addition to the active participation in our workstreams, so far, this year we have sought views from our most vulnerable communities on access to health and care and is in relation to the Health and Social Care Act 2012, The Equality Act 2010, the NHS Constitution and the latest NHS England guidance. The most recent pre-consultation engagement activity also demonstrates our commitment to the Gunning Principals, particularly ‘engaging when proposals are still in their formative stage’. In order to inform development of options, it was important to utilise public health data to recognise groups who hadn’t been given specific opportunities to share their experience or usage of services in the previous two engagement activities on urgent care in 2015 and 2016. In the month of March 2017, the following groups were identified, approached and asked for their views:

- Homeless community
- Substance misuse community
- Asylum seekers and those living in temporary accommodation
- Communities with greatest deprivation
- Students
- City workers

3. Our key areas of work

Theme objectives

The aims and outcomes of each theme have been refreshed to reflect current priorities.

Theme	Strategic Objectives
Theme 1 - People Keeping Well	The Strategic Objective of this scheme is to increase the wellbeing of people at greatest risk of declining health and loss of independence – reducing demand and dependency on the formal health and social care system. This will involve local information and advice to support self- care; community interventions to enable people to remain independent, and GP led care planning. As a result patients at medium to high risk of admission to hospital will be better motivated and supported to self-care, will have improved health and reduced reliance on health and social care services
Theme 2 - Active Support and Recovery	AS&R is the commissioner term that has been given to the range of services, predominantly community based, which supports the public, patients and clients in their own homes to remain as independent as possible despite the fact that they may have multiple health and care needs. These services do not consistently meet individual needs in a coherent and co-ordinated way. The commissioners require that in addressing these services options should be developed that: • support people to remain at home and avoid unnecessary admissions • respond quickly to the additional needs of people in this cohort and support them to remain out of hospital • make sure that people are discharged home with the appropriate support, minimising their hospital stay and maximising their recovery and level of independence
Theme 3 - Independent Living Solutions	The Strategic Objective of this scheme is to develop and promote the provision of independent living solutions in Sheffield so that more people can maintain and build their wellbeing and independence
Theme 4 - Ongoing Care	The overall aim is to integrate the assessment, placement and contract management functions related to ongoing care to improve quality, outcomes and process.
Theme 5 Adult inpatient Emergency Admissions	The overall aim is to undertake activity to reduce demand for admissions and to ensure that the patient stay whilst in hospital is as short and effective as possible. Additionally it allows monitoring of the impact of other BCF activity to reduce demand for hospital

	emergency admissions.
Theme 6 - Mental Health	The aim is to deliver a truly integrated commissioning approach which will offer more effective joined up commissioning (and therefore care), leading to better patient outcomes which will, by default, deliver better value for money.
Theme 7 - Capital Expenditure	The scheme will deliver home adaptations funded from the Disabled Facilities Grant to enable people to remain in their own homes and live independent lives reducing their need for organised care. Other Capital Grants will be used to deliver better systems to administer ongoing care.

Our Better Care Fund has 7 formal areas of work with Children and Young People added almost as a shadow run for full inclusion into the pooled budget from April 2018. We actively review the areas which the Better Care Fund cover, the following demonstrates how we are evolving.

In the 2016/17 BCF					
People Keeping Well	**Urgent Care (reducing emergency admissions)**	**Independent Living Solutions**	**Active Support and Recovery**	**Ongoing Care**	**Capital**
New to the BCF 17/18					
Mental health					
New to the BCF 18/19					
Childrens and Young People					

This section sets out in more detail what these areas of work are. Later sections of this BCF document talk about how we will measure these areas and what the financial plan for each is.

What will change?

Our plan will set out change in a number of areas which are building on our past Better Care Fund plans. Sections three of this document will set out what will change in each area.

Our Place-Based Plan sets out a range of things that we will be doing in the preventative space, which are not part of this BCF Plan. This includes:

- Our Heart of Sheffield programme: a radical upgrade in prevention

- Our Work and Health programme: supporting people moving into meaningful economic activity or meaningful employment.[2]

The changes we plan should mean that, by 2020:

- 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-centered and complements and builds on the assets they already have.

Health and care services will be more focused on a person's needs and organisational boundaries will not get in the way

[2] There are currently 85,000 people across Sheffield City Region unemployed due to low level mental health or Musculo skeletal conditions. The health and employment system do not work together and those 85,000 people are all witnesses to this poor 'system connectivity'. We have recently had approved an operating model for a trial study to overcome/ reduce poor connectivity. The basis of the study is a pilot delivering Individual Placement and Support-based employment support. It will be a randomised control trial, receiving 7,500 referrals from the health system across the region (mainly primary care) over the course of the next 18months- 2 years. It will be integrated into an increased number of employment advisors within IAPT service across the region.

3.1 People Keeping Well

Lead director: Nicki Doherty Sheffield CCG/ Dawn Walton Sheffield City Council

3.1.1 What will this area of work do and what will change as a result?

- There is growing recognition that by ensuring people are connected to and feel part of their local community we can help them stay independent and well for longer and increase quality of life
- Social prescribing is a way of linking people with sources of support within the community. It provides a non-medical referral option that can support people to improve health and wellbeing
- Alignment of locality working including Asset Based Community Development, Housing Plus offer to tenants
- Supporting demand management activity for ASC and primary care

3.1.2 What will happen in 2017/18 and 2018/19?

- Implement a social prescribing model in all areas of the City
- Develop central referral hub
- Clear and consistent approach to management information and measuring impact
- Workforce development to have empowering conversations with people
- Integrate access to Social Prescribing model in all referral and assessment pathways
- Risk Stratification needs developing to include social indicators as well as health and to get ownership and sign up by all stakeholders
- Alignment of approach with CYPF locality based provision

Deliverables:

1. Develop the financial plan and further funding mechanism for the PKW partnerships and CSW's
2. Review SCC/CCG funded key workers in relation to delivery of PKW SP and demand management to determine future need
3. Identify long term funding for PKW
4. Tender community dementia monies
5. Tender community carer monies
6. Continue to support partnership development

3.1.3 What are the main benefits of this area of work?

The Key Benefits of this approach are;

- for the individual – improved health, greater independence, less social isolation, a route to building social capital and resilient communities, enabling and supporting individuals to manage their condition.
- For the system - Demand Management – shifting from reactive to proactive approaches means we reach people earlier and begin to develop a "self-management" culture within the organisation and in communities
- Financial efficiencies - anecdotal evidence from community support workers and local GP practices is that it has reduced demand on services but this is difficult to quantify

For the system – financial efficiencies which could lead to public sector cost reduction and/or releasing capacity to better manage demand; making best use of health and care practitioners' time; and a means of promoting a shift to preventative interventions.
For the community – making optimum use of local community support, and stimulating improvements in the quality and effectiveness of the VCS community offer.

Metrics:

- 75% of partnerships with social prescribing monies have a success matrix rating of 4 (good / minimal issues) for their partnership
- 75% of partnerships with social prescribing monies have a social prescribing process

3.1.4 What are the main risks and issues?

Risks

- Lack of long term financial investment means it is difficult to plan
- CBA is unable to prove categorically that the PKW model is saving the Health and Social Care System money
- CBA proves savings in secondary health services and social care but no agreed mechanism in place to release funds for reinvestment in PKW

Issues

- Need to invest in management information systems and workforce development but have little resource and an uncertain future
- Currently commissioning activity is Via SCC.
- Sign off for the strategic approach is confused as decisions have to be agreed in more than one place

3.1.5 What are the governance arrangements for this area of work?

- People Keeping well currently reports to the Active Support and Recovery Programme Board.

