Report to Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee
20 November 2013

Report of: Kevan Taylor, Chief Executive and Lead Director for the Right First Time Programme

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Subject: Right First Time Programme Update

Author of Report: Steven Haigh, Right First Time Programme Manager

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Summary:
This section should briefly introduce the subject **and** summarise the key points of the report. It should explain the reason it is being presented to the Scrutiny Committee (e.g. the information presented has been requested by the Committee to enable it to scrutinise performance, etc.)

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**X**
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to note the progress being made with the delivery of current RFT objectives; to provide views on the impact of the programme to date; and to consider the longer term objective building an enhanced model of primary care.

Background Papers:
This paper is supported by a more detailed summary of the Programme inputs delivered so far.

Category of Report: OPEN

Report of the Director of: Kevan Taylor, Chief Executive and Lead Director for the Right First Time Programme

Title of report: Right First Time Programme Update

1. Introduction

1.1 This briefing paper provides the Committee members with a summary overview of the progress made with the delivering the current Right First Time (RFT) Programme. This briefing paper supports the presentation that Kevan Taylor, Chief Executive and Lead Director for the RFT Programme will be sharing with the Committee.

2. Progress with the Right First Time Programme

2.1 As previously reported to Committee members the RFT Programme is half way through the second year of delivery. The attachment that is included with this paper highlights the progress made with each of the key project areas of the current programme. In terms of milestone management all planned inputs are on schedule.

2.2 There is some evidence that the inputs are impacting positively on:

- Service users experience. The Community Support Workers are having a real impact on keeping people well and at home.
- Care planning for those most at risk is putting the individual in the middle of a coordinated process
- We are now testing out how many people with complex discharge needs can be supported at home rather than being consigned to long term care
- We also know that in overall terms the number of beds occupied by people who do not have an acute need is improving, although the overall admission rate for emergencies is still climbing

2.3 The Programme has also brought a much more cohesive approach to managing system pressures.

2.4 There is also active and strong engagement with service users to support the development, delivery and evaluation of programme inputs. The Programme is supported by a very active Citizen Reference Group.

2.4 The challenge for the programme is now to be clear what needs to come next. To date it has focussed very clearly on the relatively short term goals of tighter system management. It now needs to build on this and develop the ambitions for an enhanced model of primary care that actively supports and maintains the health and wellbeing of those at risk.

3. Recommendation

3.1 The Committee is asked to note the progress being made with the delivery of current RFT objectives; to provide views on the impact of the programme to date; and to consider the longer term objective building an enhanced model of primary care.

APPENDIX 1

Right First Time Programme – Phase 2

1 INTEGRATED CARE TEAMS

In March 2013 the RFT Executive agreed the priorities for phase 2 of the programme (April 2013 – March 2014). For Project 1 the following were identified:

- The development and implementation of community based Health and Social Care Integrated Care Teams to support individuals at emerging or high risk of hospital admissions or long term care

- The introduction of a single holistic care planning approach with a target of delivering 2500 care plans within 2013 2014 (later revised to 3500 over a 12 month period commencing September 2013)

Care Planning

Commencing in September 2013, 3,500 of the individuals identified as at high risk of hospital admission from across the city will be offered a GP led care planning service. This will offer systematic integrated holistic care planning for a cohort of patients within the 30 – 70 risk score. GP Practices, Health and Social Care staff will work together to explore how we can work in a more co-ordinated way to provide earlier and targeted support to help people stay as healthy and independent as possible.

Care Planning will be a collaborative, patient centred, process. It will be led by GPs and the practice teams with a range of professionals involved as appropriate. This might include community nurses, mental health workers, specialist nurses, community support workers, social workers, palliative care, housing, VCF sector etc depending on the needs of the individual.

Integrated Care Team Development

A number of Locality/GP Association based workshops are taking place where Health and Social Care professionals are working through the practicalities of integrated working to support individuals with complex Health and Social Care needs based on population needs within a particular area of the city.

The purpose of the workshops is for GP practices, Health and Social care staff to work together to explore how we can work in a more co-ordinated way to provide earlier and targeted support to help people stay as healthy and independent as possible. The workshops are being attended by Local GPs, Practice Nurses, District Nurses, Social Workers, Therapists, Mental Health, pharmacy, patient representatives and the Voluntary and Community Sector.

Additional testing

In addition to the workshops a range of other pilots are taking place to test various elements of the future ICT model and the approach to care planning.

