PAPER D

SHEFFIELD AGEING WELL PROGRAMME UPDATE

SHEFFIELD PLACE HEALTH & CARE PARTNERSHIP BOARD

9TH OCTOBER 2023

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Sponsor	Andrew McGinty, Clinical Director for Active Ageing, Long Term Conditions, Planned Care and Medicines, Sheffield ICB

Purpose of Paper

This report provides an overview of the delivery of the nationally funded Ageing Well Programme in Sheffield. In addition, it highlights work outstanding going into the final 6 months of the programme, anticipated benefits to be realised and plans for sustainability beyond the close of the programme at the end of March 2024. The report has been to the September HCP Transformation/Oversight meeting and will return in November 2023 to this meeting to consider the details of recommendations and plan for practical alignment with planning processes.

Key Issues

- The programme has delivered several citywide changes. Many of these are moving to 'Business as Usual' through embedded changes in process and commissioning decisions.
- The programme is now planning for closure at the end of March 2024 including measuring and articulating the benefits and impact of the interventions and tests of change made.
- During the next 6 months there is a requirement for the city to agree the vehicles for continuation of the strong relationships, partnership working and development work to embed and sustain the benefits realisation from the programmes core elements and tests of change.
- There are also several areas of work that will require the partnership to consider if and how they continue.
- The rationale for presenting the paper in October is to enable early planning and prioritisation in line with the annual business planning cycle.

Is your report for Approval/Consideration/Noting

The Sheffield Health and Care Board is asked to consider the report.

Recommendations/Action Required by the Sheffield Health and Care Partnership Board

The Board is asked to note the progress made and agree to a final report being presented at a future meeting describing sustainability plan in more detail and learning from the programme overall.

What assurance does this report provide to the Sheffield Health and Care Partnership Board in relations to the ambitions of the Health and Wellbeing Strategy 2019-2024

	Please ✓
Every child achieves a level of development in their early year for the best start in life	

Every child is included in their education and can access their local school	
Every child and young person has a successful transition to independence	
Everyone has access to a home that supports their health	
Everyone has a fulfilling occupation and the resources to support their needs	
Everyone can safely walk or cycle in their local area regardless of age or ability	
Everyone has equitable access to care and support shaped around them	✓
Everyone has the level of meaningful social contact that they want	
Everyone lives the end of their life with dignity in the place of their choice	✓

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

The programme is currently staffed by a programme team, which will reduce and end by March 2024.

Each element of the programme will complete their evaluations and recommendations are likely to include areas with financial impact for either continuation of the work or future commissioning where benefits have been realised and evidenced.

This is likely to include an ongoing offer for care homes, recurrent delivery of the TAP model in communities, and continued support for the ReSPECT plan.

Have you carried out an Equality Impact Assessment and is it attached?

Equality Impact Assessments have been completed for each core elements of the programme – Anticipatory Care, UCR, EHCH. These are not attached but are available.

Have you involved patients, carers and the public in the preparation of the report?

Each element of the programme and sub elements have included engagement with patients and carers and the public.

The Sheffield Ageing Well Programme

Update Report

DRAFT

Report for the Sheffield Health and Care Partnership Board

9th October 2023

Executive summary

Subject:	Sheffield Ageing Well Programme
Author/s:	Charlotte Carolan, Programme Manager for the Sheffield Ageing Well Programme Sarah Burt, Deputy Director of Commissioning (Planned Care) and SRO for the Sheffield Ageing Well Programme Helen Kay, Operations Director, Sheffield Teaching Hospitals NHS FT (Host Organisation Lead)
Status[1]:	For information

Purpose of the Report

This report provides an overview of the delivery to date of the nationally funded Ageing Well Programme in Sheffield. In addition, it highlights work outstanding going into the final 6 months of the programme, anticipated benefits to be realised and current plans for sustainability beyond close of the programme at the end of March 2024.

The report was discussed at the Transformation and Oversight Committee in September and will be discussed there again in November. At this stage, the paper is presented to Sheffield Place Health and Care Partnership Board for information and context with a view to returning in December with a final version.

