Report of:	SCC Lead Officer: Dawn Walton Director of Commissioning Inclusion and Learning SCCG Lead Officer: Nicki Doherty, Executive Director of Delivery, Care Outside of Hospital
Report to:	Joint Commissioning Committee
Date of Decision:	24 June 2019
Subject:	Joint Commissioning for Health and Care – care outside of hospital

Is this a Key Decision? If Yes, reason Key Decision:-	Yes		No	x
- Expenditure and/or savings over £500,000				
- Affects 2 or more Wards				
Has an Equality Impact Assessment (EIA) been undertaken?	Yes		No	x
If YES, what EIA reference number has it been given? 533				
Does the report contain confidential or exempt information?	Yes		No	x
Which Scrutiny and Policy Development Committee does this relate to? Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee				

Purpose of Report:

The purpose of this report is to outline the potential whole system changes required to support an improvement in the health and wellbeing of people in Sheffield and reduce health inequalities. The report outlines 2 key elements - the prevention of multi morbidity and the development of a robust out of hospital health and care system. Requirements to support these changes and next steps are outlined.

Questions for the Joint Commissioning Committee:

The Joint Commissioning Committee is asked to provide a view on the proposals within this paper.

Recommendations for the Joint Commissioning Committee:

The Committee is being asked to consider the report and provide views.

Background Papers:

Lead Officer(s) to complete:-		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance: *(Insert names of SCC and CCG officers consulted)*
		Legal: *(insert name)*
		Equalities: *(Insert name of officer consulted)*
		Other Consultees: Sheffield Clinical Commissioning Group • Brian Hughes - Executive Director of Commissioning, • Nicki Doherty - Executive Director of Delivery, Care Outside of Hospital • Sarah Burt – Director of Delivery, care outside of hospital SCC • Cllr George Lindars-hammond • Greg Fell – Director of Public Health • John Doyle – Director of Business Strategy, People Portfolio • Dawn Walton – Director Commissioning, Inclusion and Learning, People Portfolio • Eleanor Rutter – Public Health Consultant • Nicola Shearstone – Head of Commissioning, Inclusion and Schools Services, People Portfolio
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	
2	**EMT member who approved submission:**	*(Insert name of relevant Executive Director)*
3	**CCG lead officer who approved submission:**	*(Insert name of relevant officer)*
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Joint Committee by the officers indicated at 2 & 3 above. In addition, any additional forms have been completed and signed off as required at 1.	
	Lead Officer Names: Dawn Walton Nicki Doherty	**Job Titles:** Director of Commissioning Inclusion and Learning Executive Director of Delivery, Care Outside of Hospital

Date: *(Insert date)*

Joint Commissioning for Health and Care – Care Outside of hospital

1. Introduction/Context

1.1 Changing demographics, increasing demand and complexity all contribute to significant challenges within the health and care system.

1.2 Sheffield hospital admissions are high and the length of stay for people is above the target set for the city. A rebalancing of the system is needed to prioritise out of hospital care and drive better use of resources.

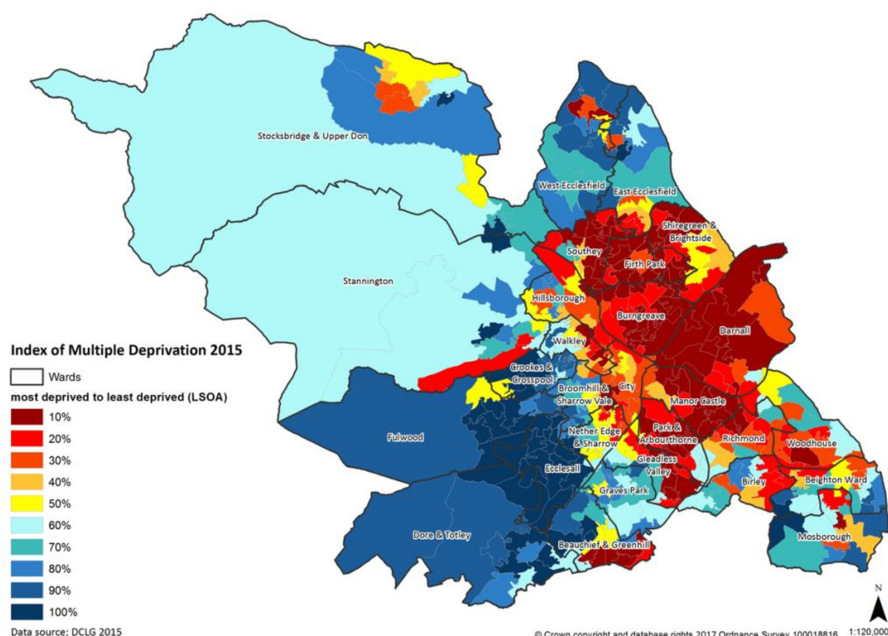
1.3 The CQC Local Area Review report 2018 was clear that too many people had a fragmented experience leading to feeling not well cared for and having to tell their story multiple times and on occasion with a lack of privacy and dignity.