3.1.6 What consultation has been carried out?

- Significant consultation with providers as the framework, outcomes and principles of PKW was developed
- Co-production is at the heart of all PKW Commissioned services. All Community Partnerships have had to evidence their approach to co-production to ensure local people have had the opportunity to engage fully
- Partnerships working with local residents

3.2 Independent Living Solutions

Lead director: Penny Brooks Sheffield CCG/Phil Holmes Sheffield City Council

3.2.1 What will this area of work do and what will change as a result?

This jointly procured contract was awarded in July 2015 and runs for up to 5 years. It is paid for from a true pooled budget into which the CCG pays around 2/3 of the total and SCC the remaining 1/3.

3.2.2 What will happen in 2017/18 and 2018/19?

British Red Cross (BRC) accept referrals from over 2000 health and social care workers for people needing equipment in their homes to enable them to continue living independently. They deliver the equipment from their warehouse in Darnall and then maintain and service the equipment before collecting it again when it is no longer required.

3.2.3 What's changed since the last BCF submission?

No changes to the service since last year. It is proposed to create a new social care capital scheme to separately capture the costs of high value community equipment. These tend to be more specialist items of equipment that are capital in nature.

What are the main benefits of this area of work?

The service is demand driven. Equipment is delivered within the timescales required by prescribers – ranging from same day delivery in urgent cases to 5 day delivery in routine cases. BRC consistently meet KPI targets and very few deliveries miss their target timescale.

- A large proportion of the equipment is loaned to people who have recently been discharged from hospital, thereby facilitating discharge. If the equipment is on the standard catalogue, it can be in place very quickly to allow the person to return home on the planned date.
- When a person is assessed in their home, equipment can be provided to enable them to retain independence from services and to remain at home for as long as possible.
- Where a person does have care needs, the appropriate equipment can be loaned to assist carers and in many cases reduce the amount of service needed (e.g. single handed calls as opposed to double handed)
- Because the equipment service is now funded through a true pooled budget, there is no longer any need for time consuming debates about who is responsible for payment.

3.2.4 What are the main risks and issues?

Risks

Financial risk – Although measures are in place and new ones being developed to contain unnecessary spend, it is highly likely that spend in 17/18 will not be any lower than in 16/17. In fact demand is expected to increase in line with increased use of other health and social care services. The measures being put in place in conjunction with implementation of a new

capital project to bear the costs of high value items are hoped to address some of the total pressures on this service which currently amount to £600k.

Issues

Whilst there is a continued financial pressure in this service it is an area that has so far been shielded from large scale budget cuts.

3.2.5 What are the governance arrangements for this area of work?

The service is governed by a Board co-chaired quarterly by Directors from SCC and CCG.

3.2.6 What consultation has been carried out?

Consultation has taken place about the service quality and performance with prescribers for the service in partner organisations and patients/service users. An annual report will be produced summarising these views together with the overall performance data.

3.3 Active Support and Recovery

Lead director: Nicki Doherty Sheffield CCG/Phil Holmes Sheffield City Council

3.3.1 What will this area of work do and what will change as a result?

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

The aim is to develop and redesign out of hospital services, to:

- Support people to remain at home and avoid unnecessary admissions
- Respond quickly to the additional needs of people in this cohort and support them to remain out of hospital
- Make sure that people are discharged home with the appropriate support, minimising their hospital stay and maximising their recovery and level of independence

The programme will potentially benefit all patients within the Sheffield area who are at risk of a hospital admission, with an emphasis on the proactive identification of those patients whose health is deteriorating.

The programme will have the following key components:

- Developing integrated, out of hospital care across Sheffield, delivered through a range of services both from within Neighbourhoods and those provided City wide.
- Has clear links with other key strategies such as primary care, urgent care, long term conditions and mental health.
- Has the provision of Care Closer to Home and person-centred care as its primary objectives.
- Is principally aimed at those patients with one or more long term conditions and aimed at helping them to maximise their independence in their own home.

To be clear, the Active Support and Recovery Programme will transform the way in which our reactive services are delivered (Intermediate Care, Rapid Response (STIT/ CICS), Community Nursing, Falls, SPA etc.). It will rebalance our resources by correcting the investment in less acute interventions that will allow a redistribution of activity from high cost interventions that are not needed to better value interventions that support, develop and promote independence. At the same time as increasing spend in less acute interventions the redesigned services will also release system savings.

3.3.2 What will happen in 2017/18 and 2018/19?

The following high-level activities are planned for the coming period:

- Social Prescribing: full roll-out of social prescribing to all neighbourhoods and an action plan for each that develops them along a maturity index; continuing embedding the community support workers. Purpose to optimise community support and intervention, support increased person activation and self-care and to increase access to the benefits and support packages that Sheffielders are entitled to

- Person Centred Care: develop a self-care strategy for Sheffield and an implementation plan , continued Care Planning LCS with introduction of PAM improvement metric, linking to self-care strategy develop Behaviour Change Academy as a partnership approach for Sheffield
- Rapid Response: implement revised rapid response service that addresses the current system limitations (needs to link to Independent Sector and Domiciliary Care solutions)
- End of Life (EoL): progress EPACCS, implementation of One Chance to Get it Right (last few days), increase number of people who die in their place of choice, increased support to care homes for EoL pathways
- Carer Support: support to carers to enable respite or temporary support whilst in hospital to keep people at home when carers cannot look after them
- Care Homes: increase nursing support to care homes to help meet increasing needs outside of hospital
- Virtual Ward: review evidence for virtual ward pilot in GPA1 and consider best model for citywide approach (links to urgent care programme)
- Case Management/Care coordination and navigation: people at increased risk of admission receiving case management support and where care needs are increased there is a coordinated response that ensure the most appropriate service provides the response
- Intermediate Care beds: re-profiling of intermediate care beds in response of increased community offer, will require shorter programmed length of stay with measureable outcomes, will also include step-up removing the need to admit in order to access this level of intervention
- Community IV: IV delivered at home and either removing the need for admission or where admission is required reducing the associated length of stay

3.3.3 What's changed since the last BCF submission?

- All 16 neighbourhoods in Sheffield are in place and are working on a development plan for 17/18
- Primary care and community care practitioners are working together to improve patient care / experience e.g. district nurses and practice nurses working together on wound care
- Further development of person-centred care including care planning, PAM embedded as outcome measure
- Roll out of Virtual Ward pilot to City Centre Neighbourhood incorporating 21 Practices – June
- Alignment with Test Bed technologies development
- Intermediate Care Beds re-profiled and reduced
- Digital Literacy pilot established in two Neighbourhoods (Porter Valley and South Sheffield Health Group) to support people with LTC/complex needs
- Revised and strengthened programme Governance
- Initiation of Virtual Ward / Enhanced Case Management pilot across Central Locality
- Digital Literacy projects in place in 2 Sheffield neighbourhoods in partnership with the Good Things Foundation
- Initiation of falls prevention pilot in Sheffield in partnership with Aesop and Yorkshire Dance

- Initiation of work on Active Recovery service to deliver greater efficiency through integration
- Business case in development to support community IV

3.3.4 What are the main benefits of this area of work?

Standard KPIS include:

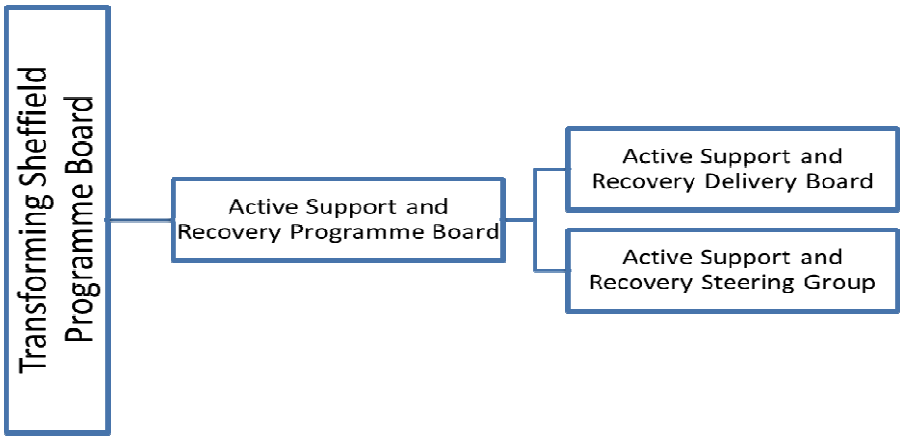
- Reduction in non-elective admissions
- Reduction in permanent admissions to long term care (ASCOF 2a2)
- Reduction in delayed transfers of care (ASCOF 2ci)
- Improvement in the number of patients still at home 91 days post admission (ASCOF 2bi)
- Improvement in the proportion of older people (aged >65) who received reablement/rehab after discharge from hospital (ASCOF 2b2)
- Improvement in the overall satisfaction of people who use services with their care and support (ASCOF 3a)
- Delivery of financial savings equating to £4.6mm in 2017/18

3.3.5 What are the main risks and issues?

- Project Management Resource: successful service redesign in key project areas
- Neighbourhood maturity
- Collaboration between neighbourhoods
- Availability of business intelligence resource to model data necessary for service redesign
- Contractual solutions to new models of care in an accountable care partnership
- Ability to reinvest resource as per the Sheffield Memorandum of Understanding
- Reactive solutions to current demand and capacity in existing service models e.g. STIT
- Contractual issues with Intermediate Care beds
- Primary Care Sustainability and Resilience
- Transformational Funding to pump prime the redesign in order to release the savings

3.3.6 What are the governance arrangements for this area of work?

The AS&R Board will oversee this programme of work, reporting to Transforming Sheffield Board. The AS&R delivery group owns development and delivery of the plan.



3.3.7 What consultation has been carried out?

The projects of work haven't progressed to a point where a consultation is required. However there has been active discussion with provider partners through Active Support and Recovery Workshops, Active Support and Recovery Delivery Board, and Active Support and Recovery Programme Board, Locality Meetings. Public engagement has happened through multiple avenues including the 2020 Vision, urgent care (which covers the same ground), and the citizen's reference group.

3.4 Ongoing Care

Lead directors: Penny Brooks Sheffield CCG/Phil Holmes Sheffield City Council

3.4.1 What will this area of work do and what will change as a result?

Ongoing Care programme is redesigning and integrating Continuing Health Care and adult social care to achieve a single integrated assessment, with shared market management function and integrated group decision making on funding decisions s. With a focus on planning and delivery of support to meet the ongoing care needs using a joined-up approach from the Clinical Commissioning Group (CCG) and Sheffield City Council (SCC), and commissioning and contracting relevant services in the long term.

The Ongoing Care programme in partnership with CCG and SCC has been working through solutions to improve quality, process, and outcomes within a financial envelope. By establishing the right care, the right package, there are opportunities for savings, and the patient and carer experience should be measurable improved.

Sheffield citizens will experience:

- Improved patient experience through streamlined patient pathways through a joined up approach from the CCG and SCC, in relation to the determination of their care needs, and the planning and deliver of support to meet these needs
- Well-trained and supportive staff who are confident of providing robust and lawful advice, assessment and support
- A clear approach to charging for care including care provided free at the point of use where Primary Health Needs are identified
- Access to clinical leadership and support that is appropriate to their situation
- Access to information, advice and early intervention that will prevent avoidable deterioration in physical and / or mental health
- Being supported to leave acute beds as soon as they have no further need of treatment in that setting
- More emphasis upon support at home and less likelihood of having to move into care home
- Care and support arrangements that will best meet their needs

Sheffield's care providers will experience:

- A consistent approach with respect to fee rates, payment and contract management
- A consistent approach with respect to quality improvement and safeguarding
- A collaborative commissioning approach that builds good relationships, celebrates innovation and enables early problem solving

Attached CCG and SCC staff will experience:

- Practice configured around the person rather than the organisation
- Reduced bureaucracy and streamlined decision-making
- Greater trust and joint working, including emphasis on early intervention and problem solving
- Encourage professional development

3.4.2 What will happen in 2017/18 and 2018/19?

Single integrated assessment and care management pathway

- Review the current pathway and processes
- Reduce bureaucracy and streamline processes
- Gap analysis of workforce
- Review of all high cost CHC and Social Care packages to ensure clients are receiving appropriate and cost effective care.
- Exploring scoping options of shared Information Technology system

Engagement and Stakeholder involvement

- Engagement workshops with carers to develop joint practice principles for short breaks allocation
- NHS England commissioning a video to support 'For Pete's sake!` initiative to develop culture across the whole system
- Shared workforce training across CCG and SCC

Improved contracting and market management

- New commissioning arrangements for homecare and Supported Living (by October 2017)
- Review of commissioning arrangements for care home placements locally(TBC)
- Discussions across STP/ACP for equity and economies of scale
- Review of commissioning arrangements for Direct Payments and Personal Health Budgets (timescale TBC)
- Integration of CCG and Council contracting and market management functions with respect to registered care settings and Direct Payment / Personal Health Budget markets (by April 2018)

Reduction in Delayed Transfers of Care and Rates of Readmission

- Pilot home first (5Q) approach to ensure long-term needs are not assessed in acute beds (by September 2017)
- Review the outcome from the 5Q pilot with a view to rolling out if pilot successful

- Work with AS&R to review and plan step down intermediate care capacity to provide discharge to assess to commission step-down intermediate care capacity to provide a “Plan B” where D2A cannot be provided at person’s own home (by September 2017)
- Formal arrangements for integrated assessment and support planning underpinned by appropriate alignment of budgets and processes (timescales TBC) to support
    - 0-25 inclusion programme
    - Mental Health and Transforming Care programmes
    - Active Support and Recovery & Urgent Care programmes

3.4.3 What are the main benefits of this area of work?

- Reduction in bed days for patients in scope at both STH and SHSC, including reduction in DTOC
- 85% of Decision Support tools (DST) to be completed outside of hospitals
- 80% of DST’s completed within 28 days
- Reduction in care home placements
- Increase in uptake of Personal Health Budgets
- Patients receive appropriate and value for money care.