Key Points

- Our population is ageing, and with that often comes an accrual of long term conditions, multimorbidity and frailty which, in turn increases demand on health, social, voluntary care and social enterprise organisations and more significantly affecting a person's quality of life.
- The experience of ageing in Sheffield is significantly influenced by deprivation and health inequality
- The Sheffield Ageing Well programme is in the final year of a three year funded programme of work.
- Key priorities have included:
    - The development **of a 2- hour Urgent Community Response** primarily aimed to support Same Day Urgent Care within a person's place of residence, with secondary gains of reduced conveyance and hospital admission
    - **Enhanced Health in Care Homes**, including a focus on workforce development, falls, nutrition and hydration, dysphasia management, management of the deteriorating individual, mental health review, and geriatric medicine advice and guidance
    - Delivery of **Anticipatory Care** via the Team Around the Person multidisciplinary model of care, ReSPECT emergency care planning, implementation of an end of life (EoL) care pharmacist and testing of a stroke emotional support counsellor role, and 'Team Sheffield' falls prevention recommendations.
- To ensure successful ongoing delivery of the NHSE recommendations, sustainable models of improvement must be embedded and the momentum and motivation of those engaged given a vehicle to continue to develop and engage to improve people's potential to age well in Sheffield.
- There is a need for Sheffield Place to consider the strategy and plan going forward that will continue to support the population of Sheffield to 'Age Well' more fairly

Recommendations:

- **The Sheffield Place Health and Care Partnership Board is asked to note the achievements and position of the programme going into its final phase, and the developments in relation to sustainability.**

- **The Sheffield Place Health and Care Partnership Board is asked to consider how the city will continue to collaborate in order to ensure our population is supported to 'Age Well' and consider the recommendations for the vehicles needed.**
- **The Sheffield Place Health and Care Partnership Board is asked to note the learning from the collaborative approach taken within the Ageing Well programme and lessons learned**

Background to the Sheffield Ageing Well Programme

Prior to the Covid-19 pandemic the work of the Ageing Well Board and Delivery Group (established in 2019) focused on supporting those at greatest need and risk of admission to an acute hospital environment. The aim of the Board was to 'prevent, reduce or delay the trajectory of multi morbidity' with a key focus on people with one or more long terms conditions. The aim was to build on the work of the Active Support and Recovery Programme, to further develop the capacity and capability of the out of hospital environment to provide care closer to home for more people and embed a personalised care approach, based on the principle of "What Matters to You?" within each of the key programme areas. Workstreams were established covering the care home population, end of life care, care planning, intermediate care, early help, and personalised care focused on two exemplar conditions – Diabetes and COPD.

Partners involved in the work included (but were not limited to):

- Sheffield Teaching Hospitals NHS Foundation Trust
- St Luke's Hospice
- Sheffield City Council
- Age UK Sheffield
- Primary Care Sheffield
- South Yorkshire ICB (I think we were the CCG at that time)
- Voluntary Action Sheffield
- SOAR
- Sheffield Health and Social Care NHS Foundation Trust

The Board was paused in March 2020 at the start of the Covid pandemic. The Board came together to review the status of the Board in March 2021. It was clear through this review that much of the work of the task and finish groups had continued through covid however the connection between the groups had been lost.

The NHS Long Term plan had identified a focused national Ageing Well Programme, with specific asks of partners at local place for delivery of key objectives. Additional discussions with directors led to the agreement to form a new group under the more focused banner of the Ageing Well Programme as there was no Sheffield coordinating group overseeing this work in the city. It was felt that elements of the work would benefit from establishing an overarching Collaborative Group engaging partners, commencing from February 2022.

Context

The NHS Long Term Plan aims to give people greater control over the care they receive, with more care and support being offered in or close to people's homes, rather than in hospital. It also aims to improve the use of technology to support people with long term health problems in new ways, helping them to stay well and live independently for longer.

The national NHS Ageing Well programme has specific work areas aimed at the most frail and vulnerable of our current older generation. These include

- promoting a multidisciplinary approach,
- giving people more say about the care and support they receive,
- offering more support for people who look after family members, partners or friends
- promoting more rapid community response teams
- and offering more NHS support into care homes

NHS Long Term Plan » Ageing well

Main Objectives

NHS England identified three Priority areas of work within the programme to be delivered:

1. **Urgent Community Response** (UCR) is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis response care in their normal place of residence within two-hours and/or reablement care responses within two-days. From 1 July 2020 data has been collected on the delivery of the two urgent community response standards – crisis response care within two-hours from any referral source and reablement care within two-days from any referral source except a hospital ward/bed – through the Community Services Data Set (CSDS). NHS England » Community health services two-hour urgent community response standard guidance

   Summary of core achievements as of September 2023:
   Sheffield is sustainably delivering against the UCR target and has the lowest percentages of See Treat and Convey in South Yorkshire and second lowest in NEY. We have the highest percentage of those going to elsewhere other than ED recognising the focus on integrated primary and community services offer in Sheffield. (YAS)

2. **Enhanced Health in Care Homes (EHCH)** moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Requirements for the delivery of Enhanced Health in Care Homes by Primary Care Networks (PCNs) are included in the Network Contract Directed Enhanced Service (DES) for 2020/21. There are complementary EHCH

requirements within the NHS Standard Contract for 22/23 for relevant providers of community physical and mental health services. An implementation framework has been published that supports the delivery of the minimum standard described in the DES and standard contract. NHS England » Enhanced Health in Care Homes Framework This element of the programme links to other work and groups in Sheffield considering the development of care home provision e.g., Care Provision Group, Care Home Strategic Planning Group (which covers Care Home Managers forum, Quality, Implementation of vaccine programme, Strategic review of care homes market, workforce development inc. education) The EHCH group established as part of the Ageing Well programme has focussed on the specific implementation of the EHCH framework.