Community Support Workers

A number of Community Support Workers (CSW) funded by the CCG but employed by Sheffield City Council are linked to GP associations

The aim of the CSW role is:

- To support people with non-medical needs that impact on their wellbeing; specifically housing related issues, social care, loneliness and isolation
- To complete prevention and early intervention work with people GP Practices / District Nurses identify with a Combined Predictive Modelling score of 20-40 over 65 years old
- The above two aims combined should lead to a reduction and delay in the need for acute hospital services and social care packages.

Virtual Ward

As part of the overall approach to care planning a virtual ward model is being tested at two GP practices. This targets patients with a combined predictive score of 50 and above.

The virtual ward model aims to integrate primary, community and social care at micro (clinical level) and explore the cost effectiveness of this type of integrated, multidisciplinary care management in reducing emergency hospital admission for patients at moderate to high predictive risk.

The purpose of the virtual ward pilot was to develop an integrated multi professional approach to patient support and care in the community, to defer patients reaching crisis point and avoiding the need for admission to care, to streamline access to other professionals cross organisationally in order to deliver care planning and support in the timeliest manner and to optimise the health and wellbeing of the patient.

The VW is able to target those patients who are not known to mainstream services and/or who would be best supported by an intensive coordinated approach from the ICT.

Psychological Wellbeing Practitioners

The purpose of this pilot is to train a number of practitioners who work with people with physical health conditions as IAPT Psychological Wellbeing Practitioners (PWP), and testing an innovative model for integrating delivery of physical and mental health care.

The pilot has two aims:

1. To test whether this model improves access to talking therapies for people with physical health problems who also have common mental health problems such as anxiety and depression

2. To explore the contribution of IAPT PWP intervention skills to the facilitation of self management in people with long term conditions.

Medicines Optimisation Pilot

This project is a 6 month pilot of a domiciliary medicines service, jointly funded by health and social care, focusing on compliance, adherence and re-ablement for patients with long term conditions.

- To assess the impact of a domiciliary medicines service on patients, social services and GP practices.
- To inform the development of the Integrated Care Teams in relation to medicines/pharmacy input.

Community Nursing Expansion
Additional investment has been identified to expand the Community Nursing Service at weekends and evening to create a fully established 7 day 8am – 10pm service (in line with Active Recovery) from October 2013. This additional capacity will support additional first assessment and contact plus ensuring the active case management of care plans.

TRANSITIONAL CARE

In March 2013 the RFT Executive agreed the priorities for phase 2 of the programme (April 2013 – March 2014). For Project 2 the priority has been to develop effective and timely discharges from and flow through the acute hospitals and intermediate care provision across the city. The aim is to reduce the average length of stay in hospital and/or intermediate care and to maximise individuals potential to return home and live as independently as possible for as long as possible.

To achieve this aim several pieces of work are now in place. A summary of the different projects can be found below.

Active Recovery

Active Recovery has been developed from a model to align the Community Intermediate Care Service (CICS) and the Short Term Intervention Team (STIT). Active Recovery has been developed to provide an integrated health and social care response team to support core services in preventing inappropriate hospital admissions, facilitate discharges from hospital and intermediate care beds and enhance inter-disciplinary working. The first phase of Active Recovery went live on the 28th October 2013 when staff deployment were aligned and processes and systems were integrated to enable access into Active Recovery via a Single Point of Access.

New Reablement Pathway (expansion of intermediate care)

In order to support national policy to make sure people are given the best opportunity to remain at home and as independent as possible for as long as possible a new reablement pathway has been developed and went live on 16th September 2013 (replacing the Home of Choice schemes). It is hoped that by increasing the capacity in intermediate care services across the city we can reduce the numbers of people entering permanent care (nursing and residential). There has been an increase in the number of intermediate care beds already and more will be opening over the next few weeks. There has also been recruitment of extra therapy staff to meet the demands of the increased bed base. Work is ongoing to monitor this new pathway and examine the outcomes for people going through this route.