3.4.4 What are the main risks and issues?

- Release savings from redesign to other parts of the system
- Need to invest in shared information systems but limited resource
- Meeting assurance frameworks and timeframe
- Capacity and demand on resources and growth internally and across the system

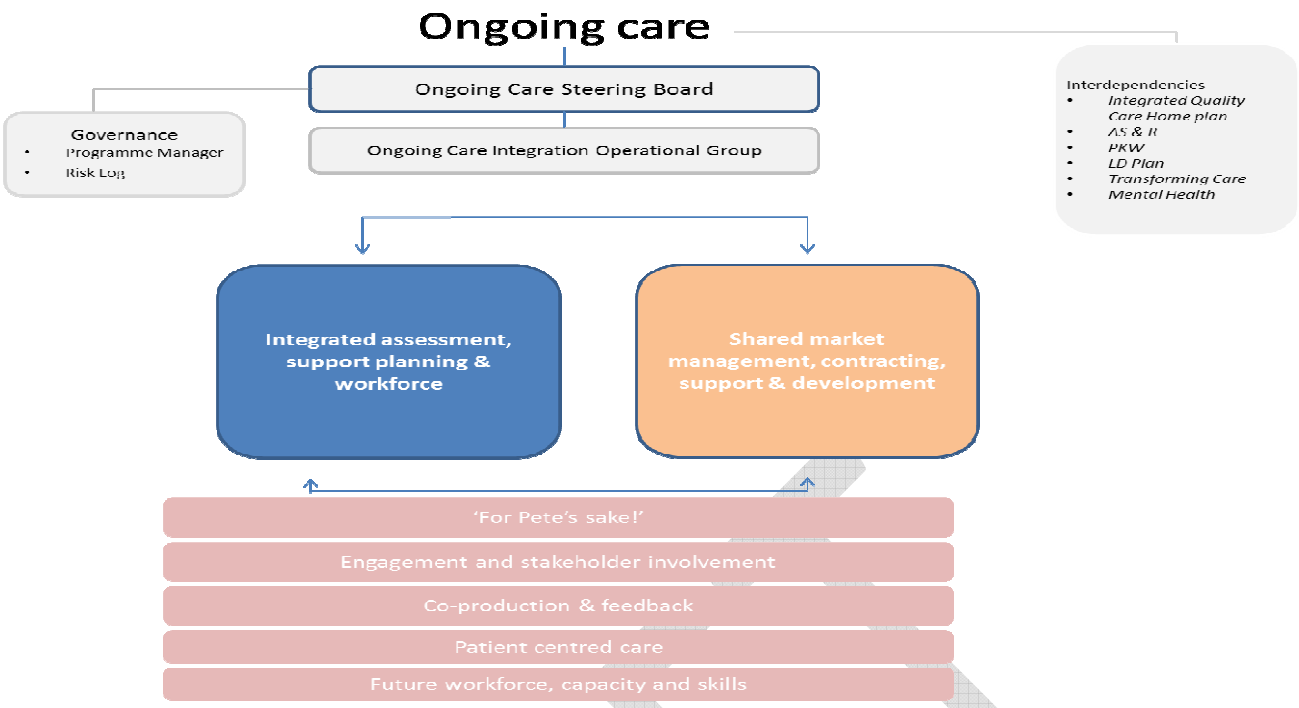
3.4.5 What are the governance arrangements for this area of work?

The Ongoing Care Steering Board is responsible for the ownership and implementation of the Ongoing Care Delivery Plan. This board is in now in place.

An Ongoing Care Integration group is established to take forward the Ongoing Care Delivery Plan, and provide a forum where all issues related to work streams can be managed. Accountability for these work streams will be provided by the Ongoing Care Integration group, who will feed back regularly to the Ongoing Care Steering Board.

The Ongoing Care Integration group reports directly to the Ongoing Care Steering Board, which in turn is accountable to EMG. EMG acts as the overall accountable group for the delivery of Sheffield-wide health and care transformation as defined within the Sheffield place-based plan and the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

The chart below details the Ongoing Care programme and individual work streams. All of which are governed by the Ongoing Care Steering Board.



3.4.6 What consultation has been carried out?

A number of engagement **workshops have been** held with patients, carers and stakeholders to help shape, and identify the key priorities for the Ongoing Care programme. Consultation will be taking place with the development of the short practice principles guidance for short breaks allocation in the next few months.

3.5 Urgent Care

Lead director: Peter Moore Sheffield CCG/Phil Holmes Sheffield City Council

3.5.1 What will this area of work do and what will change as a result?

This programme will deliver:

- A change in the offer for urgent and same day care in primary care
- Assessment and reduction in non-elective admissions
- Reduction in delayed transfers of care (DTOCs)

3.5.2 What will happen in 2017/18 and 2018/19?

- Review and redesign of the Urgent care in primary care system in Sheffield with implementation of some aspects having commenced
- Further improvements will be made to the assessment and step up facilities when patients' needs can no longer be met in Primary Care
- Patient flow through hospitals will be improved with care optimised and discharges planned on admissions.

3.5.3 What's changed since the last BCF submission?

- The review and redesign of Urgent care in primary has commenced
- Implementation of STH Excellence in Emergency Care – revised assessment models have been implemented in the Admissions units; implementation of the planned approach to discharge management has commenced and themes of safer, better, faster have been adopted.
- A taskforce has been established to reduce the number of DTOCs in the city

Key developments/successes in the last year:

SCH:

- The children's hospital continues to be one of the top three highest performing A&Es in England

STH:

- Conveyance rates by ambulance to A&E where patients then receive no treatment or diagnostic (or walk out before seeing a clinician) have reduced by 50% this year compared to last which is approximately 2000 less patients.
- There has been a step change in reducing the numbers of patients regularly attending A&E. Data from STH suggests a more than 10% reduction and a continuing downward trend.
- Following the relocation of the GP collaborative to effectively co-locate it with A&E there has been a steady improvement in the number of patients who are redirected there from A&E with 15-20 patients redirected every weekend day.

- Pathway protocols for assessment pathways for GP urgent referrals have been strengthened via the SPA. Patients are now actively encouraged wherever possible to self-convey to hospital when accessing assessment pathways. This reduced travel time to 45 minutes (as opposed to 2-4 hours) greatly increases the opportunity for patients to return to their own home that day (and access other supporting services in the community) rather than being admitted.
- 35-40% of GP referred patients attending the reconfigured Medical Assessment Unit (MAU) are now being discharged rather than being admitted into the core hospital as in the past.
- 25-30% of patients attending the Acute Medical Unit (AMU) from A&E are also now being discharged rather than being admitted into the core hospital as in the past.
- Discharge of patients at weekends is now supported by volumes of Planned Discharge Dates (PDDs) which are shared with transport providers enabling them to plan additional capacity when required to support the hospital at times of peak demand.

3.5.4 What are the main benefits of this area of work?

- Patients requiring urgent primary care being seen in the most appropriate setting
- Reduction in conveyances to hospital which do not result in provision of significant care or diagnostics
- Reduction in non-elective admissions
- Reduction in DTOCs

3.5.5 What are the main risks and issues?

That system wide flow issues (particularly with regard to patients requiring short term reablement support) leading to high levels of DTOC are not resolved, leading to high levels of DTOC.

3.5.6 What are the governance arrangements for this area of work?

- Urgent care and same day care in primary care programme board
- A&E Delivery Board
- Weekly meetings – citywide CEOs

3.5.7 What consultation has been carried out?

- Urgent care in primary care – broad community engagement to develop the Urgent Care Strategy with further specific engagement with vulnerable groups on Urgent care in primary care. Additional engagement with local and potential providers to develop options for the future.. A formal public consultation will be undertaken September – December 2017..
- Discussions at A&E Delivery Board and elsewhere around assessment model and non-elective admissions.
- Taskforce joint working across STH/SCC/CCG.

3.6 Mental Health

Lead directors: Peter Moore Sheffield CCG/Dawn Walton Sheffield City Council

Developing our approach to transforming Mental Health Services requires us to focus on prevention, improved access to early support and help and to better support those with complex and crisis needs. Our plan requires a move towards an all age approach and therefore integration between Children's, Young People's and Adult Mental Health Services.

