Making it better

Sheffield's Action Plan
Health and Care for Older People
2018-19

Background

This action plan sets out the priorities for continually improving the experience that older people have when they encounter Sheffield's health and care services. The plan pulls together a wide range of work that will be carried out by Sheffield organisations in partnership. It is in response to The Local Area Review of Sheffield's health and care support for older people that was carried out by the Care Quality Commission (CQC) in the spring of 2018.

The Local Area Review used an approach that focused on three areas for older people in Sheffield. CQC looked at how health and care organisations worked together to:

1 Ensure wellbeing so older people could live happily and healthily at home for as long as possible
2 Respond to crisis, for example in the event of illness or injury that created a sudden need for treatment, care and support
3 Help older people recover after crisis

Sheffield was one of twenty areas chosen by CQC for a Local Area Review because performance was not as good as many other parts of the country on a number of measures, including:

- Higher than average numbers of older people being admitted to hospital
- Once there, many older people having to wait a longer time than should be expected before returning home
- Where they needed support in their own home to be able to leave hospital, it too often took significant time to arrange this
- When they received support at home to help them recover after being in hospital, after 3 months had passed they were more likely than older people in many other areas to be back in hospital, or perhaps having to be supported in a care home.

The Care Quality Commission took Sheffield's recent performance against these national measures to be a strong sign that more could be done to improve the three areas above. Health and care organisations in Sheffield agree that these are absolutely key indicators of successful outcomes for older people and will continue to monitor them. Improvements in these measures will be driven by:

- A stronger grip on community prevention and wellbeing that reduces avoidable admissions to hospital
- Better planning and coordination inside and outside hospital to ensure older people are able to return home as soon as their hospital treatment is complete
- Community support that helps older people leave hospital quickly, supports them to stay in their own home and keeps them safe, well and independent for as long as possible.

Priorities

The CQC Local Area Review has helped identify the areas of focus that will drive the necessary improvements. Key actions for each of these priorities are set out over the next few pages. In summary these are:

1 A way of working that is built around acknowledging and improving older people's views and experiences and which drives a citywide vision (sections 1 and 2)
2 A shared citywide workforce strategy to support front-line staff in delivering this vision and in particular further develops multi-agency working (3 and 4)
3 Clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for our Voluntary, Community and Faith sector (5 and 6)
4 A meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability (7 and 8)
5 Strong system focus on enabling the right support from the right person in the right place at the right time, to give the best possible experience for older people and to ensure the best use of resources (section 9)

Oversight

This plan will require coordinated work from partnership organisations across the city. The plan covers 2018-19 only and focuses a lot of actions in the autumn to avoid progress being overtaken by operational pressures in the winter.

The overall shared responsibility for the health and wellbeing of older people in Sheffield lies with the city's Health and Wellbeing Board. The Health and Wellbeing Board have been consulted about this plan and will hold partners to account for delivery of improved outcomes for older people. A strong start to this plan is vital and monitoring of improved outcomes will begin by October 2018.

The Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee also has an essential role in holding partners to account using the mandate of local elected Councillors. The delivery of the plan and the improvement of outcomes for older people is part of the Scrutiny work programme and progress will be reviewed on a six monthly basis.

Sheffield's Accountable Care Partnership (ACP) is the group of health and care organisations responsible for enabling and delivering this plan. As such, the ACP and its constituent organisations will be directly accountable for progress made.

What we will do	The difference we will make	What we will check	The key actions	Who will coordinate	By when in 2018-19			
					Q1	Q2	Q3	Q4
1 **A shared city wide vision** for older people's care, developed and shared between service users, carers and families, the wider population and frontline staff across the NHS, Council and voluntary sector.	Co-production of the vision and approach to delivery. Improved sense of a shared direction. Stronger prevention through greater emphasis on helping older people stay healthy and valuing the contribution they make.	The delivery of our overall programme of work for older people. Evaluation of events and shared understanding between frontline staff and strategic leadership.	1.1 Articulate, share and develop the vision for older people across the city and hold a series of workshops to further develop this and a high level delivery plan to support the work. This will focus on older people as well as other key work streams. The workshops will include older people and carers and staff. The approach will be discussed and agreed with Union partners across Sheffield.	ACP Programme Director			X	

