Working together to transform Sheffield's health and social care services

Sheffield Overview and Scrutiny Committee

16 January 2013

Phase 2 RFT Programme

1. Introduction and Context

At the October Transforming Sheffield Health Steering Group (now the Programme Board for RFT) initial discussions confirmed that:

- All parties supported the revised scope and breadth of RFT in Phase 2
- The relationship between the children's "future shape" work and the children's content of RFT would need to be clarified to avoid duplication
- All organisations would support Kevan Taylor in his role as leader of the city wide Programme Executive
- The details of an organisational development programme still needed to be finalised in order to underpin delivery of the next phase; and that this included translating RFT strategic goals into everyday reality for frontline staff.
- The governance arrangements were signed off by all organisations

The RFT Programme Executive has now met on two occasions since the October TSHSG meeting and this paper summarises the progress made with the development of Phase 2 goals within the context of the original Programme Initiation Document (PID) that was authorised in June 2011. The original objectives for the Programme PID remain relevant, but this paper reshapes Phase 2 to include:

- The original component parts for unscheduled care and long terms conditions that have been part of Phase 1.
- Component parts of the elective care programme.
- The unscheduled care components of the Children's Future Shape Programme.
- Component parts of adult mental health.

2. System Modelling: Population needs (PN) Workstream

It is recognised that success of the RFT programme will see a development of primary and community services in Sheffield and that that development will depend on a shift of resources from hospital to community. Managing such a transformational shift will require confident leadership and detailed planning, neither of which can happen without a clear view of the required 'end-point'.

One of the main aims of the PN workstream is to quantify need for health and social care at its different levels in Sheffield. The first stage in that process is to try to quantify 'need' for emergency hospital beds.

The model is based on a population of NHS Sheffield patients of all ages who experienced an emergency hospital admission in the financial year 2011/12. It uses

ICD 10 primary diagnostic coding and estimates the potential for reductions in emergency bed use at three separate points in the system:

- Reduced emergency admissions at the 'front door' according to the evidence based list of ambulatory emergency care sensitive conditions produced by the NHS Institute for Innovation and Improvement.
- Reduced emergency admissions due to ambulatory care sensitive conditions (ACSCs) from the community by bringing 'admissions per level of need' in more poorly performing GP practices towards that in the better performing practices.
- Reducing average length of stay for emergency admissions in Sheffield to that of the best performing PCT in the core cities.

The opportunity for the programme is clear, up to 15500 avoidable admissions (for approximately 12000 patients) where alternative care provision in the community would deliver better outcomes. The RFT Programme Board has now agreed that a more detailed plan to deliver the strategic goals described in section 3 should be delivered over the next three years.

3. Phase 2 Strategic Goals, Deliverable and Measures of success

The RFT Programme Executive has developed a range of strategic goals, deliverables and measures of success that are described below. They build on the early achievements of Phase 1 and will develop to ensure that the opportunity identified from the PN modelling can be realised.

Strategic Goal	Key Deliverables	Measurable Outcomes
1. Optimise admission avoidance for Ambulatory care Sensitive Conditions (ACSCs)	1. Embedding the Integrated Care Teams with primary care at a locality level. 2. Developing the use of Combined Predictive Model to proactively manage patients at emerging risk 3. Deliver interventions in primary, community services that address the causes for ACSC admissions 4. Deliver a coherent self care strategy. 5. A joint health and social care strategy for Assistive Technology	1. All patients identified as moderate, high or very high risk of admission have an appropriate level of care planning and coordination. 2. Reduction in ACSC. 3. Cost of community interventions versus unplanned hospital admissions (with the aim to make them more cost effective)
2. Reduce LOS for emergency admissions to the upper quartile for core cities and reduce the numbers of going into long term care	1. Transform the discharge process from assess to discharge to discharge to assess. 2. Develop a system where the community (ICT and IC) pull patients out of hospital. 3. Develop the model of community care where the core ICT and intermediate care manage the step up and step down care	1. The initial 4 day maximum delay guarantee improves to 1 day by July 2014. 2. There is sufficient capacity within community health and social care to maintain flow and it is able to flex according to the peaks of demand.

