**Matter Arising: Minute 149/16(e) refers)**

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

# Active Support and Recovery (AS&R) Update

**Governing Body meeting**

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**2 February 2017**

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| **Author(s)** | Sarah Burt/Sam Merridale. |
| **Sponsor** | Peter Moore, Director of Strategy and Integration |

**Is your report for Approval / Consideration / Noting**

Noting

**Are there any Resource Implications (including Financial, Staffing etc)?**

None

**Audit Requirement**

**CCG Objectives**

***Which of the CCG's objectives does this paper support?***
Objective 1-4

**Equality impact assessment**

***Have you carried out an Equality Impact Assessment and is it attached?*** n/a

**PPE Activity**

***How does your paper support involving patients, carers and the public?***
n/a

Recommendations

The Governing Body is asked to note progress to date as per Governing Body's request at the meeting held on 1 December 2016.

NHS
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# Active Support and Recovery (AS&R) Update

## Governing Body meeting

## 2 February 2017

1. The purpose of this paper is to provide an update on the AS&R Programme as at January 2017, with priorities for the coming year 2017/18.

2. At the December AS&R Board meeting the group agreed the ongoing scope of the programme and refreshed vision, following a timeout meeting which took place in November. The programme plan has been refreshed and circulated to all key stakeholders, and changes to the governance structure have now been discussed and agreed.

3. The AS&R programme, working in partnership across Sheffield, will continue to focus on the integration of health and social care services, with an emphasis on the early identification and proactive management of patients who are at risk of development of their condition and thus hospital admission. At a locality / primary care level this will be delivered through "Neighbourhoods", with individualised care pathways meeting the needs of local people. In addition, there will be city-wide services and pathways delivered at scale, which will ensure seamless provision of all out of hospital based services. It is envisaged that approximately 20% of services will be provided at a Neighbourhood /locality level; with the remaining 80% provided city wide (the distinction being neighbourhood services being tailored to that population and city wide being more suitable to a city wide model – neighbourhoods will still be key to delivering the services).

4. The objectives of the Neighbourhoods will be to provide a flexible and responsive service, proactively managing their patients through a single care planning / case management approach which will demonstrate admission avoidance and discharge facilitation.

5. 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.

**6. Key components:**

- Developing integrated 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 services 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

**7. Governance arrangements:**

Governance will be maintained by means of the AS&R Board, which is held monthly and currently has membership from all partner providers, SCC commissioners and members of the CCG. It is proposed to recommend that membership of this group is escalated to Exec level from each partner organisation to enable greater strategic decision-making in the Board meeting and ensure the programme is able to move further, faster .

8. The previous "provider group", which reports directly to the AS&R Board, has now been given a wider remit in terms of taking accountability/responsibility for the 2017/18 AS&R Delivery Plan. This group will also manage risks / issues raised both Citywide and from Neighbourhoods, with membership also including Locality Managers. The Delivery Group will manage the list of projects agreed as part of the 2017/18 plan by means of Task and Finish Groups, and will implement a consistent set of documentation for use within Neighbourhoods and other project teams, making reporting more consistent across other dependent programmes of work – e.g. urgent care, primary care etc.

9. A Neighbourhood Learning Network has now been established by PCS. The first meeting of this group took place before Christmas and excellent engagement with all practices has resulted in a clear steer and direction for taking forward developments at Neighbourhood level. This has been fed into the delivery plan for 2017/18. This group will also feed directly into the AS&R Board in the future, to ensure read across between the two subgroups and ensure consistency of delivery.

10. At the AS&R Board meeting on 25th January 2017, we will present the outline (draft) QIPP/ delivery plan for the programme, for the period 2017/18. At the time of writing, the list of projects covered in this plan (attached) is not exhaustive and there are still dependencies with other programmes (e.g. primary care, urgent care) which need further analysis to understand where the savings are to be made and ensure that we do not duplicate effort or double count savings. Once the list of projects within this plan has been agreed by the Board, it will be populated with further metrics which demonstrate improvements in performance, quality and spend.

11. However, the projects described have all been discussed and agreed to be priorities for development during 2017/2018 and will contribute to the overall QIPP savings for this year of £4.9M.

12. Many of the projects are linked and will be developed as an overall programme of work, however it is helpful to be able to describe the associated savings as accurately as possible at a granular level so that we can better analyse progress and success (or otherwise) throughout the year. A good example of this would be the development of the frailty pathway, and the links with the development of virtual wards at Neighbourhood level, along with other improvements such as care planning, Test Bed and EoL care.

13. The plan is being presented diagrammatically (see Appendix 1) which represents a whole system pathway approach, with the patient moving through increased dependency and our improved ability to provide a wider and better range of community/primary care driven services which will ultimately both **keep them both fit and well at the beginning of the pathway** (and more independent in their own

home), or, if acute admission is required, with savings represented through **fewer admissions and reduced length of stay**. The end of the pathway represents our ability to **provide better step down care which will shorten length of stay through easier discharge planning**, again in the community / patients own home. This same diagram can be used in other programmes of work (e.g. urgent care, primary care) to show the links / dependencies between the programmes and where savings are to be made.