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2 Ensuring **older people's views and experiences** become integral to our approach.	Improvement in self-reported satisfaction from older people and family carers in receipt of health or social care support.	Self-reported satisfaction of older people who use health and care services. Self-reported satisfaction of family carers. Evaluation measures to be built into Person Centred initiatives to ensure individuals feel their individual needs and goals are met. Ongoing collation of staff, user and carer feedback to help us shape our improvements.	2.1 Working with communities and system representatives to develop a comprehensive approach to becoming a Person Centred city across our health and care system across Sheffield. This will focus on "What Matters To Me" and bring together linked work such as Health Conversations, For Pete's Sake and the Alzheimer's society "This is Me" tool to identify the personalised needs of older people. These initiatives are gaining momentum across Health and Social Care in Sheffield & we need to build on this. Steps will be - Strategic agreement to scaling up work and a tangible plan at July 2018 EDG - Developing joined up training plans to scale up this work and techniques - Working in partnership with the voluntary sector to benefit from their considerable expertise in this area	Executive Delivery Group, Accountable Care Partnership (ACP).			X	

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		.	2.2 Take a set of individual patient case studies and review end to end experience of our health and care system. Consider what could be better, does our action plan sufficiently address these cases and agree any additional actions. Use feedback received from CQC Review as our starting point. Repeat on a 6 monthly cycle to assess whether our plan is making a difference.	Patient experience leads (co-ordinated by Head of Patient and Healthcare Governance, STHFT) This will work with voluntary sector and carers to capture their knowledge of individual experience too			X	
			2.3 Agree and implement an approach to engagement and co-design with Healthwatch and Voluntary Sector that builds on good examples within the city (i.e. Testbeds, MSK) and build capability and capacity across local health and care services to effectively involve local people.	Programme Director, ACP, CEO Healthwatch		X		
			2.4 Develop regular mechanisms to systematically share and learn continuously from older people's "end to end" feedback as part of our evaluation and monitoring mechanisms in relation to capturing and responding to system-wide patient experience. This will be facilitated by vibrant quality improvement approaches across the system.	Patient experience leads (co-ordinated by Head of Patient and Healthcare Governance, STHFT) This will work with voluntary sector and carers to capture their knowledge of individual experience too			X	
			2.5 Ensure system themes from older people's feedback is shared with, and built into, training and development plans for our workforce to ensure a tailored and responsive approach.	HR OD Director, SCC, part of Workforce ACP Work Stream			X	

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3 Develop a joined up city-wide strategy for the **workforce** across NHS, SCC, VCSE, and private sector that makes progress on shared strategic workforce issues, delivers a great staff and user experience and ensures stronger engagement with the front-line	A joined up approach to ensure that Sheffield is an attractive place to work in health and care. A joined up approach to tackling some of the shared recruitment and retention challenges within the older people's workforce. A joint approach to improving quality so that staff working across health and care have the tools they need to put "What Matters to You?" into action. A joined up vibrant training programme to support and develop a compassionate workforce.	Self-reported satisfaction of staff who work in health and care services. Turnover and vacancy rates, particularly in job roles that are difficult to fill. Improved experience of our older patients.	3.1 Establishment of a workforce oversight group to steer the development of a strategy, to be co-designed with frontline staff across the city. The approach will use a national workforce planning tool and 12 week rapid improvement approach. This will involve 3 workshops, the gathering of data and activity to help prompt shared discussion amongst frontline staff to generate strategic workforce plans and ideas to redesign and reshape the workforce.	CEO Sponsor of ACP Workforce Work Stream (SHSC CEO)			X	
			3.2 Analysis of workforce data and planning of engagement workshops.				X	
			3.3 Workshops to develop strategy using data, input of front-line staff, and views of local older people.				X	
			3.4 Publication of overall city-wide strategy for workforce, with a focus on older people that is co-designed and connects the frontline and the strategic vision. This needs to incorporate the private sector, voluntary and community sector as well as the statutory organisations. We will involve the unions across Sheffield in our approach. .					X

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			3.5 Progress the key workforce initiatives identified in the Place Based Plan, including: - a workforce passport that enables seamless working across organisational boundaries - working in partnership with the universities and colleges to develop skills across multidisciplinary teams to support new roles and delivery on new models of care (with a focus on mental health and communications skills).	CEO Sponsor of ACP Workforce Work Stream (SHSC CEO)			X	X
			3.6 Work with provider, voluntary, and education partners to embed a training module on person-centred care as part of the What Matters to You initiative.	Executive Director for Care Outside of Hospital, CCG			x	