Summary of core achievements as of September 2023:
Scoped core training requirements and rolled out training to care homes across range of areas including deteriorating resident (RESTORE), Dysphagia, Falls etc.
Established nutrition and hydration plan, training, a catering forum, and tests of change.
Implemented Collaborative Falls assessment on admission, trialled technology, introduced direct access referral to ICT Therapy for care homes, and rolled out IStumble and Raizor chairs
Codesigned, implemented and embedded Geriatric Medicine Advice and Guidance offer for GPs
Mental health project initiated to scope and codesign mental health offer for care homes

3. **Anticipatory Care** is designed to support those patients who are at high risk of unwarranted health outcomes to live well and independently for longer, through structured proactive care. Typically, it involves structured proactive care and support from a multidisciplinary team (MDT) and focuses on groups of patients with similar characteristics (for example people living with multimorbidity and/or frailty) identified using validated tools (such as the electronic frailty index) supplemented by professional judgement, refined on the basis of their needs and risks (such as falls or social isolation) to create a dynamic list of patients who will be offered proactive care interventions to improve or sustain their health. A National Operating Model is available in draft for delivery of Anticipatory Care. FutureNHS Collaboration Platform - FutureNHS Collaboration Platform

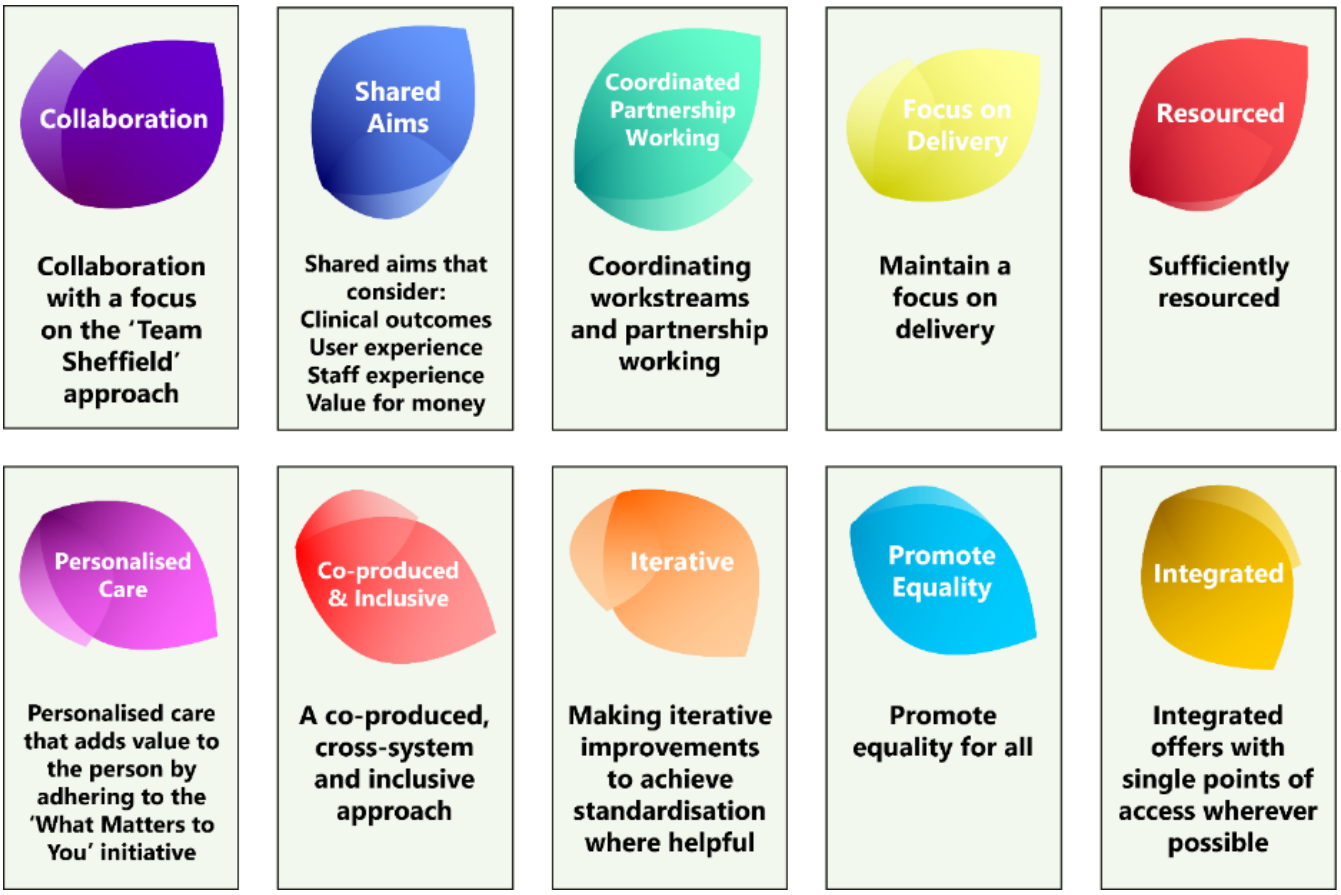
Summary of core achievements as of September 2023:
Citywide ReSPECT plan live and in use from May 2023
Team around the Person rolled out across all areas with evidence of benefits realisation and shortlisted for several national awards.
Falls Collaborative review, tests of change and resulting recommendations
Embedded specialist palliative care pharmacy