3.6.1 What will this area of work do and what will change as a result?

The aims of this piece of work are to ensure:

- Pooled commissioning budget;
- Single/integrated commissioning team;
- Single vision for mental health services across Sheffield;
- Ability to commission whole pathways of care;
- Development of single transformation programme; delivered jointly with main provider; and
- Begin to instil Accountable Care Organisation (ACO) principles; joint delivery and joint accountability.
- Integrated transition between Children's and Adults

This area of work links to the Five Year Forward View for Mental Health and Implementing the Five Year Forward View for Mental Health.

3.6.2 What will happen in 2017/18 and 2018/19?

Initiation of large scale transformational programme including:

- Full review of dementia care pathway;
- Development of primary care mental health service;
- Implementation of Core 24 Liaison Mental Health Service (which starts outside of hospital);
- Development of neighbourhood based 'low level' provision (social prescribing); Early Help
- Maximising our range of prevention and early help services
- Review of long term nursing and residential care;
- Better access to step-up and step-down provision;
- Better integration between physical and mental health provision (parity of esteem); and
- Reduction in long term high cost out-of-city packages through targeted investment in local community based services.
- Improved access to training and employment
-

3.6.3 What are the main benefits of this area of work?

Key Benefits

- Greater focus on early intervention; reducing severity and complexity by tackling illness earlier;
- Greater choice and personalised care;
- Delivery of care closer to home, adopting least restrictive principles;
- Better integration of physical and mental health care, delivery of holistic services;
- Driving efficiency through the delivery of less resource intensive services tailored to the needs of each individual.
- Improved access to training and employment
- Reduced pressure on crisis services across Social Care and Police

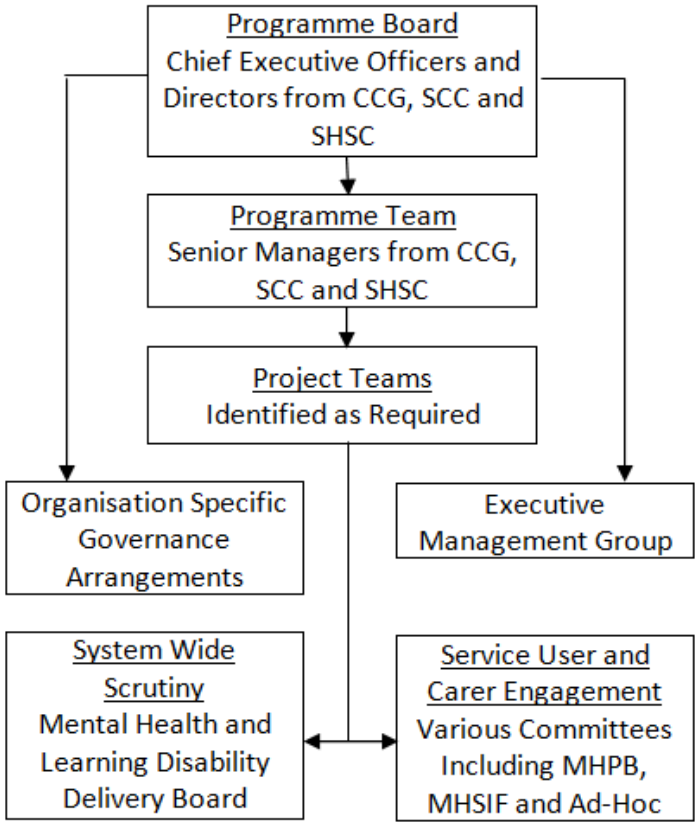
Metrics

- Better patient feedback and satisfaction scores;
- Reduction in overall mental health spend;
- Less activity delivered by secondary care mental health services;
- Reduction in acute hospital lengths of stay, outpatient attendances and accident and emergency presentations for those with a comorbid mental health diagnosis;
- Reduction in mortality gap between those with and those without a mental health diagnosis;
- Reduction in long-term nursing and residential care;
- Reduction in out-of-city placements; and
- Development of robust neighbourhood based portfolio of services; evidenced through increase in social prescribing.

3.6.4 What are the main risks and issues?

- Delivery of transformational programme is reliant of all parties working collaboratively and jointly. There is not statutory requirement for them to do this.
- Transformation programme does not deliver efficiencies within required timescales; this may therefore generate financial instability.
- Transformation programme is very ambitious and will require dedicated resource to ensure full delivery. Although a joint post has been created and has been filled, working across all three organisations, the delivery of each respective programme area is being undertaken on top of a number of individual's current roles. This will need to be reviewed regularly; joint working is being underpinned by the need to address system wide financial challenges; not through a formally constituted mechanism.

3.6.5 What are the governance arrangements for this area of work?



3.6.6 What consultation has been carried out?

- Service User and Public consultation will form a key element of individual project delivery plans.
- Engagement with providers has already been undertaken, in part, through the Mental Health and Learning Disability Delivery Board. This forum will continue to be used for wider engagement as well as ad-hoc engagement as required.

3.7 Children and Young People

Lead director: Peter Moore Sheffield CCG/Dawn Walton Sheffield City Council

There is a growing need to develop an all age life cycle approach to our services ensuring long term plans to complex care needs are addressed

3.7.1 What will this area of work do and what will change as a result?

- **Future in Mind:** Children's Emotional Wellbeing and Mental Health work stream – Improving Access to Emotional Wellbeing and Mental Health, providing more early intervention, provide new models of care across that meets need.
- **Community Health:** Joining up Children's Primary and Secondary Care, Children's Education, Social Care and Family Support Services to ensure families get early help and care close to home.
- **Maternity and Best Start:** Improving the health and wellbeing of women and babies by ensuring we plan together between health and public health and provide evidence based models of care that ensure every child has the best start in life. Revise the local offer of Maternity care within localities.
- **Children with Complex Needs:** Increase personalisation of care between health, social care and education. Develop new provision to meet future need.
- Locality based working to improve access to Early Help Services through schools and primary care

3.7.2 What will happen in 2017/18 and 2018/19?

Inclusion in the BCF

- The main activity in 2017/18 will be to understand which areas of Children's expenditure will benefit the most from integrated working. It is proposed to formally add Children's activity to the BCF in 2018/19.
- Mental Health and SEND

Future in Mind

- Improve access by providing a crisis café and dedicated section 136 suite for young people
- Improve access to community mental health specialist services by reducing waiting times, and embedding evidence based treatment pathways Provide healthy minds support in more schools
- Provide a one stop shop for young people in need of emotional wellbeing support in the city centre.

Community Health

- Link primary care and secondary care within localities in Sheffield, and ensure rapid access to specialist healthcare when needed.
- Develop the skills of primary care and local communities in making sure children stay well and managing minor ailments, by working with GPs, schools and parenting practitioners.

- Link Children's and Families support services and health within localities into one integrated local offer
- Redesign community nursing so that children with Long Term Conditions can be cared for at home instead of in hospital.