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4 A city-wide **organisational development approach** to improve multi-agency integrated working at the front line and develop greater system leadership skills throughout the city	Improved multi-agency working for older people Improved pathways and communication between different services and parts of the systems More seamless care for older people Higher job satisfaction Better service user experience Development of a workforce that works across boundaries and has the skills to continuously improve	Self-reported satisfaction of people who use health and care services. Measures of quality of team work amongst frontline agency staff. Measures of self-reported working relationships between system partners.	4.1 Develop organisational development interventions to support and improve multi-agency working between frontline inter-agency teams.	AO, Sheffield CCG (CEO Sponsor of Organisational Development Group			X	
			4.2 Develop improved system leadership, behaviours and attitudes at all levels to develop collective leadership approaches across the city. The first stage will to be build a plan, as agreed by the Organisational Development ACP Workstream. This will build on the Liminal Leadership pilot delivered in Q1 2018/19.				X	
			4.3 Working towards a single Quality Improvement approach across health and social care organisations.				X	
			4.4 Build on and accelerate specific system wide improvement programmes for pathways within the ACP requiring improvement including A. Continuing healthcare processes B. End of Life care	CCG Chief Nurse / STH Chief Nurses/ Director of People Services SCC		X		
			4.5 Develop a learning culture, with the first step a process that shares and reviews incidents, risks, complaints and patient, family and carer experience across the system and routinely undertakes joined up system-wide analyses and investigations, including root cause analysis, where appropriate.	Clinical Governance Leads (coordinated by Head of Patient and Healthcare Governance, STHFT)		X		

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5 Strengthening our **strategic partnership with the Voluntary, Community and Faith Sectors**	More seamless joint working for older people	Measures of self-reported working relationships at strategic level between system partners Develop what else we will check (as part of defining our new strategic working relationship with the VCF sector)	5.1 Define new strategic working relationship with Voluntary, Community and Faith (VCF) sector and consider how we create a mind-set shift to this relationship across the city.	Joint-chairs of ACP Board		X	X	
			5.2 Recognise the contribution of the VCF to health and care across the city through formal invitation to be a 7th formal full member of the ACP.		X			
			5.3 Develop clear plan about how this will be different and how the ACP will enable the VCF to have capacity to provide strategic leadership to the ACP and be a full partner. First steps will be - Discussion at ACP Executive Delivery Group (following strategic agreement from June ACP Board decision) - A discussion to understand and consider the sustainability of the sector for the future. - Agree what we will check to ensure ongoing improvement in the strategic partnership between health and social care and the VCF	CEO Voluntary Action Sheffield and ACP Programme Director			X	

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6 Strengthening our supporting **governance** to turn vision into timely action	Review how housing links into services for older people at operational and strategic level. Clear definition of key respective roles for Health and Wellbeing Board (understanding needs and driving priorities at city-wide level), Accountable Care Partnership (driving actions to help achieve those priorities), Overview and Scrutiny Committee (ensuring accountability to local people both to work in partnership with them and to achieve good quality outcomes). Timely decision-making via clear governance. Shared understanding of progress and pitfalls.	Overview of other measures referred to in this plan: citizen and staff satisfaction, outcomes, responsiveness, use of resources. Work ongoing to establish measures for Active Support and Recovery work.	6.1 Hold a public session of the ACP Board with additional members of Healthwatch and VCSE as a first step to improving transparency.	Accountable Care Partnership Board Chairs	X			
			6.2 Establishment of 6 monthly monitoring of partnership delivery at Overview and Scrutiny.	Overview and Scrutiny Board, SCC	X			
			6.3 Review relationship and operation of Health and Wellbeing Board and ACP. This will include: - Active review of practice by other Health and Well-Being boards - Review of membership	Chairs of Health and Wellbeing Board and ACP Board			X	
			6.4 Review and strengthening of relationship with housing in operational, governance and strategic inter-agency working for older people	Director of Adult Services, SCC and Director of Commissioning, SCC		X		
			6.5 A clear programme ACP delivery plan with milestones informed by the plans for each of the work streams; this will require the partnership to identify and secure the resource to coordinate, communicate and drive each of the programmes	Programme Director, ACP			X	