FOR INFORMATION ONLY_Anticipatory C


Interventions Framework v1.pdf

Principles underpinning the approach

Principles underpinning the approach to the work were agreed by partners as below:



What we have done, what is planned before programme close (March 2024) and what will sustainability look like?

RAG Status:
RED: Sustainability plan not in place
Amber: Planning in action for sustainability
Green: Sustainability plan in place

Workstream	Project	What has been done (Sept 2023)	What will have been done by end of March 24	Sustainability plan	Sustainability RAG status
Enhanced Health in Care homes	**RESTORE2mini**	•Rolled out RESTORE2 full training package to 38 care homes ahead of transitioning the project to RESOTRE2mini •Commenced Roll out of RESTORE2mini training from May 2023 via bimonthly ECHO, working in collaboration with YAS	•Completed the roll out of training via ECHO of RESTORE2mini to care homes •Evaluated the training offered and options for creating sustainable training for care home staff	In Progress There will be a need to consider ongoing workforce development for care home staff including regular training on the deteriorating resident. Options for recurrent provision are under review.	
	ReSPECT	•ReSPECT went live across the city from 2nd of May 2023 •Commenced Roll out of ReSPECT training via bimonthly ECHO, working in collaboration with YAS	•Completed roll out of ReSPECT to care homes •Evaluated the training offered and options for creating sustainable training for care home staff	In Progress There will be a need to maintain and support the ongoing use of ReSPECT and optimise its use and development. Options for recurrent provision are under review.	
	Nutrition and Hydration	•Identified food first approach to malnutrition pathway •Fortnightly Zoom drop in sessions for care home teams being offered •Upskilling Care home teams in MUST screening •Piloting of the Good hydration! Project •Established catering forum	•Review of community dietetic service offer to embed nutrition and hydration support to care homes •Completed the Pilot of Good Hydration! In 4 care homes •Evaluated the Good Hydration! pilot Including detailing if there is a future need for expanding citywide with business case if required	In Progress Additional recurrent Community dietetic funding has been approved through 23/24 contracting and x 2 WTE band 7 dietitians have been recruited to increase the citywide resource. Good Hydration! Project – In Progress. Following evaluation of the pilot recommendations will be made for upscaling citywide	
	Dysphagia management	•Delivered dysphasia links training •Fortnightly Zoom drop in sessions for care home teams being offered •Testing an allocated care home model of working	•Evaluation of workstreams and staffing models •Continued delivery of Dysphasia management training •Created a business case to agree additional funding to support SLT work into care homes	In Progress There will be a need to maintain the delivery of the current tested and evaluated offer. This will require expansion of community SLT services to enable continuation of training delivery and development of links to care home and GP teams.	
	Workforce development (Enhancing health knowledge in care home staff)	•Scoped health focussed training being offered in the city •Identified gaps in training offer •Delivered and evaluated training •Explored opportunities for a single point of access to training	•Develop an options appraisal for delivering sustainable health training platform for care home staff detailing offer and resource requirements. This will include opportunities for a Single Point of Access to training e.g. linkage to existing models such as Skills for Care	In Progress Options appraisal underway with recommendations to be made	
	Falls	•Developed a Collaborative Falls Assessment on admission •Trialled use of the Rita device for falls prevention •Implemented iStumble and razor chairs to 18 care homes to support the management of the immediately fallen patient •Implemented a direct referrals pathway to ICT falls prevention team from care home staff •Rolled out react to falls training	•Engaged Care homes to adopt the Collaborative Falls Assessment on admission •Evaluation of the Rita device, in view of falls prevention to identify if there is a future need for city wide roll out •Evaluation of the Raizor chairs/ iStumble pilot in view of reducing conveyance to consider future needs across the city/ need for city wide roll out. •Evaluation of the pathway for direct referrals to ICT therapy, including capacity and demand modelling, identifying future service needs •Roll out of react to fall training complete	In Progress Standard approach to care home falls risk screening, this will require agreement from care homes to embed falls screening as standard, with inclusion falls screening in contracting guidance •Agreed referral pathway and service offer for care homes to access ICT therapy, requiring commitment from ICT Therapy to continue direct referrals. •Evaluation results and recommendations for citywide roll out of the Rita, Raizor chairs and iStumble app, dependant on findings.	
	Geriatric Medicine Advice and Guidance	•Delivered Geriatric Medicine Advice and Guidance for GPs supporting care home residents (extended to all GPs), with a codesigned advice and guidance model	•Continued delivery of the service as BAU	•Embedded service within IGSM at Sheffield teaching hospitals recurrently agreed	
	Mental Health Review	•Recruited mental health resource to: •Scope current mental health provision for care homes •Identify opportunities for improvement	•Report written identifying current Sheffield provision of mental health support for care homes and potential options and recommendations for future service improvement.	In Progress Options appraisal with recommendations for enhancing mental health support for care homes to be considered by the place partnership board	

