Right First Time
Transforming the way Health and Social Care is delivered

Right First Time Update
17th September 2014

"ENSURING ALL SHEFFIELD'S RESIDENTS LIVE LONGER AND HEALTHIER LIVES"

Sheffield Health and Social Care NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield City Council

Sheffield Children's NHS Foundation Trust

NHS Sheffield Clinical Commissioning Group

What is the Right First Time Programme?

- Joint Health and Social Care Programme and a Partnership

- Sponsored by the Chief Executives of
  - Sheffield City Council
  - NHS Sheffield CCG
  - Sheffield Health and Care Trust FT
  - Sheffield Teaching Hospital FT
  - Sheffield Children's Hospital FT

- Working together to deliver better outcomes for patients

'Right Care, Right Time, Right Place, Right Person'

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The Vision

‘Ensure all Sheffield’s residents live longer and healthier lives, and are supported in their local community wherever possible by joined up, high quality, responsive, health and social care services which offer continuity of care, shared decision making, and a lifelong, personalised, preventative approach to health and wellbeing’

Structure

- Achievements over the last two years
- Impact – Dashboard
- Evaluation
- RFT Transition

1. Developing Integrated Care in the Community

- Risk Stratification – 98% population risk stratified
- Care Planning – 3500 commissioned
- ICT development workshops, including joint working between social workers at a practice level – across all 4 localities
- Virtual Ward tests – in HaSL
- Community nursing developments – 8-10am, 7/7
- Community Support Workers – 8 across7 Associations
- Medicines Optimisation – 26% had reduced level of support
- Psychological Wellbeing Practitioners – 2 cohorts of community staff trained

2: Transitional/ Intermediate Care

- Active Recovery – 95% of patients access within 24 hours (in January ave wait was 10 days)
- IC beds (step up and down) – most transfer within 48 hours (in January was up to 2 weeks)
- Non Re-ablement Pathway – 10 day pathway working and Home of Choice closed down in 2013
- Community equipment – less discharge delays
- SPA – near threefold increase in calls/ triage since 2011
- Dementia Liaison – fully integrated community based model
- Discharge to Assess from STHFT wards – All GSM wards and rolling out to respiratory and endocrine wards
- FMI/ FICS/ STIT – small numbers of patients discharged earlier
- Front Door Response Team – integrated into D2A process

3: Urgent Care

- Frequent Flyers
- Primary Care Stream

4: Improving the Physical Health Needs of People with Serious Mental Illness

- Annual Physical Health checks
  (audit, Care Planning SMI template, Insight)
- Community Development Worker – CPM 30-70, frequent attenders – has supported close to 50 clients in the last few months
- E learning training package – for primary and community services
- Smoking cessation (SCIMITAR bid successful)

5. System Oversight

- System Operational Flow – reportable delays in January were 135, now around 40

- 7/7 – 7 day discharging, acute clinical standards and influencing the development of community standards.

- Development of a system wide dashboard

6. Cross Cutting Work streams

- Informatics (vision and options appraisal)
- Engagement (Citizens Reference Group)
- Organisational Development
- Communications