Maternity and Best Start

- Consult with women to find out how we should provide care for them.
- Work with the Local Maternity System across South Yorkshire and Bassetlaw to improve maternity care.
- Increase the personalisation of maternity care
- Ensure access to support is available to women as near to their home as possible to ensure they have a healthiest pregnancy possible.
- Develop atonement and attachment between infants and families
- Improve the pathway of maternal mental health

Children with Complex Needs

- Join up assessment and review between health and care for children with complex needs and SEND
- Provide support earlier when families are struggling and support children to be within their communities
- Joint agreements to placements of children in Health, Education and Social Care settings

3.7.3 What are the main benefits of this area of work?

- Future in Mind – increase in access and reduction in waiting times. Reduction in admissions
- Community Health –Reduced attendances and admissions
- Maternity and Best start – Reduced complexity and intervention, increase in midwifery lead care.
- Children with complex needs – Reduction in placements out of area.

3.7.4 What are the main risks and issues?

- Lack of engagement from clinical staff
- Diversion in approach and methodology with providers/ SCC/CCG
- Other agendas and initiatives such as in adult services with competing priorities on resource and direction of travel
- Demand on resources and growth in need could delay implementation of early help and early intervention and prevention models
- Public health resources being challenged which could impact on need
- Statutory duties still being met through changes in pathways and shared governance and accountability framework
- Meeting assurance frameworks and timeframe for mobilising new models of care
- Resources to deliver the changes needed within timescales needed.
- Clinical engagement and leadership

3.7.5 What are the governance arrangements for this area of work?

Children's Transformation Board

3.7.6 What consultation has been carried out?

- Co - production in place with young people
- Joint programme planning in place with providers
- Consultation with local users of maternity care services being undertaken
- joint programme planning in place with health watch and VAS

3.8 Capital

Lead director: Penny Brooks Sheffield CCG/Phil Holmes Sheffield City Council

3.8.1 What will this area of work do and what will change as a result?

With DFG work has started to see if there is potential to use some of the money more strategically to help with Delayed Transfers of Care and Out of Hospital Targets. There are strict rules on how the money must be spent and so it will take some time during 17/18 to scope out what is possible. The first potential new strategic capital proposal for DFG is the use for high value community equipment which is discussed above. If further scoping is successful then some additional capital funding may be available to support other health and social care capital initiatives.

The social care capital grant is being rolled forward into 2017/18. This grant will be used to help fund the cost of the replacement of the Care First – Sheffield City Council's social care case management system.

3.8.2 What will happen in 2017/18 and 2018/19?

- DFG scoping to identify strategic opportunities for capital investment
- Maximise the increased grant value by further promoting the service.
- Replacement of Care First

3.8.3 What are the main benefits of this area of work?

- The DFG currently funds (subject to eligibility) work to provide safe access into and around a person's home so that they and their carers can remain living there as comfortably as possible. Works that can be funded include large equipment such as stair lifts, hoists, through floor lifts and ramps and major adaptations such as level access showers. For more complex needs structural alterations and extensions can be funded.
- Need is assessed by Occupational Therapists and clients are further assisted through the financial and construction process by officers in the Adaptations Housing and Health (AHH) Team. The AAH team work closely with clients to help them achieve adaptations that are appropriate to their personal circumstances, offering to support them to carry out alternative works to meet their personal aspirations where possible. Around 400 people per year benefit from these grants.
- DFG strategic scoping is a new area of work for 17/18 which will consider if there are other ways this grant can be used for the benefit of patients.
- The replacement of Care First will improve the efficiency of the system leading to better service to patients. The project will also help in improving the integration of systems between Health and Social Care.

3.8.4 What are the main risks and issues?

- DFG may provide some strategic capital investment opportunities, but there is no additional revenue funding to support these initiatives. The scoping may not find any meaningful projects to support.

3.8.5 What are the governance arrangements for this area of work?

- Care First Replacement is a large and complicated project which will be governed within SCC under normal project management processes.
- The DFG scoping will take place within Sheffield City Council and will be discussed at EMG if some opportunities are identified.

3.8.6 What consultation has been carried out?

- For Care First this will be covered within the project
- For DFG scoping this will be uncovered as the work progresses.

3.9 The Improved Better Care Fund (iBCF) Direct Grant

3.9.1. The Government announced as part of the last budget an additional £2 billion to councils in England over the next 3 years to spend on adult social care services. Sheffield is to receive £24m of non-recurrent funding in total over the 3 years.

- The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

- In terms of the wider context, the funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

3.9.2 The Government had made a previous commitment to provide funding to Local Authorities as part of the Better Care Fund (BCF) arrangements on top of the funding which already flows through CCGs. Sheffield is to receive additional funding of £2.2m in 2017/18 building up to a recurrent figure of £21.9m in 2019/20. The table below provides the detailed breakdown.

Year	Annual £000 BCF	Cumulative £000 BCF	Annual Additional Investment £000	Cumulative Additional Investment £000	Total Annual £000	Total Cumulative £000
2017/18	2,200	2,200	12,500	12,500	14,700	14,700
2018/19	10,400	12,600	7,700	20,200	18,100	32,800
2019/20	9,300	21,900	3,800	24,000	13,100	45,900
Total	**21,900**		**24,000**		**45,900**	

3.9.2 As can be seen from above the impact of the additional funding is twofold:

- A much greater level of funding is available for 2017/18 than originally envisaged; and
- The overall amount of the BCF monies is effectively doubled over the three year period.

3.9.3 It is important to note, however, that the original Better Care Fund investment over the next three years is effectively cancelled out by continued reductions in the Revenue Support Grant (RSG) and hence needs to be used to maintain care budgets at existing levels.

3.9.4 The £24m additional funding must either be used on a one-off, non-recurrent basis, or be used to lever change that enables savings in other parts of the health and care system which can then be “recycled” to maintain agreed initiatives. At the time of writing this report, Sheffield’s proposals which have been discussed with key partners across the city, are currently being finalised with a paper to SCC’s Cabinet in July.

3.9.5 The government will also invest £325 million over the next three years to support the local proposals included within STPs for capital investment where there is the strongest case to deliver real improvements for patients and to ensure a sustainable financial position for the health service. In the autumn, a further round

of local proposals will be considered, subject to the same rigorous value for money tests. Investment decisions will also consider whether the local NHS area is playing its part in raising proceeds from unused land, to reinvest in the health service. It is anticipated that this funding will be allocated through CCGs at the local level.

Challenges for Adult Social Care

3.9.7 Challenges for adult social care can be split into three categories. These are listed below.

- The need to build the sustainability and resilience of key services so that capacity is there to support the whole health and social care system, particularly in times of high external demand
- The need to ensure that adult social care needs can still be statutorily met where there is significant financial constraint that might otherwise result in a service reduction.
- The need to invest in the infrastructure of adult social care so that services are effective, efficient and make best use of resources, ensuring that adult social care capacity continues to grow in the longer term.

3.9.8 Areas of potential investment that would help address the challenges are set out below:

- Improving medication management for people who receive care at home.
- Greater efficiency within the Short Term Intervention Team (STIT)
- Further whole system innovation to reduce Delayed Transfers of Care and improve outcomes for Sheffield people after their hospital stay.
- Improving life chances for young people moving into adulthood.
- Improving partnership working between specialist mental health services and the police.
- The need to improve systems and reduce bureaucracy in the delivery of adult social care
- The need to develop the social care workforce to support delivery
- Sustainability of the social care provider market supporting older people.
- The need to improve outcomes and use of resources for people with learning disabilities and people with mental health problems
- Support the high number of people who require assessment under Deprivation of Liberty Safeguards (DoLS)
- The need to maintain social work capacity until improvements are in place that increase productivity

- The need to maintain Community Support Worker capacity while their preventative impact is evaluated.