1.4 The CQC review highlighted insufficient focus on prevention. The report stated that understanding that a focus on preventing hospital admission was as crucial to the effectiveness of the health and care system as enabling safe and timely discharge had not yet been fully translated into joint strategic delivery plans and as such the approach to prevention was underdeveloped.

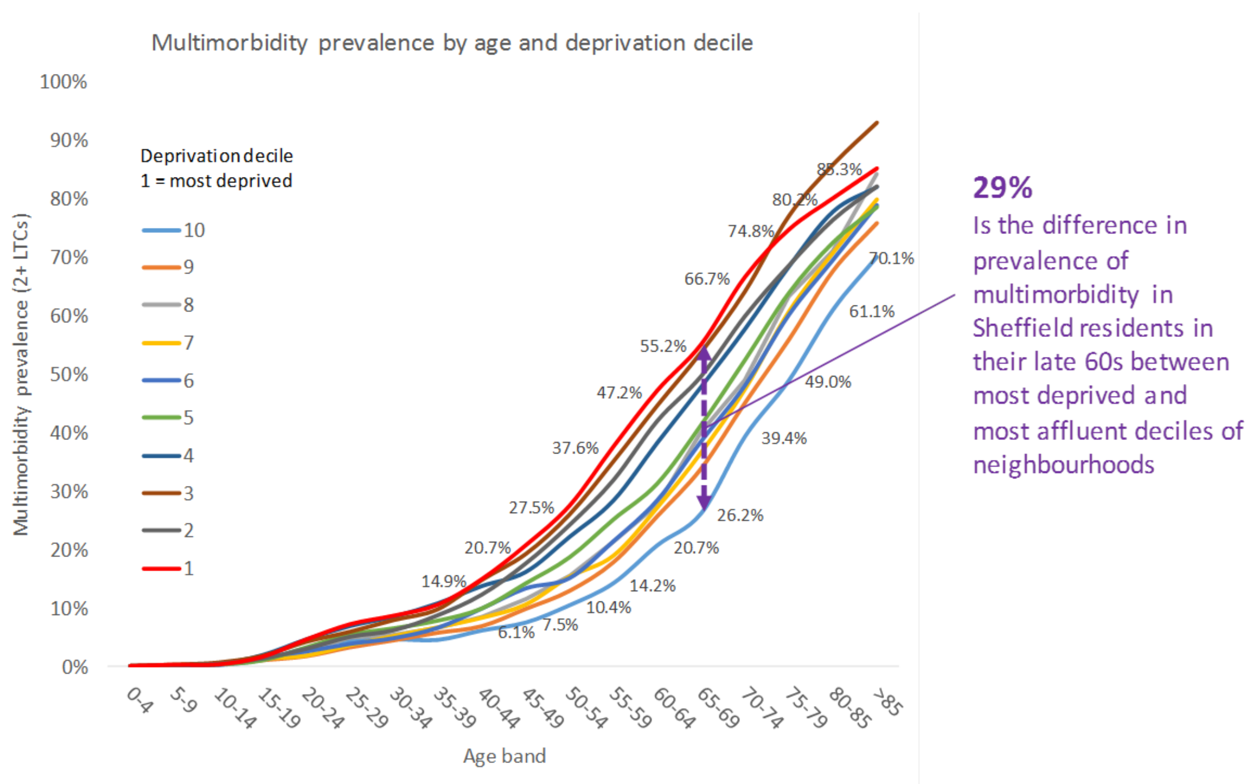
1.5 There is increasing financial pressure across the system. People are living longer and public sector funding is reducing creating long term financial sustainability issues.

