Right
Care, Time, Place, Person
Working together to transform Sheffield's health and social care services

SHEFFIELD OVERVIEW AND SCRUTINY COMMITTEE

RIGHT FIRST TIME - PHASE 1 REPORT

16 JANUARY 2013

Introduction

The purpose of this report is to report on the Right First Time programme and its progress and achievements over the last 12 months.

- Section 1 describes delivery to date
- Section 2 describes the impact of the programme at an organisational level
- Section 3 recommends the need to move away from reporting and scrutiny of the programme at an organisational level toward a focus on the impacts to the whole system.
- Section 4 provides some reflection on the lessons learnt from the first phase of the programme and describes some of the challenges to be considered in the development of phase 2

SECTION 1 - Phase 1 key projects and processes

Over the past 12 months phase 1 of the Right First Time programme has been split into 3 projects which have begun to deliver real benefits to patient care and the start of the transformation journey across the health system.

- **Project 1** has focused on the development and prototyping of integrated care teams (ICTs) that align with the emerging GP Practice Associations, enabled by Risk Stratification, Assistive Technology and Self Care.

  Discussions around the concept of GP Practice Associations have been taking place over the last year and practices are now starting to align themselves into groups of between 30,000 – 40,000 patients with a view to creating more integrated working with other Health and Social Care resources within the community. 16 associations have been identified across the 4 CCG Localities Hallam and South, Central, West and North). The emerging associations have started to meet and early discussions have identified some opportunities for working together.

  District Nursing services been reorganised around the emerging GP Practices associations and these will form part of the core of the new integrated care teams. A reorganisation of the Assessment and Care Management Services (SCC) has also taken place aligning with GP Practices. Further work has now commenced to explore the next phase of development for the Integrated Care Teams and how they will incorporate Social Care activities. Initial discussions have also taken

place with Community Mental Heath and Community Pharmacy to try to identify possible links and ways of working.

Project 1 is working closely with a number of ongoing pilots across the city (including Low Edges, Batemoor and Jordanthorpe) and supporting the development of other prototypes within GP Associations, for example the recruitment of Community Support Workers to provide the interface between Health and Social Care.

The combined predictive model of risk stratification has been rolled out to 98% of GP practices, allowing them to identify patients of high and emerging risk of admission to hospital and to work with other health and social care professionals to put interventions in place to support these patients. Further analysis is required to understand what actions practices are taking as a result of using this tool and impact on patient care and outcomes.

- **Project 2** has focussed on redesigning the 'front door' response at Sheffield Teaching Hospitals by reducing the number of elderly admissions and by completing comprehensive assessments at the point of referral and developing consistent thresholds for admission. Detail of the impact of these changes on STH is provided in the next section.

  In conjunction with project 1, developing services to provide better response to crises, particularly for residential/nursing homes and the investment and expansion of the falls service (the number of interventions rising from 1,682 to 3,364 in12/13). Q1 data shows falls admissions down by 29%

- **Project 3** has focussed on facilitating discharges for people no longer requiring acute medical care. It has done this through a series of non recurrent investments (SCELS, Home of Choice, Dementia Services and Intermediate Care) and the development of a new integrated health and social care process for transferring care from hospital to intermediate care and community services which is due to go live at the end of October. The development of the Transfer of Care documentation and processes has brought together nursing, therapy and social care assessments and enabled trusted assessors to access more services (irrespective of their profession) reducing duplication of assessments and opening up pathways through a single referral process, acceptable to multiple services, thereby simplifying documentation and ultimately reducing delays of transfer.

SECTION 2 - Impact of RFT on organisations

In summary the operational benefits of RFT have been felt mainly by Sheffield Teaching Hospitals acute directorates. Community and social care services have faced the opposite with increased workload due in part to higher

numbers of patients coming through but also due to the increased complexity and levels of dependency of the people they are seeing. Right First time is a long term programme and it is therefore not surprising that the planned benefits have not been realised in all areas yet.

Sheffield Clinical Commissioning Group (CCG)

There are several areas where the impact of the programme is having a positive impact:

- Length of stay and reduced excess bed day payments are better than plan
- Delays for transferring into longer term care are continuing to fall and are now at very low numbers
- The improvements achieved in the Frailty Unit (increased short stay admissions, reduced hospital mortality rate and reduced readmission rate) are being sustained. In particular the readmission rate for geriatric admissions discharged from the Frailty Unit has halved since May

There remain concerns from a CCG perspective regarding the impact of the programme on:

- Emergency admission rates
- A+E attendance rates
- Financial impact of emergency admissions, in particular the ratio between short stay and full spell admissions

Sheffield Teaching Hospitals (STH)

The process redesign work within Geriatric and Stroke Medicine (GSM) at STH is delivering:

- Increase in the discharge rate for short stay (days 0 and 1) patients by around 40% for GSM patients.
- Reduction in overall length of stay in GSM from a historic level of around 19 days to currently just over 16.
- Reduction in hospital deaths for GSM (proportion dead at discharge reduced from an average of 11% to 9.5%)
- Decrease of 3% in readmission rates to GSM from all specialities.
- In addition to the 28 beds closed in the middle of June, STHFT closed a further 28 beds in August. These are both winter pressure wards that in previous years had not closed through the summer months
- The numbers of delayed discharges are reasonably static (decreasing slightly) but the processes for managing them have improved.
- Overall rate of emergency admission to geriatric admissions is higher than planned and the case mix for contract monitoring indicates that more patients are attracting a full tariff than expected.
- Investments (described in the table above) have gone into the Community Care group of STH.