What we have done, what is planned before programme close (March 2024) and what will sustainability look like?

RAG Status:
RED: Sustainability plan not in place
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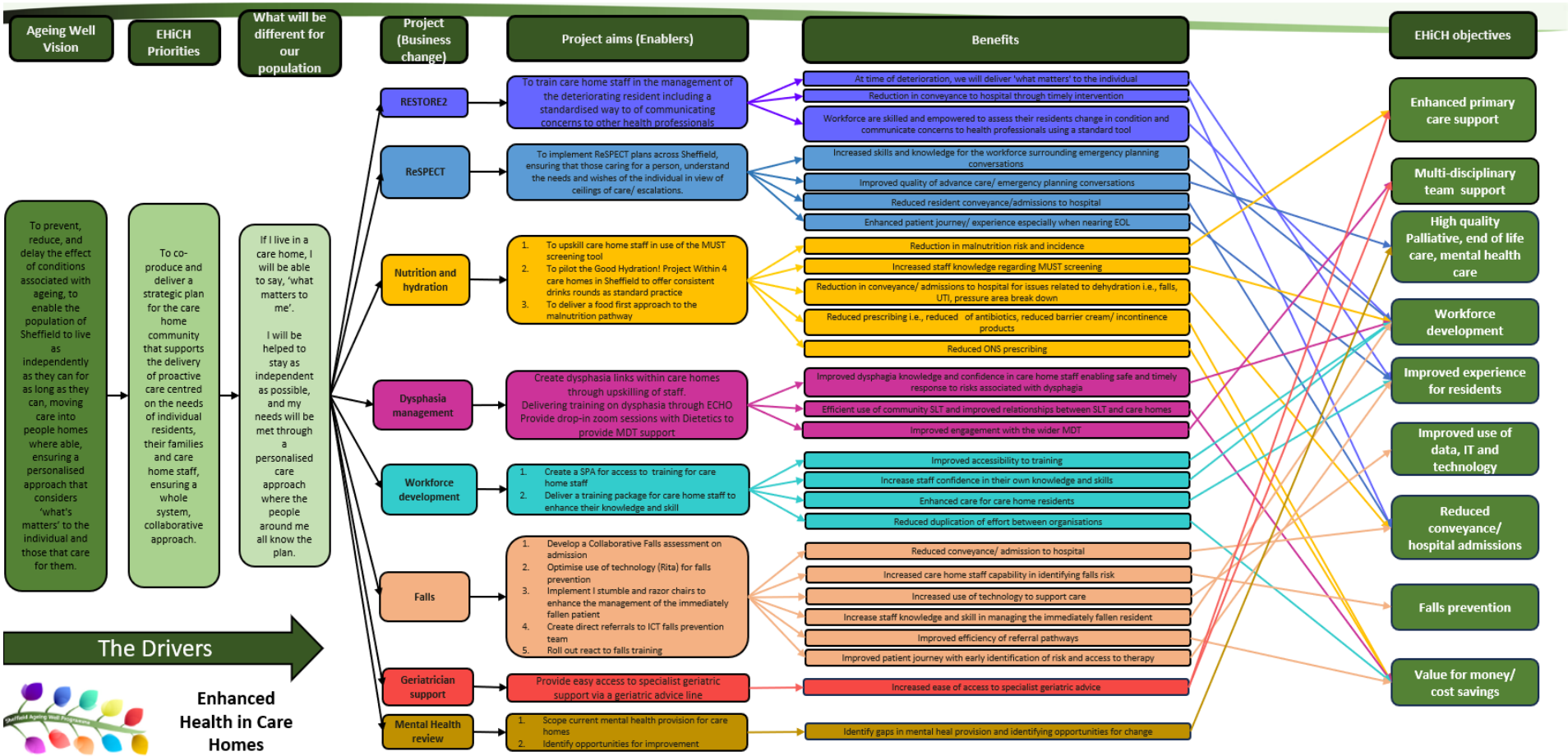
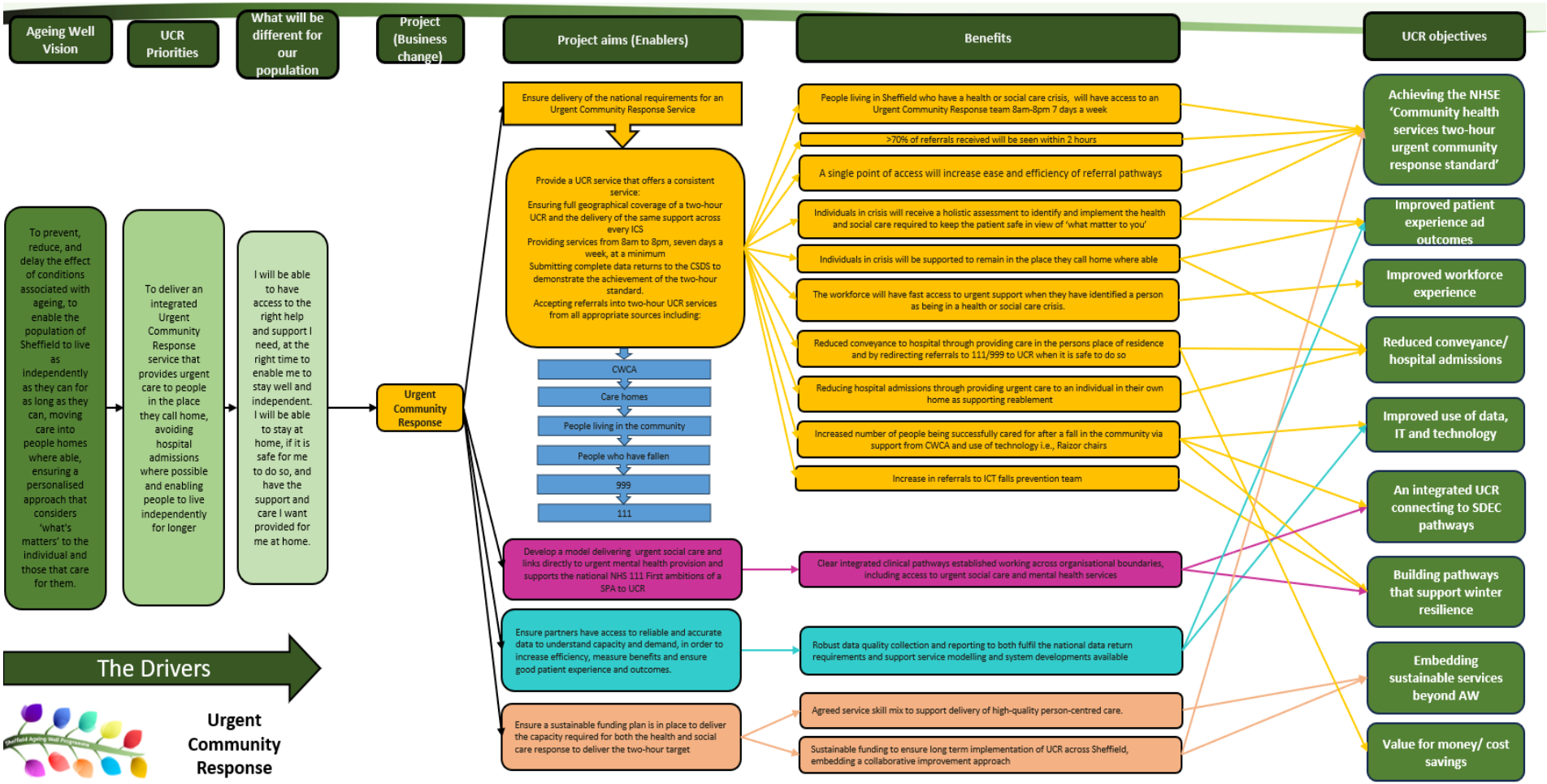
Workstream	Project	What has been done (Sept 2023)	What will have been done by end of March 24	Sustainability plan next steps	Sustainability RAG status
Urgent Community Response	Urgent Community Response	Embedded a UCR pathway to support people in crisis in the community Expanded CWCA offer to enable pick up of the immediately fallen and referral to UCR available 24hrs a day Created a service offer for UCR support in care homes Established a 'Push' model from 999 to UCR Sustainably delivering against target supporting Sheffield to achieve the lowest percentages of See Treat and Convey in South Yorkshire and second lowest in NEY. We have the highest percentage of those going to elsewhere other than ED recognising the focus on integrated primary and community services offer in Sheffield	•Embedded and evaluated pathways from all available resources •Implemented a pathway for referrals to UCR from 111 •Embedded the robust data reporting as BAU	•Agreement in place to fund recurrently a city wide UCR offer, linking into virtual ward and other SDEC services •UEC Board accountability for UCR in place and revised structure to include wider same day urgent care outside of hospital	