	needs. 4. Following robust demand and capacity modelling to ensure there is sufficient capacity in and out of hours to maintain system flow	3. Assessment for care needs is undertaken in the community. 4. Reduced numbers requiring long term care (health or social care funded). 5. Reduced LOS for STHFT, IC, and SHSC acute beds.
3. Develop a capable level of response to unscheduled care needs that supports the reduction of avoidable admissions, signposts patients effectively and provides a consistent response 24/7	1. Expand the Frailty Unity Model to all acute admitting specialties, targeting those that receive patients with ACSCs. Develop the model of refer to assess, rather than refer to admit 2. Develop and implement a primary care stream that deflect patients from A+E services and offers a 24/7 alternative linking the current, WiC, GP OOH and primary care services 3. Develop the concept of virtual wards across the city that draw on primary, community and secondary care resources that keep people at home when their care needs escalate	1. The proportion of emergency referrals for assessment and transfer back to the community increases., with a commensurate 29% reduction in ACSC admissions 2. 30% of A+E attendances are managed through the primary care stream that is more cost effective. 3. The “virtual ward”/ Intermediate Care model delivers the majority of step up care for ACSC avoidable admissions
4. Planned care services will be optimised to ensure that Out Patient Services are transformed and the efficiency of hospital services are optimised	1. To implement a programme of work that optimises the use of Choose and Book. 2. IT developments that include e-discharge, e-consultations and other digital innovations 3. A number of commissioner led workstreams that will determine future service model shaping	1. Significant reduction in O/P follow ups, particularly for LTCs 2. More referrals managed as a single, one stop shop, advisory service
5. Reduce inequalities in the morbidity and mortality rates for people with severe mental illness (SMI)	1. “Staying well” care plans for all patients with SMI (agreed within ICT) 2. Cross city sign up to “Time to Change” 3. Joint approach with Mental Health Commissioning plans	1. To be in the upper quartile for all elements of the National Audit of Schizophrenia 2. Annual health checks for all with SMI 3. Measurable reduction in premature mortality for SMI
6. The unscheduled care response for children in Sheffield reduces avoidable admissions to hospital	Under the auspices of the Future Shapes Programme 1. The current consultant led triaging of GP referrals for admission expands. 2. A single pathway for childrens urgent care is developed in and out of hours	1. 30% reduction in paediatric admissions for the under 5’s

5. Interdependencies

There are a range of cross cutting workstreams that were identified in the initial PID for the RFT Programme in 2011. They remain relevant and need further development to ensure that that the strategic goals for Phase 2 are deliverable.

- **Commissioning intentions, financial flows and contracting assumptions** need to reflect the level of ambition stated in section 3
- **Workforce development** needs to reflect that for many staff in the future their skills will be utilised in the community rather than in a hospital setting
- **OD/ culture change and staff communication** needs to clearly share the message that more care will be provided in the community
- **Informatics** as a workstream will need to join up the different parts of the system and make it easier for clinicians and practitioners to make the right decisions
- **Assistive Technology** will be a key enabler to supporting people to stay at home and manage more of their own care
- **Medicines management** is perhaps one of the simplest interventions to helping optimise people's health and reduce avoidable admissions

The Programme Executive will need weave these cross cutting workstreams into the delivery of Phase 2 strategic goals.

6. Programme structure for delivery of Phase 2

It is highly likely that the current structure for RFT Phase 1 will need to change and the RFT Programme Executive will take responsibility for this. The key issue will be to ensure that the whole system of care delivery is mapped out and the inputs to deliver system change across self care, primary care and the ICT, intermediate care and the acute hospital. The Programme Board will be advised of the changes to the RFT Phase 2 programme management arrangements at the April meeting.

Steven Haigh, RFT Programme Manager
On behalf of Kevan Taylor, Chief Executive and Programme Director

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