Sheffield City Council (SCC)

The improvements in patient flow at STH have inevitably impacted on social care. There has been an increase in the numbers of people accessing social care, sooner than previously and an increase in the number of people entering long term residential care as a result of the Home of Choice initiatives. Increasing numbers entering long term care is contrary to the national and local policy direction of optimising independence and care at home, rather than institutional environments. People transferring to STIT are now requiring more intensive care packages compared to previous years (13hpw compared to 10 hpw). It is not yet clear whether this reflects higher levels of need/dependency or more 'cautious' sizing of the package by non social care 'trusted assessors'.

There is a recognised need to shift appropriate care currently delivered in a hospital setting into community locations and to redesign a structure through which integrated community services could be delivered at a reasonable scale, whilst at the same time improving quality of care and better access for patients. With this in mind, we have been able to start the shift of some appropriate hospital based resources into intermediate care and community assessment and care management teams.

Sheffield Health and Social Care (Dementia Services)

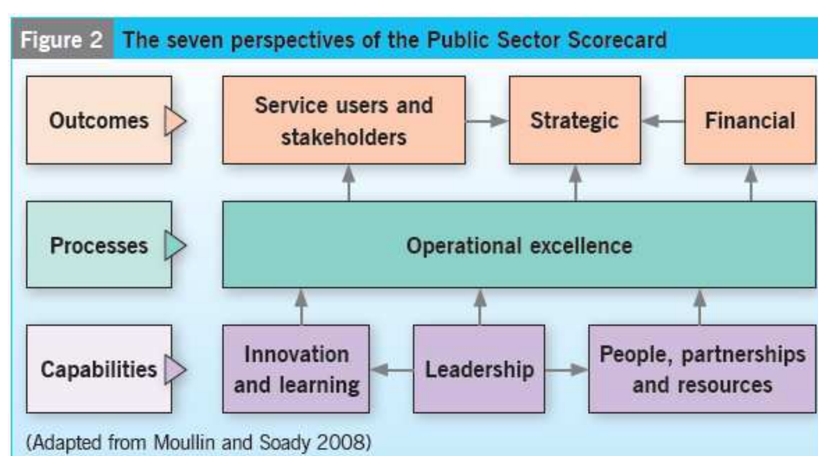
Three band 6 mental health nurses, funded through the Accelerated Dementia Discharge Team (ADDT) are providing input into STH's Front Door Response Team (FDRT) and have provided (at least) one nurse per day, Monday to Friday and are moving to seven days per week cover from 13/10/12. Averages of four patients per day are being seen, assessing mental health, cognitive impairment and risk, and arranging post-discharge mental health care. In addition to this, advice and consultation to FDRT staff is provided on approx three to four cases per day. Additional nursing capacity is also being used across the existing ADDT and Liaison Psychiatry functions with a more proactive approach to case finding being undertaken taking an earlier and more assertive role in discharge planning.

RFT has funded a temporary Speciality Grade Psychiatrist who has been working across both Older People's Liaison Psychiatry and Dementia Rapid Response Teams since the end of August and band 5 nurses into Dementia Rapid Response, however, these staff are yet to take up post.

The integration of RFT, ADDT and Liaison Psychiatry functions has moved apace, primarily because working as a single team has been the only way to ensure clinical resources are allocated in an efficient and justifiable way. Work with STH colleagues on a joint approach to information relevant to this service commenced today and it is anticipated that information regarding lengths of stay in STH, emergency readmission and mortality will be available by the end of December.

SECTION 3 - Performance Monitoring in Phase 2 - Balanced Scorecard Development

RFT is adopting a systematic approach to develop a suite of measures aimed at aligning the delivery process with target goals and outcomes. This approach is called the public sector scorecard (PSS) methodology, which a development of the balanced scorecard adapted for use in the public services. The PSS aims to achieve an alignment between organisation capability (workforce / skills / capacity), its delivery processes (operational / services / projects) and the key target outcomes sought. The PSS does this by mapping the delivery system onto seven key elements of organizational excellence as set out below.



The procedure begins with the identification of outcomes that: i) reflect service user needs plus other stakeholders as appropriate, e.g. carers, ii) the strategic aims of the organization(s), and iii) financial and quality objectives. The delivery processes are then examined – or designed / reviewed – to ensure consistency with achieving the objective outcomes. The capacity and capability requirements of the organization (RFT programme) as set out in the graphic above are then mapped onto the operational needs. The resulting mapping identifies the causal linkages and value drivers in the programme (the 'strategy map') from which key measures can be identified that critically reflect the chain of delivery.

It is proposed that once developed, this scorecard becomes the basis for a dashboard for monitoring and performance managing the RFT Programme of work.

SECTION 4 - Reflections / Lessons Learned – challenges ahead

The reflections below are lessons learnt at a programme level. There needs to be additional discussion to understand lessons learnt by each organisation

- Overreliance on organisations to cascade messages to own staff and services.

- Differential speeds of change in different parts of the system leading to potentially unsustainable developments.

- Lack of clear programme mandate and scope and therefore lack of change control processes leading to scope creep.

- By hosting the RFT Programme Team within one of the organisations it becomes perceived as part of that organisation rather than an autonomous programme – this should be considered in review of the team in Phase 2 and the governance arrangements for RFT.

- The difficulties in identifying and allocating realistic financial savings to the programme when there is insufficient data and modelling available.

- Subsequent reporting on RFT should be at a system level rather than at an organisational impact level.

- The need to more vigorously pursue an approach which works on the premise that primary and community care is the organising principle of the whole operating model. With hospital and/or other care being the focus only for people who have either the need for short term specialist interventions or who have life threatening or highly complex conditions which cannot be addressed in the community.

- The importance of pro-actively designing and shaping solutions with expert patients, carers and people who use services.

- The significance of drawing on new business models operating in sectors outside of the NHS and social care, which reflect how a modern, digitised society works.

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On behalf of Kevan Taylor, Chief Executive and Programme Director

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