Anticipatory Care	Team Around the Person	•Created a city wide multi-agency approach that supports an individual's anticipatory care needs via holistic assessment of needs and care coordination, leading to creation of a jointly shared action plan with the patient wishes at the centre. •Identified individuals in Sheffield at higher risk; with an aim of reducing risk of escalation and involvement from statutory services, reduce duplication, improve outcomes, and advocate for right care at the right time	•Business case to be taken to Place Partnership Board to agree long term funding of the service •Support to create a secure data system for recording and reporting	•Long term funding for continuation of TAP •Secure data system for recording and reporting	
	Falls	•Mapped the provision of falls prevention in the city highlighting opportunities for change •Undertook Tests of change: a) Optimising referrals to community council and voluntary services from triage in health. b) Optimising referrals from health discharge to community / VAS. c) Identifying opportunities for Community referrals from CSW etc. to health (not via GP) •Reviewed the training needs in the city of staff, describe the gaps, and develop a training offer to meet the needs of staff across council, health, and voluntary services •Reviewed the training needs in the city of staff to identify and screen for falls risks, deliver training regarding falls screening. •Developed a package to support self-management in the community including self-assessment tools, exercise booklets and us of KoKu app. Produced a Team Sheffield Falls Plan options appraisal identifying opportunities to progress Anticipatory care in view of falls	•Written report detailing options for delivering Anticipatory Care in the area of falls with recommendations for future models of care, including workforce training, shared with Place Partnership Board