Impact of RFT

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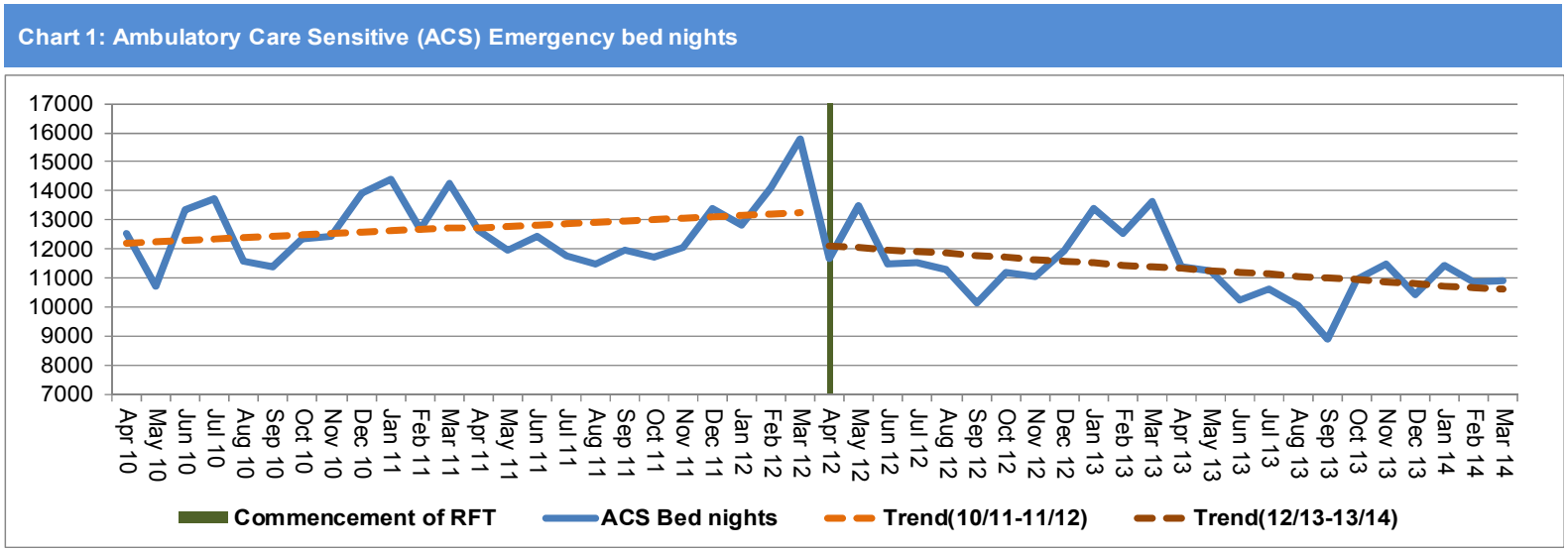
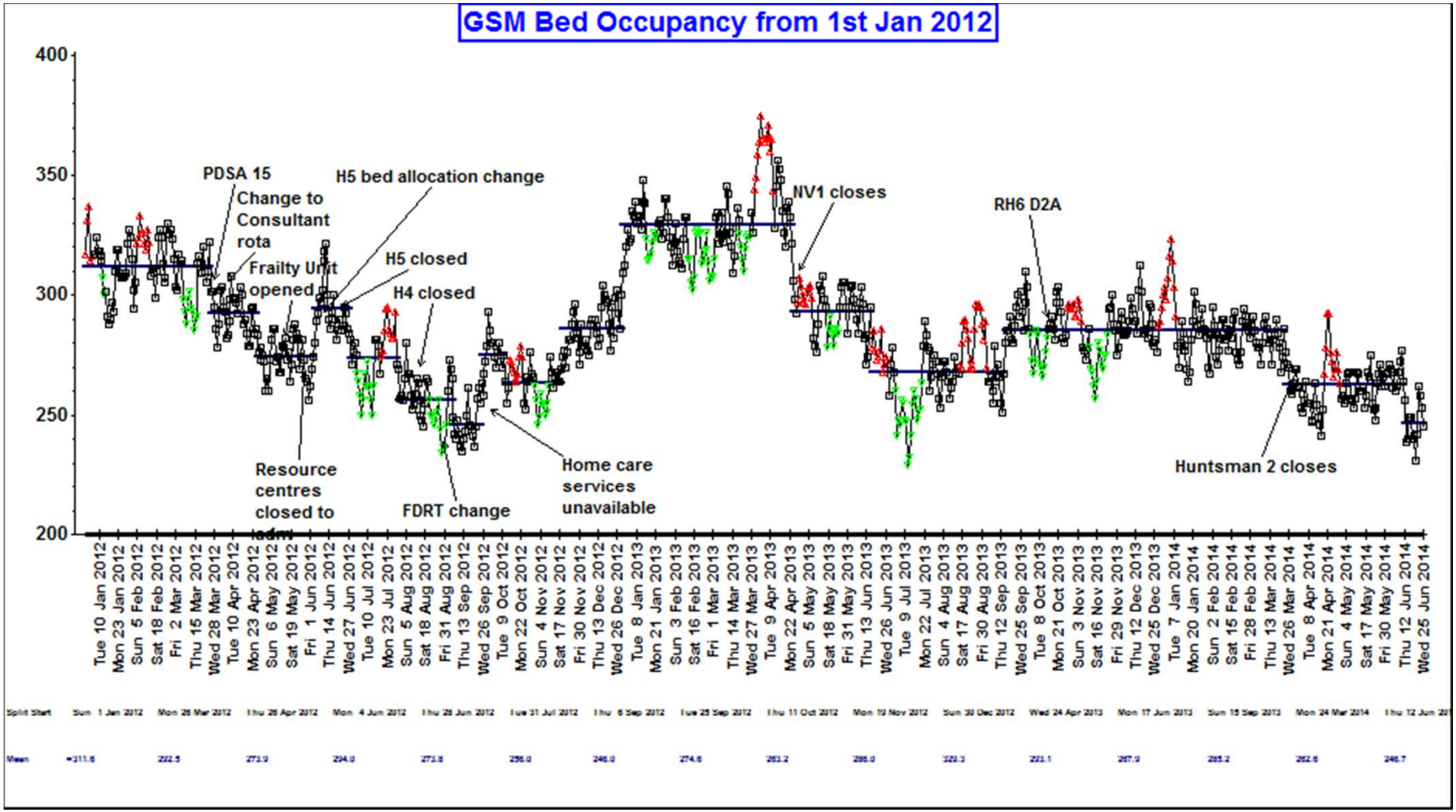


- This is a measure of preventable (= ambulatory care sensitive) hospital bed usage – a key indicator of success in reducing the need for emergency hospital care.
- RFT started in April 2012. Before that preventable bed usage was increasing. Since April 2012 preventable bed usage has been declining steadily.
- We can't say with certainty that RFT has uniquely caused this, but it tells us something about a positive aggregate impact from the various measures in place across the city to reduce usage of emergency care resources.

Impact of RFT



Evaluation of Impact

Transitional Care – OPM now leading an evaluation of investments made into:

- Active Recovery
- Intermediate Care Beds
- Non Reablement Pathway
- SPA
- SCELS
- Front Door Response Team
- Community IVs

Evaluation of Impact

- **Integrated Care Team Development** project lines already evaluated/ being evaluated

- Aim to bring individual evaluations together under process known as “Sharing the Learning”, which will start in September

Moving Forward

- BCF alignment
- Provider Alliances

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