14. This plan is being presented to the AS&R Board for sign off as a programme of work, and will also be shared with other programmes (e.g. primary care, urgent care) and the CCG Board. We will be developing integration model for ASR services with a view to developing a new model of care, to include

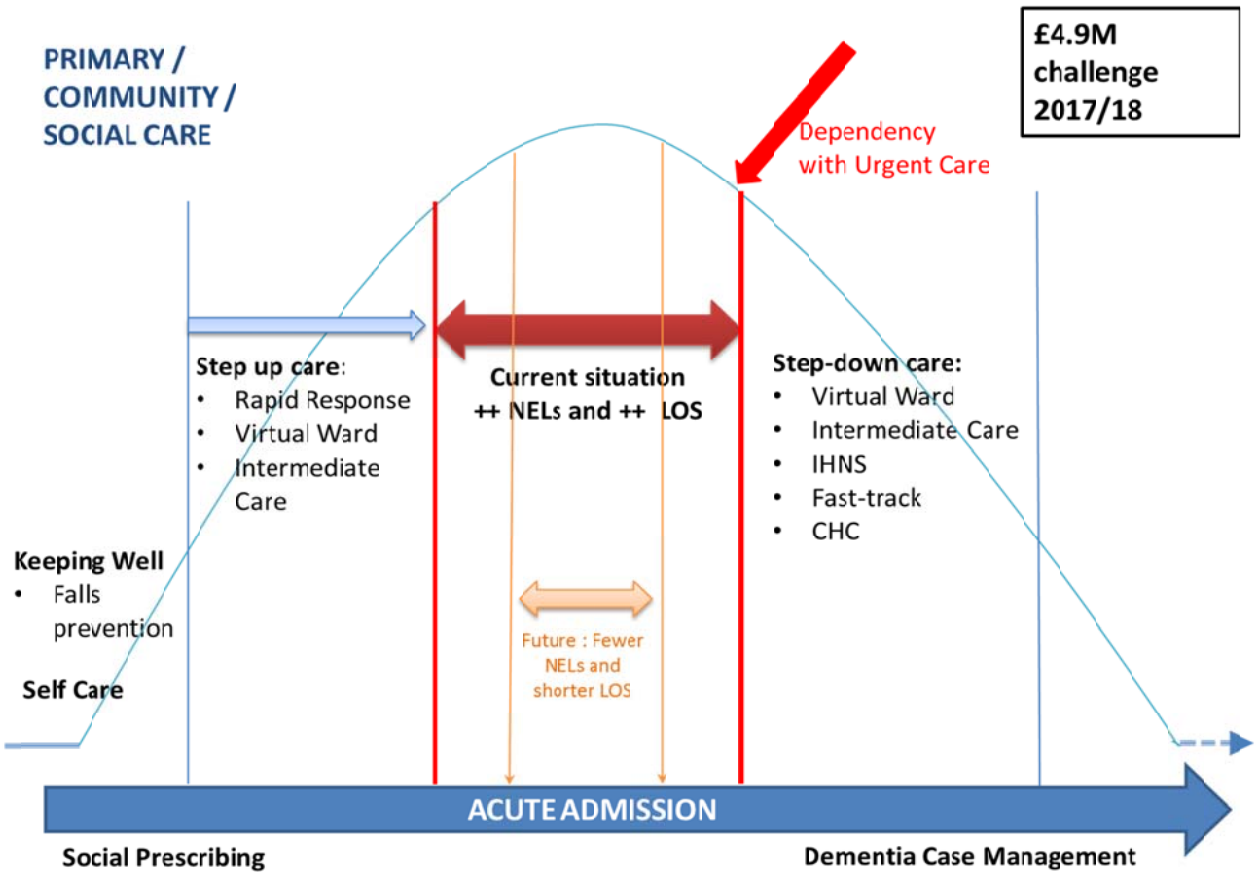
- Simplifying and ensuring robust discharge pathways for patients being discharged from acute services
- Single risk stratification (including incorporation citywide deployment of eFI)
- Ensuring effective admission avoidance (step up offer, Active Recovery, rapid response)
- Admission reduction from care homes (aligns with care home quality)
- Social prescribing – citywide deployment

15. **Progress on Delayed Transfers of Care**
Throughout winter there has been a significant pressure on both CICs STIT and the IS. There has been a short term 'task team' put in place to actively support the discharges from the hospital and this has had a significant effect mid-November to December and saw DTOCs fall from 156 down to around 50 over the Christmas period. Much of this work focussed on more effect aligning of patients needs on discharge with their prescribed care package. There have also been some specific changes to pathways around CHC assessment within STH which reduces previous delays. In addition the CCG has purchased a block of offsite beds which has allowed patients who are waiting for IS support to wait in a more setting more appropriate to their care needs rather than in an acute setting.

16. In the medium term the CCG, Sheffield City Council and Sheffield Teaching Hospitals are looking to bring in some additional national level support to review the whole discharge pathway. There was an initial view that we would use an Exec Director from another trust with a much more integrated post acute service however, with the current pressures within their own organisation it appears unlikely that they will be released before April which is too late for this important work so alternatives are currently being sought.

Sarah Burt / Sam Merridale
24 January 2017

**Appendix 1**


£4.9M challenge 2017/18
PRIMARY / COMMUNITY / SOCIAL CARE
Dependency with Urgent Care
Step up care:
• Rapid Response
• Virtual Ward
• Intermediate Care
Current situation
++ NELs and ++ LOS
Step-down care:
• Virtual Ward
• Intermediate Care
• IHNS
• Fast-track
• CHC
Keeping Well
• Falls prevention
Self Care
Future : Fewer NELs and shorter LOS
ACUTE ADMISSION
Social Prescribing
Dementia Case Management