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7 Scaling up pilots into sustainable, large scale change to ensure a meaningful shift to prevention	Focusing available resources on the support that has most impact for local people in helping them stay safe and well, and preventing avoidable deterioration.	Higher physical and mental health and wellbeing for older people, particularly in the most deprived parts of the city. A higher proportion of older people supported safely to stay at home. Older people getting back home more quickly after hospital admission.	7.1 Agree priorities for any short-term funding available to alleviate winter pressures.	Urgent and Emergency Care Transformation and Delivery Board, ACP		X		
			7.2 Evaluate successful pilots and assess scale up and implement on a city wide basis. This will include a review of Better Care Fund schemes.	ACP Executive Delivery Board CCG Director for Out of Hospital Services			X	
			7.3 Make recommendations about longer-term system reshaping of investment priorities to develop new models of care and support (i.e. facilitated through the Sheffield Outcomes Fund etc.). This will include a collated review of evidence from voluntary sector, health and social care about evaluation of models and recommendations for decisions and a reshaping of investment to be considered by the ACP Executive Delivery Group on a city-wide basis, based on evidence.	ACP Executive Delivery Group			X	
			7.4. Mobilisation of new models of care and support, through collaborative working which focus on multi-disciplinary multi-agency working and single inter-disciplinary care planning and records. These models must approach both the physical and mental health and well-being of older people building on approaches such as IAPT and other models across the city.	Commissioning leads – SCC and CCG				X

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8 Review key supporting strategic and functional **enablers to improve effectiveness**	Focusing available resources on the support that is has most impact for local people in helping them stay safe and well, and preventing avoidable deterioration. More seamless joint working for older people	Self-assessment of key areas, e.g. data maturity	8.1 Review of digital inter-operability and ability to share care information across boundaries.	IT Leads coordinated by Programme Director, ACP		X		
			8.2 Work towards a joint commissioning strategy across health and social care that includes a commitment to creating stability in the parts of the market that we wish to develop and strengthen as part of our new models of care. We will avoid successive short term funding initiatives with smaller out of hospital providers/partners - Recommend an Integrated Commissioning Strategy - Develop an Integrated Commissioning Infrastructure - Complete mapping of provision/services across life stages and levels of intervention - Identify and agree priority areas for integrated commissioning	Accountable Officer, CCG Executive Director of People, SCC		X	X	X

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9 Ensure **flow and best use of system capacity** so older people get timely support from the right person in the right place	Older people being able to return home as soon as their hospital care is complete, ensuring quickest possible recovery. Enabled by: - What Matters To You conversations engaging with carers and professionals who know the older person in the community and can help make decisions in the context of their whole life. - Linked approach between physical and Mental Health. The evidence is clear that effective MH Liaison can improve flow. - Timely in-patient discharge planning ensuring all time in hospital adds value for the older person. - Simplified “three routes out” with a focus on discharge to assess to enable return home. - Integration of community intermediate care including using “trusted assessor” principles. - Improved organisation of independent sector homecare capacity.	The experience of older people and those who care for them. A higher proportion of older people supported safely to stay at home. Older people getting back home more quickly after hospital admission A step change in both of the above measures ahead of winter 2018-19.	9.1 Ensure that the voice of the older person and those who care for them in their home is heard and listened to relation to getting them home. This will help to provide the right support, and minimise the risk of the provision of non-value adding interventions which introduce waste and do not benefit the individual.	Deputy Chief Nurse, STHFT		X		
			9.2 Refresh of independent sector homecare “Primary Providers”.	Director of Adult Services, SCC			X	
			9.3 Development of outcome-based independent sector homecare.					X
			9.4 Joint commissioning and quality assurance of homecare and care homes between Council and CCG.	Director of Adult Services, SCC Chief Nurse, CCG				X
			9.5 Agreement and joint commissioning of non-home, non-acute bed capacity.	Clinical Director, CCG		X		
			9.6 Gold Level Board Rounds on all wards with high DTOC levels.					
			9.7 Continued roll-out across STH of the ‘SAFER’ patent flow bundle (which incorporates daily **S**enior medical review, **A**ll patients having a planned discharge date, **F**low of patients beginning **E**arly in the day, and all patients with a long length of stay being frequently **R**eviewed). All these actions are of vital importance in ensuring that patients receive timely and safe care in the most appropriate location.	Deputy Clinical Director, STH		X		

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			9.8 Initial evaluation of “Red to Green” work to speed hospital decision making and discharge actions.	Deputy Medical Director, STH		X		
			9.9 Physio and OT assessment in acute setting within 24 hours.			X		
			9.10 Therapy Core Assessment and Triage Tool rolled out to all wards.			X		
			9.11 Streamlined handover from hospital and community to single point of access for community services.	Operations Director, STH Head of Access and Prevention, SCC		X		
			9.12 Integration of Active Recovery services provided by Council and STH: common assessment, trusted assessors, single rostering system.				X	

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