for agreement of next steps •Evaluation of the pathway for direct referrals to ICT therapy, including capacity and demand modelling, identifying future service needs •Evaluation of the self-help management resources	In Progress Recommendation report to be produced for decision by HCPartnership as to Sheffield model. Service Specific: •Agreed referral pathway and service offer for people who have fallen in the community to access ICT therapy, requiring commitment from ICT Therapy to continue direct referrals. •ICT therapy to promote self-management tools with their patients as BAU	
	ReSPECT	•ReSPECT went live across the city from 2nd of May 2023	•Evaluation of implementation including organisational data and audit •Model for ongoing delivery of data and audit from organisations agreed to support future Resus council audit	•TBC however there is an expectation that the ICB will be accountable for auditing and annual reporting to the resus council	
	EoL Care Pharmacy	•Implemented the Syringe driver switch project •Provision of the Sheffield Specialist Palliative Medicines •Management Framework •Commenced the 'Pink card' project •Reviewed the Sheffield Palliative Care Community pharmacy stock and the Sheffield Palliative Care Formulary	•Evaluation of the syringe driver switch project completed •Completion of the 'Pink card' project including evaluation •Sheffield Palliative care Community pharmacy stock and the Sheffield •Palliative Care Formulary review complete	•Embedded and in place.	
	Stroke emotional support counsellor	•Tested the addition of a Stroke emotional support counsellor	•Completed evaluation of the service and embedded the role as BAU	• Embedded and in place.	