1.6 There are significant inequalities in health & causes of ill health within Sheffield experienced by both adults and children. The problem of multi-morbidity is seen more frequently in deprived communities, where how well people are able to engage in preventative behaviours or early support, results in a higher rate of emergency hospital admissions and shorter healthy life expectancy.

1.7 The healthy life expectancy of both males and females is strongly correlated with the indices of multiple deprivation for Sheffield.



1.8 There is a clear difference in prevalence of multi morbidity in Sheffield residents if age and deprivation are compared. This is evident in the graph below.



2.0 Main body of report and matters for consideration

2.1 Target population

2.1.1 There is no clear definition of frailty but the term relates to impairment of physical function and resilience most often the result of multiple long term conditions.

2.1.2 Used without qualification, the term frailty is often assumed to relate to the older population, leading decision makers to potentially exclude the needs and demands that are evident in the whole population. Multi-morbidity is a precursor to frailty and is now widely accepted to be a clear manifestation of inequalities affecting all ages.

2.1.3 Multi morbidity is therefore the preferred term as it encourages us to focus our attention equitably, on areas of greatest need, to focus on the key principle of prevention at all levels and by setting this work within a population context, to shift our focus upstream in terms of age and locus of intervention.

2.1.4 By focusing on multi morbidity and its impacts on both people and services, we are compelled to consider whole system changes which impact on the entire population rather than particularly high-risk cohorts.

2.1.5 Particularly the impact of multi-morbidity enables us to consider whole system changes which also impact on the whole population rather than specific cohorts.

2.2 Existing good practice

2.2.1 The CQC Local Area review report 2018 recognised that there were some good practice examples, but that these were not effectively evaluated and not given sufficient oversight to translate across the system. This led to projects being developed in silos rather than strategically cross the system.

2.2.2 There are number of examples of good practice developing across the city. These include primary care networks/neighbourhoods, person centred approaches, social prescribing, governance arrangements that support integrated working, agreed strategic priorities and existing tripartite risk shares.

2.2.3 It is recognised that there is scope for improvement. To do this we must develop more focus on prevention, further embed the person centred approach, develop the integration of primary and community care with a focus on the re-provision of treatment and care in a community setting. To do this we need to develop an outcomes focused approach, focusing on what we want to achieve and the difference we want to make to peoples life rather than how we will achieve this. This requires improved working with key stakeholders, developing ideas and initiatives through co production.

2.3 Vision and Aims

2.3.1 Our vision is to improve the health and wellbeing of people in Sheffield and reduce health inequalities. There are 2 key elements to this – the prevention of multi morbidity and the development of a robust out of hospital health and care system.

2.3.2 A number of aims have been identified:

- To develop a prevention focused health and care system
- To identify people who are at risk of developing long term conditions and multi morbidity and maximise independence and resilience within their own home and community
- To provide optimal support to people (and their families) who are multimorbid/complex or at the end of life
- To build on an integrated approach across health and social care to ensure best use of shared resources

2.3.3 This vision and associated aims aligns with a number of key strategy commitments including the health and wellbeing strategy and the accountable care priorities for the city: care closer to home, living well / ageing well, personalisation, reducing health inequalities, a focus on prevention, neighbourhood development, and the best use of resources (sustainability).

2.4 What do we need to do?

2.4.1 To have a positive impact on people's health and wellbeing we need to shift to preventative and proactive evidence informed care which is delivered closer to home and away from hospital. This requires more than a change in service delivery models. We must change the culture in the way in which we manage people's health and social care needs. This includes improving people's confidence to

manage their needs in the community rather than relying on hospital treatment. This is reliant on increasing the capacity in communities to manage demand in order to prevent attendance in acute services.

2.4.2 There are a number of whole system changes that require exploration with key stakeholders to identify opportunities for development. These changes have a population approach which can support the long term sustainability of a more efficient and effective provision of care. These changes should develop a system that supports and enables future transformation.

2.4.3 Building resilient communities enables individuals and communities to harness local resources and expertise to help themselves. It enables them to take collective action to increase their own resilience as well as that of others. This gives a greater sense of community and reduces the impact of social, financial and health pressures.