3.10 Delayed Transfers of Care

As a national outlier in Delayed Transfers of Care(DTOC), the CCG, Sheffield Teaching Hospitals and the Local Authority agreed to bring in the expertise of Newton Europe, a specialist in working with whole systems to work together to get to the root of why our delayed transfers of care remain a challenge, and to work with us to develop an action plan ready for delivery for this winter.

The work was launched at a city summit on the 23rd May to which all stakeholders were invited to learn of the outcomes of the two week diagnostic which Newton Europe had undertaken, to identify the underlying problems and then facilitated by Newton Europe, work together to identify how we can improve our discharge services for patients.

What was recognised in the first instance was what we do well,

- we all have a common purpose to always put the patient first
- Some outstanding best practice
- Significant progress made to increase reablement capacity
- Common view of the behaviours needed in a good system
- Unanimous high desire to improve.

Key facts on delayed transfers over the last 12 months which Newton Europe had highlighted in their diagnostic:

- People in Sheffield have spent **72,000** more days in Hospital over the last year than they needed to.
- 32% of those impacted on DTOC are waiting for a pathway to be allocated to them
- 30% of those impacted by DTOC are on a pathway to either intermediate, nursing and residential care
- 31% of those impacted by DTOC are waiting to go home with some extra support.

The key wokstreams agreed at the Summit were to:

- Get people home
- Rapid Community care
- Assessment at Home.

Current Position

Based on the work and outcomes of the summit, STH, the Local Authority and the CCG have worked together to develop the plans for the next stages of the programme. These have been presented to Chief Executives of the Council, CCG and STH who supported the plans. Our agreed reduction of numbers of DTOCs is to 50 with locally managed stretch targets.

In summary, we agreed that we will work towards developing only three routes out of hospital (replacing the myriad of current pathways), these being:

1. People who just need to go back to what they had before (ie no D2A)
2. People who might need more and should be assessed at home to determine what that might be (D2A at home)
3. People who might need more but MDT are anxious about them returning straight home so they go to step down for assessment (D2A in stepdown which would include Intermediate Care beds)

To develop these routes, we are establishing three workstreams:

1. Work in hospital to navigate people into one of these 3 routes as quickly as possible on admission .
2. Work in community to ensure rapid response community services are there to enable D2A
3. Work in community to ensure rapid capacity and response assessment is there to enable D2A

Our improved service model will be underpinned by the Improved Better Care Fund Direct Grant as described in section 4.

Key activities to help deliver the above workstreams will include –

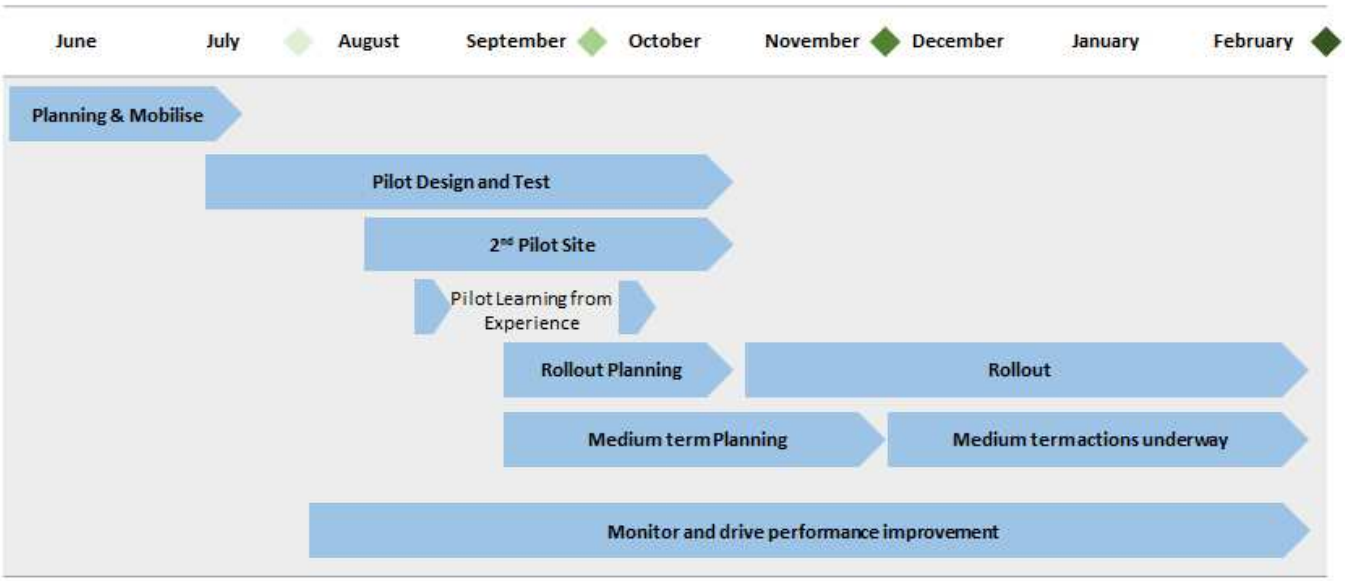
- Understanding the perceived barriers to discharge.
- Increase support to therapists to develop a more holistic risk conversation with patients
- Integrate active recovery to provide a seamless service to patients to improve outcomes and productivity
- Increase resilience of Independent Sector Homecare
- Improve outcomes and productivity in regards to intermediate care beds
- Increase complex discharges via discharge to assess/more home based assessments.

This will be underpinned by robust metrics and governance. Our main action plan

DTOC
A CLOSER LOOK

Sheffield Teaching Hospitals NHS
NHS Foundation Trust
NHS Sheffield
Clinical Commissioning Group
Sheffield City Council

PLAN



Use of the High Impact Change Model

Sheffield's approach will explicitly incorporate the High Impact Change Model to enable maximum benefits to be delivered in shortest possible time.

Workstream 1, Work in hospital to navigate people into one of the 3 discharge routes as quickly as possible on admission, will focus on mainstreaming Changes 1, 2, 3 and 7.

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be setwithin 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services aroundthe individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Workstreams 2 and 3, providing rapid response community assessment and services will focus on mainstreaming Changes 4, 6 and 8.

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

All three workstreams will be mindful of Change 5 to ensure that both discharge planning and community capacity is geared to support optimal flow all seven days a week.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

4. Our financial plan

Overview

The Sheffield Better Care Fund recurrent Pooled Budget was £272m in 2016/17 and the current budget for 2017/18 is £352m. The respective contributions of Sheffield NHS CCG and Sheffield City Council are shown below. These figures are the initial budgets as agreed by the Executive Management Group on 15th May 2017.

The biggest proposed change to the BCF in 2017/18 is the addition of a new Theme in relation to Mental Health which is the main reason for the c£79m increase in value of the BCF budget. Sheffield NHS CCG and Sheffield City Council have agreed to pool their mental health budgets and to risk share the combined financial position.

A truly integrated commissioning approach for Mental Health will offer more effective joined up commissioning (and therefore care), leading to better patient outcomes which will, by default, deliver better value for money.

The initial BCF budget shown below currently excludes the £12.5m iBCF additional government funding announced in the Spring Budget but resources will be added to relevant budget lines as a formal variation once the proposals have been signed off by SCC's Cabinet in July. The £2.2m original increase in BCF funding for Sheffield has been added to the BCF, but this has been offset by an equal and opposite adjustment to recognise the impact of the reduction to the revenue support grant to the funding of SCC services.