Development of the Single Point of Access (SPA)

It was agreed that the SPA should be developed to become a single and simplified pathway for both hospital discharges and provision of support to people in crisis. Bed bureau staff are now located in SPA at Lightwood and continuing to work to streamline processes. The District Nurse Line calls are also now handled through SPA and an additional 4 nurse advisors have been recruited to the team. Consultation has commenced to create core working hours of 08:00am-10:00pm 7 days a week. A key next step is to audit incoming calls (over Oct / Nov 13) to inform future development of the SPA offer (including potential linkage to social care, access to secondary care expert opinion and supporting developments to hospital discharge processes)

Access to Short Term Intervention Team (STIT) from Functional mental Illness (FMI) wards

A business case to develop a referral pathway from Sheffield Health and Social Care Trust (SHSC) Functional Mental Illness (FMI) beds into SCC Short Term Intervention Team (STIT) was submitted to and approved by the CCG in August 13. A small group to operationalise the new pathway has been established and the pathway opened 14th October 2013. To date 3 patients have been discharged with this support.

Extension of the Sheffield Community Equipment Loan Service (SCELS) Out of Hours provision

Since March 2012, SCELS has been funded on a non recurrent basis to provide a rapid response, out of hours service. Funding has paid for additional staffing hours, any equipment loaned has been from existing SCELS stock. Initially the OOH service was to support the Front Door Response Team at STH (facilitating admission avoidance), but as the FDRT function has developed over the past 18 months SCELS availability has been widened to 'referrers' from several teams within the overall RFT programme. Demand for this service has continued to rise month on month since commencement. An evaluation of the OOH service is planned for later this year.

Dementia Liaison

£190k was invested in 2012/13 as part of the dementia project. This has been used to:

1. Increase capacity for identifying patients in STH requiring rapid access to community dementia services in order to reduce delayed discharges
2. Increase capacity within Dementia Rapid Response teams in order to meet this increased demand
3. Increase capacity within the Memory Service in order assess additional number of patients identified as needing diagnostic assessment by Liaison Psychiatry services within STH

SERIOUS MENTAL ILLNESS & PHYSICAL HEALTH

Background

In March 2013 the RFT Executive agreed the priorities for phase 2 of the RFT programme (April 2013 – March 2014). This included a project focussing on patients with serious mental illness (SMI) and their physical health needs (Project 4).

The issue

People who suffer with a serious mental illness (schizophrenia, bi-polar or severe depression) can be especially vulnerable of becoming seriously ill with physical health conditions such as heart disease or diabetes. These problems can often go unrecognised and untreated. The aim of Project 4 is to make sure all organisations and service users work together to change this. The main aim is to improve the physical health of people with SMI so people stay well for longer, services are improved and fewer people end up in hospital or in long-term residential care.

People with SMI have a three-fold increased risk of premature death and a reduced life expectancy of 16 years for women and 20 years for men. Although suicide accounts for about 25% of these deaths, physical illnesses causes around 75% with cardiovascular disease (CVD) is the commonest cause of death and diabetes is a significant cause of increased morbidity and mortality.

The increased risk of mortality from CVD is most significant in younger people. Those under 50 with SMI are 3.6 times more likely to die of CVD than those without SMI. Meanwhile, those over 50 with SMI are still more than twice as likely to die of CVD, than those without

SMI. Over the last 20 years CVD mortality rates have fallen considerably in the general population, but these benefits have not been shared by people with SMI.

Progress
Project 4 has a number of workstreams in place to take this forward. A summary of the different projects can be found below:

(i) A SMI pilot project has been developed with 3 practices in the central locality to test out holistic goal based care planning for patients on the practice SMI register. The pilot commenced during October with a baseline audit followed by the implementation of the Annual Health Check (which is an approved intervention framework for patients with psychosis on antipsychotic medication) across the three practices. Resources have also been secured to appoint a Community Development Worker (CDW) to proactively support and help meet the physical health needs of people with SMI within the pilot practices.

(ii) The component parts of the Annual Health Check have now been included within the overall Care Planning template recommended for all GP practices across Sheffield. Discussions regarding the inclusion of drugs and alcohol assessment are also ongoing. In addition, exploratory discussions are underway looking at the possibility of integrating the Annual Health Check within the SHSC Care Programme Approach (CPA).

(iii) A 'Test for Change' Smoking Cessation/Improving Physical Health Project is being established within the locality served by East Glade Community Mental Health Team. The project will be led by the East Glade Team with support and broader involvement provided by RFT to:
- engage service users and staff in shaping the project
- agreeing the aims and objectives
- provide relevant data and provide in house training, intervention and evaluation.

(iv) An Involvement Plan survey is currently underway with relevant SMI user groups across the city. The results of which will be presented to the November Project 4 Steering Group. A workshop for user groups will then be held during the new year to describe how the recommendations will be addressed.