Benefits Map for Enhanced Health in Care Homes

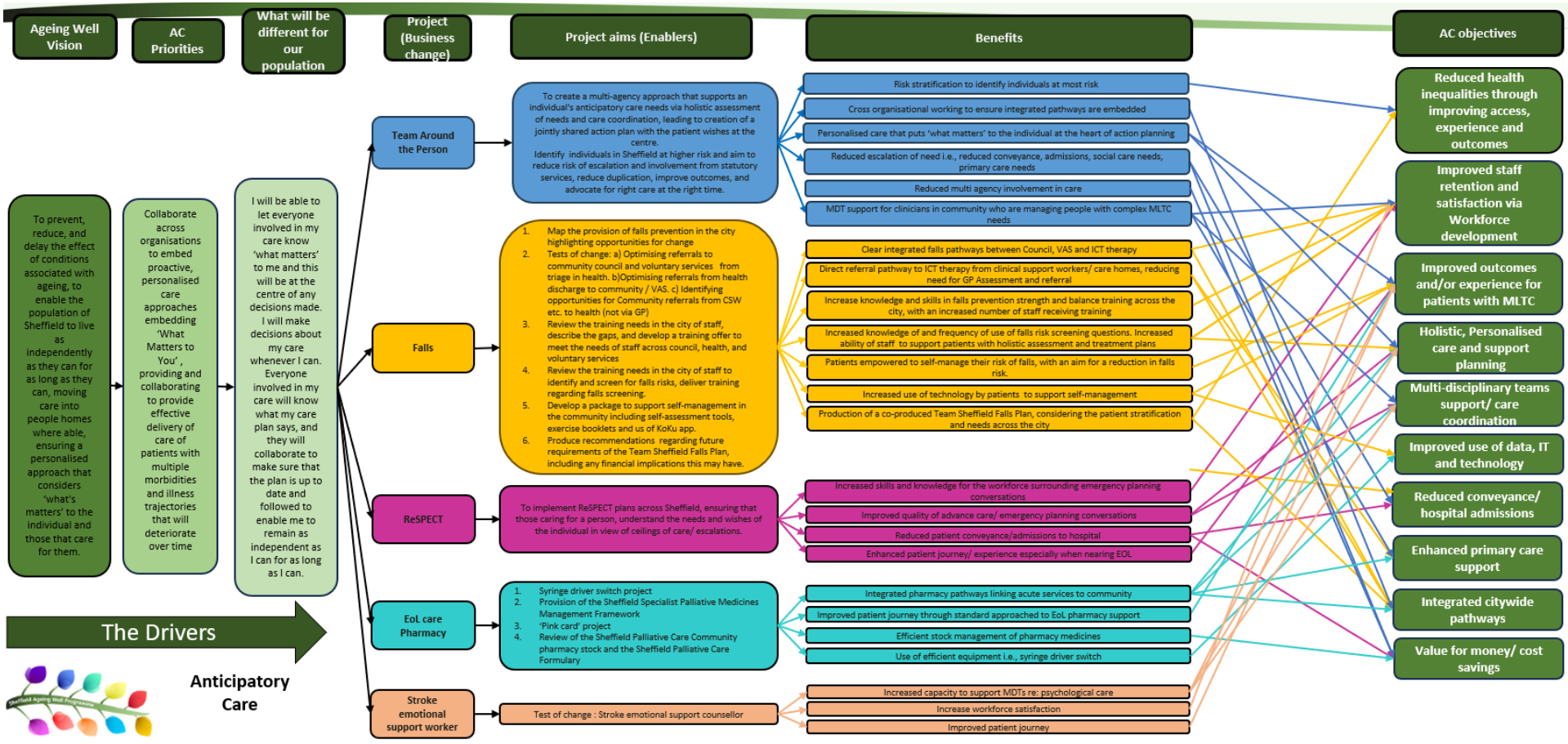
2023-07-28 benefits map Vs2.pptx



Benefits Map for Urgent Community Response



Benefits map for Anticipatory Care



Summary

The Ageing Well Programme has made excellent progress over the last 2+ years. We have articulated the achievements of the programme to date and the learning from taking a collaborative, multidisciplinary, system approach to several system challenges. We have identified that some projects will reach a natural conclusion by the end of the programme but also there will be some projects where the Sheffield system may choose to continue to progress to maximise the benefits that can be realised for the people of Sheffield.

Notes/ recommendations:

- The Sheffield Place Health and Care Partnership Board is asked to note the outputs to date of the programme and plans for sustainability in view of supporting embedding improved models of care for the Ageing population of Sheffield
- The Sheffield Place Health and Care Partnership Board is asked to note the learning from the collaborative approach taken within the Ageing Well programme and lessons learned
- The Sheffield Place Health and Care Partnership Board is asked to consider how the city will continue to collaborate in order to ensure our population is supported to 'Age Well' beyond close of the programme. It is recommended that:
    - The city continues to offer dedicated space/ a vehicle for all city organisations, with equal input from health and social care, to continue to work collaboratively with a focus on our population in care homes and those who care for them.
    - Funding requirements for sustaining outputs from the Ageing Well programme should be aligned to citywide funding conversations i.e. Better Care Fund Plan, annual financial planning.
    - A further report is brought to the Board focussed on the outcomes, learning, sustainability plan and financial implications later in the year.