The tables and narrative below cover the plans for 2017/18. Work is underway on finalising both the targets and financial plan for 2018/19 which will be reported at a later date

Allocation of Resources

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

Budget Overview	**2016/17 Recurrent Budget £000**	**2017/18 Initial Budget £000**	**2017/18 Change £000**
Theme 1 - People Keeping Well	8,130	8,262	132
Theme 2 - Active Support and Recovery	50,321	49,807	(515)
Theme 3 - Independent Living Solutions	3,879	3,864	(15)
Theme 4 - Ongoing Care	151,892	127,186	(24,705)
Theme 5 Adult inpatient Emergency Admissions	54,565	56,505	1,940
Theme 6 - Mental Health	0	100,772	100,772
Sub total - Revenue	**268,788**	**346,397**	**77,608**
Theme 7- Capital Expenditure	3,509	5,537	2,028
Total	**272,297**	**351,934**	**79,636**

Note - the reduction in ongoing care is predominantly a transfer of Mental Health purchasing costs into the new Theme for Mental Health.

The 2017/18 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.

Management of the Pooled Budget

Work has started to draft the amendments to the S75 agreement for 2017/18 which should be finalised in July.

The Community Equipment Service (budget £2.8m) and Mental Health (Budget £101m) are jointly managed schemes with a risk share arrangement for any over or underspends. These schemes represent around 30% of expenditure lines within the BCF, with the balance being solely managed or jointly managed schemes that are funded solely by the partner responsible for that scheme.

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 and 2016/17. Work will continue in year to explore whether there are more services which would benefit from alternative mechanisms for the organisations to share risk when implementing integrated activities.

At present there is no agreement to implement a risk share arrangement for non-elective admissions. 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.

Protection of Social Care Services

One of the national conditions of the BCF in 2017/18 is to maintain real terms funding from Health to support social care services. Sheffield NHS CCG is committed to meeting the funding conditions attached to the BCF. There has been an increase in CCG funding for social care to satisfy the mandatory minimum contribution, and a significant additional contribution primarily due to the inclusion of mental health activity. The CCG total investment in the BCF increases to £244.4m in 2017/18, some £206m more than the mandatory minimum. In addition, investment in out of hospital services has been maintained.

Sheffield City Council is investing £107.5m in the BCF in 2017/18 which represents an increase of £7.8m mainly in adult social care.

BCF Funding Sources	2016/17 Recurrent Budget	2017/18 Initial Budget	2017/18 Change
Funding Sources	**£000**	**£000**	**£000**
Sheffield Local Authority	95,103	101,975	6,872
Sheffield Local Authority - Disabled Facilities Grant (Capital)	3,058	4,031	973
Sheffield Local Authority - Other Capital	1,506	1,506	0
Sub Total Local Authority	**99,667**	**107,512**	**7,845**
Sheffield NHS CCG minimum contribution	37,657	38,331	674
Sheffield NHS CCG additional contribution	134,973	206,090	71,117
Sub Total CCG	**172,630**	**244,421**	**71,791**
Grand Total	**272,297**	**351,934**	**79,636**

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This increased spend on social care is predominantly to satisfy demographic and national living wage pressures, but there is also allowance for an increase in home care rates to improve the resilience of the independent sector and to support hospital discharge processes.

5. Targets for 2017/18 and 2018/19

The number of mandatory BCF targets has been reduced in 2017/18. An overview of the mandatory targets is shown below.

	Actual 14/15	Actual 15/16	Target 16/17	Actual 16/17	Target 17/18
BCF Target Summary					
Mandatory BCF Targets	**No.**	**No.**	**No.**	**No.**	**No.**
Delayed transfers of Care					
Delayed transfers of Care (Delayed days)	24,138	23,411	19,000	48,969	21,203
DTOC (Delayed Days) rate per 100,000 of population (BCF Me	5,324	5,152	4,146	10,686	4,601
DTOC (patients) per 100,000 of population (ASCOF 2C1)	15.2	15.7	n/a	29.1	14.1
Non Elective Admissions	58,665	55,075	54,335	53,631	48,021
Admissions to residential and nursing care					
Admissions to residential and nursing care homes (Age 65+), per 100,000 population	820	987	824	816	768
Admissions to residential and nursing care (absolute number)	748	909	763	756	717
Reablement					
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /	77%	77%	85%	75%	80%

Delayed transfers of care are monitored on three measures and have risen sharply in 2016/17. The target for 2017/18 assumes a 10% reduction on 2015/16 levels which is consistent with the Sheffield City Council ASCOF (Adult Social Care Framework) targets.

Non Elective Admissions

Non Elective admissions performed better than target in 2016/17. The cost of non-elective admissions was higher than budget in 2016/17, but this was predominantly due to excess bed day costs associated with a higher level of delayed transfers of care. The target for 2017/18 is based on reductions delivered primarily from activities within AS&R and urgent care

Admissions to residential and nursing care

The number of admissions in 2016/17 has fallen 17% compared to 2015/16, and achieved target. The target for 2017/18 is based on the ASCOF submission and assumes a 6% reduction in admissions compared to 2016/17. This will primarily be achieved via the implementation of the discharge to assess process.

Reablement

The proportion of older people still at home 91 days after discharge is forecast to increase to 80% in 2017/18. The final position for Q4 2016/17 was 75% which was affected by a higher number of deaths than in the prior year. The target for 2017/18 is based on the ASCOF submission is 80%.

6. Our delivery plan and approach to risk

The strategic leadership and delivery assurance of the Better Care Fund is undertaken by our Executive Management Group (separate groups managing strategy and delivery). The Executive Management Group includes representation from Executive Directors and Directors leading the workstreams from both CCG and Local Authority.

The group was originally constituted as part of the integrated work between Sheffield CCG and the Local authority three years ago when the provider landscape, national direction and financial challenges were different. The focus has changed now following the Five year forward view, to more of a partnership approach for commissioners and providers together. Sheffield now has a broader plan as demonstrated in the Sheffield Plan, works in a South Yorkshire and Bassetlaw accountable care system, and the Better Care Fund and its governance needs to ensure it remains fit for purpose going forward to deliver all of our ambitions.

With this in mind, the group is reviewing its governance, roles and responsibilities to ensure it can:

- Work seamlessly within a joint commissioner/provider partnership
- That due to the ambitious savings plans, it can take responsibility to project manage progress, manage risks and inter-dependencies across all our workstreams.
- It uses resources smartly and does not duplicate any existing functions.

Programme Management

We understand that if we do not manage risk and focus on realising our benefits, we are at risk of not succeeding. We are therefore reviewing our programme management function across our workstreams to ensure that there is a system overview.

It has acknowledged that because of the huge savings needed in Sheffield it is reviewing its cross system assurance process to ensure all workstreams are on track and will ensure success and realise our benefits.

We are putting in place more systematic reporting processes to ensure that the system leaders are assured that all the workstreams are on plan to deliver. We are planning to put this in place over the next three months. All the risks have been mentioned in each of the workstreams and are being managed within each of their own governance arrangements and highlighted to Executive Management Group on an exception basis.

It is also mindful of wider programmes of work, such as the Public Sector Reform programme which will include health and care initiatives as well as the wider social value elements including employment, education and the economy.

As well as reviewing its roles and responsibilities, the Executive Management Group is also reviewing its scope, terms of reference and membership.

We are developing a wide range of outcomes, to meet our wide ranging objectives. Some are specific to each of the workstreams but it has been acknowledged that it is difficult to

develop outcomes which can also be evidenced as been achieved, given our strong emphasis on prevention initiatives.

We are part of the national pioneer network and we share as well as learn from our partners across the network.