2.4.4 Locally accessible integrated services in communities enables all sectors to work together to provide the support needed at the earliest opportunity. This multi-disciplinary approach should prevent the escalation of need and demand on more acute services.

2.4.5 There are currently a range of access points to services which can be confusing and lead to a delay in response to requests for support. Improving this should lead to a better customer experience through a quicker response, managing need in a timely and cost effective way.

2.4.6 Delivering health care out of acute hospital settings and closer to people's home aims to provide a better experience for people and reduce the number of unplanned bed days. Exploration of the opportunities for this need to assess the impact on quality and outcomes for patients and the financial impact.

2.4.7 There is a significant amount of data held within organisations but this is often not shared in an effective way. Improving this and utilising data and intelligence from across the system would enable the identification and targeting of early support which in turn should support a reduction in demand on services.

2.5 What would look different?

2.5.1 There are a number of significant differences that would be seen if we achieved the system changes required. These include:

- Care focused around communities and focused on wellbeing, self-care and prevention
- Improved use of all assets within a community – voluntary sector working alongside primary care and specialist teams
- Local people knowledgeable about how to access support within their own community
- Person centred approaches across all providers
- Hospital care used only when care cannot be provided in the community
- A system that is supported by shared intelligence and information which allows a proactive offer of support
- Improved access to specialist support from acute hospital to the community
- Investment in community based health and social care

2.5.2 It is important that we now work with providers and key stakeholders to explore these differences in more detail and identify actions required to achieve these outcomes.

2.6 How do we make this happen?

2.6.1 Delivering whole system change requires engagement from all stakeholders. A critical element of this will be the engagement of health and care providers at all levels, including senior leaders, to support the development of changes and delivery plans to enable the implementation of those changes. Communication with providers needs to identify key system leaders that can support the delivery of this work. Key to this will be a robust communication and engagement plan for all providers including the statutory, community, voluntary services and the public.

2.6.2 Initial steps require a detailed understanding of the existing services and what would look different if key outcomes were achieved. This includes intelligence which provides detailed knowledge of the population and interventions that currently take place. This can lead to the development of new initiatives, with identified ACP groups taking responsibility to develop detailed business cases for these areas of work which can start to create a shift in the system.

2.6.3 A crucial element of this will be workforce development and plans for this to align to the principles and vision for the city.

2.6.4 An outcomes framework is required to underpin the delivery plans. This would include agreed impact measures that support the measurement of progress and which are agreed by partners across this system.

2.7 What are the requirements to support system change?

2.7.1 The agreed changes that are developed to support this whole system transformation require a unified approach to commissioning. This will include the ability to matrix work across organisations and disciplines, identifying a shared commissioning resource with project management functions that enable the programme to be established and delivered. Information sharing will be a key element and will require exploration of existing information systems.

2.7.2 The whole system change proposed in this paper requires a change in organisations, networks and communities and this requires the active involvement and commitment from multiple stakeholders in order for this to be effective and sustainable, An ability to work at scale is crucial for this to be successful.

2.7.3 Clear leadership and decision making will be a driver for the delivery of this programme. It is proposed that this is managed through the Long Term Conditions Accountable Care partnership (ACP) Board, enabling the involvement of stakeholders from across the system. This will require the engagement with other ACP boards to recognise and manage the interdependencies.

2.7.4 The Joint Commissioning Committee will be required to agree joint health and social care commissioning plans that support this system change, managing risks collectively, and ensuring these changes meet the required outcomes for the city.

3.0 Next Steps

3.1 Discussions have not yet taken place with the ACP Long term Conditions Board to agree the role of that board and its interdependencies with the other ACP board priorities. This meeting is due to take place on the 24th June.

3.2 The CCG and SCC need to identify the multi-disciplinary joint commissioning function to support the development of this work by the end of June.

3.3 The next stage will be to develop a high level programme plan which should be in place by the end of July with a co-designed strategy and plan with stakeholders by the end of September. Engagement with other ACP boards in relation to the interdependencies would need to form part of this planning.

4.0 Recommendations

4.1 In summary this paper sets out the approach to whole system changes that would support the prevention of multi morbidity and the development of a robust outside of hospital health and care system.

4.2 Joint Commissioning Committee support the next steps set out in this paper, noting a follow up paper will be presented to the committee in September.

This page is intentionally left blank