Sheffield Better Care Fund Plan – (DRAFT) – June 2023

Executive Summary

The Better Care Fund (BCF) is a key enabler in taking forward joint commissioning between health and social care in Sheffield and has evolved over a number of years to include over £480 million of services. The Sheffield Better Care Fund plan has been jointly developed in accordance with ICB governance rules with local partners, including providers, Voluntary Community and Social Enterprise Sector representatives and local authority service leads. The plan is focused on key priority areas that have been identified through the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Plan and supports our ambitions for every adult in Sheffield to have:

- Access to a home that supports their health
- A fulfilling occupation and the resources to support their needs
- The ability to safely walk or cycle in their local area regardless of age or ability
- Equitable access to care and support shaped around them
- The level of meaningful social contact that they want
- The end of their life with dignity in the place of their choice

To enable successful delivery of our plan we know that we need to do things fundamentally differently working with people and communities, our Voluntary Community and Social Enterprise Sector (VCSE) as equal partners and strengthening our collaboration between NHS organisations and wider partners.

Overview of Sheffield Population Health

Sheffield is ranked as the 57th most deprived local authority in England, out of 317 with approximately 24% of the population of Sheffield living in the most deprived local decile. In 2022 the population of Sheffield was 595,100, this is expected to grow to 648,400 by 2043 representing a 9% increase. Within this increase the older persons grouping (aged 65+) is expected to grow to 19% with the working age reducing. The implications of an ageing population are wide in terms of people living longer with a higher burden of chronic disease and increased demand for health and well-being services. The reduction in working-age people (15-64) means a reduced contribution to the economy and lower incomes against increased human resources for care services (paid and unpaid carers).

Large inequalities in life expectancy remain in Sheffield. The gap in life expectancy at birth between the least and most deprived areas is estimated at 10.9 years for males and 8.7 years for females. The Better Care Fund is a key enabler across health and social care in securing better outcomes for the population and reducing unwarranted variation. Cancer and Circulatory Diseases are the top contributors to the gap in life expectancy between the least and most deprived areas by sex.

The main population risk factors for the population are smoking (13 per cent of the adult population in 2022), and excess weight (64 per cent of the adult population are overweight or obese in 2022). If these risk factors could be reduced in the population even just by a few percent, we would see a significant reduction in the number of people experiencing poor health. The diagnosed prevalence of CVD conditions including hypertension, coronary heart disease, stroke, diabetes and chronic kidney disease show a large number of the population affected yet only 15% of the eligible population have had an NHS Health check.

The scale of mental and emotional health and wellbeing need in Sheffield is great. We know that 138,000 children, young people and adults in Sheffield will experience a health problem each year and it is estimated that 15,000 children and young people live with a parent who lives with a mental health disorder. Many will be young carers. The proportion of homeless people in Sheffield with a diagnosed mental health condition (63%) is over double that of the general population (around 25%). In addition, there are approximately 7,000 people living with dementia in Sheffield – just over 1% of the whole city's population.

For the older age groups social isolation and loneliness should also be taken into account as a key factor influencing quality of life, health outcomes and service demand. Being lonely has been estimated to have the same negative effect on health and wellbeing as smoking 15 cigarettes a day. In a recent survey (2022) of older people in receipt of social care services, 37 per cent described themselves as not having as much social contact as they would like.

For multiple reasons, elderly care is becoming a pressure for the health and care services locally. Multi morbidity is not solely an issue for older age groups but does present more commonly in those groups. The result of having more complex patients to manage is increased demand on health and care services. Nationally this work has been modelled to show that as the baby boom cohort age and present with multiple long terms conditions we can expect to see significant health and service and social service provision being required. Prevention of development and more long-term conditions and better management of the existing, will be more and more important to prevent premature mortality.

Access to health and care is not the most important determinant of health in Sheffield (poverty, inequality, education, work, family life and other determinants have a greater effect). A people-centred primary health and care system with general practice playing its full part can make a significant contribution to health improvement especially when economic resources are constrained.

Our Approach to delivering integrated health and social care

As every year passes, we move closer to a joined a up experience for people using health and social care services. This is our expressed aim for all our staff, and we take opportunities to do so. Some examples include:

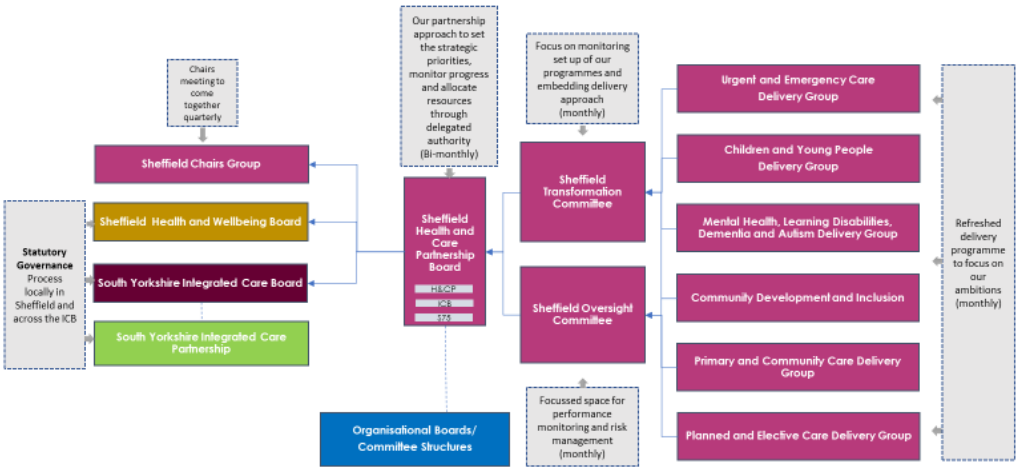
- redesigned social work teams to map against health relationships (older people community around Primary Care Networks and care home / support living teams with linked workers,
- implementing a multi-agency safeguarding hub for adults
- close working around discharge from general hospital beds, including discharge hub and joint escalation routes. Jointly funding a joint senior role with overall responsibility for discharge.

At a more cross-cutting level, examples of how we work together include a joint strategic review of the city's care homes and our workforce recruitment / retention approach. The partnership has recently led developments around trauma informed care across the organisations, which is creating a common language and approach for our joint work. There is a joint leadership development scheme, helping current and future leaders solve system-wide challenges while building long lasting relationships.

Sheffield's scheme of governance for our plan

The Sheffield BCF plan is the delivery mechanism for the health and social care elements of the Health and Wellbeing Strategy. The plan is aligned to all elements in the Sheffield Adult Social Care Strategy and takes into account the expectations set out in the NHS Long Term Plan, NHS Planning Guidance, and recovery plans. The plan also supports the South Yorkshire Integrated Care Partnership Strategy and South Yorkshire Joint Forward Plan deliverables.

The Sheffield Place Governance Structure



The Health and Wellbeing Board

The Health and Wellbeing Board oversees the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of its statutory duty to encourage integrated working between commissioners. This includes signing off quarterly and annual Better Care Fund submissions such as the annual plan and performance targets.

Adult Social Care Policy Committee

Given the focus on integrated working and in particular the focus of the fund and targets relate to hospital discharge, the plan and schemes have oversight and scrutiny from the Adult Social Care Policy Committee given most of the funding provided to the Local Authority through the fund sits within the remit of the Adult Social Care Policy Committee and the Sheffield Oversight Committee.

Sheffield Oversight Committee (SOC)

The purpose of the Sheffield Oversight Committee is to oversee and manage the Sheffield system risks and performance relating to finance, quality and key performance indicators where partners are equally responsible for delivery and achievement. The SOC is established by the Partners of the Sheffield Place Health and Care Partnership, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Partners.

Sheffield Place Health and Care Partnership Board

The Sheffield Place Health and Care Partnership Board oversees the section 75 agreement and has three core functions:

1. As an ICB Place committee providing a mechanism for delegation within the Integrated care Board so that decision on priorities and resources can take place locally with the wider health and care partners. It is one part of the wider set of arrangements in each place to enable integrated working at a local level enabling delegated authority from the ICB Board to make decisions about the use of ICB resources in Sheffield in line with its remit. The ICB Place Committees is accountable to the ICB Board.
2. As a Health and Care Place Partnership providing a mechanism to deliver on strategic policy matters relevant to the achievement of the Place Plan. All health and care partners across Sheffield work collaboratively to plan and deliver joined-up services and to improve the health of people who live and work in Sheffield.
3. Joint Commissioning S75 Arrangements – a joint committee between the ICB and Local Authority to manage business related to the S75 agreement.

The Partnership Board plays an active part in overseeing and developing the Place Plan (below) alongside other partners. Social care is represented on all the sub-boards and for 2023/24 the Partnership have agreed to focus on five jointly prioritised areas supporting the Better Care Fund primary objectives of enabling people to stay well, safe and independent at home for longer and ensuring that services are provide the right care in the right place at the right time.

1. **Development of hospital discharge processes**, building on our 'home first' model in order to reduce delays in discharge.
2. **To develop and implement our model for same day care.** To develop a new model for the provision of same day care to enable our population to access the right service based on need
3. **To ensure there is 24/7 access to mental health crisis** support for children, young people and adults in Sheffield
4. **To improve the support for people who are neurodiverse**, reducing waiting times to access services and ensuring we have appropriate support offers available.
5. **To develop a new model of neighbourhood working** with our communities to support their needs and reduce health inequalities.

Sheffield Place Plan Overview April 2023.p

The Voluntary Community and Social Enterprise Sector

The Voluntary, Community and Social Enterprise sector has long contributed to reducing health inequalities and improving population health in Sheffield. The Voluntary, Community and Social Enterprise sector organisations are rooted in communities and bring an understanding of the issues faced and the trust and confidence of those least likely to access traditional health and care services and most likely to experience health inequalities. But they also bring a valuable voice to strategic decision making and to re shaping how we deliver services and reach those most at risk of poor health outcomes and reduced life expectancy.

Many Voluntary, Community and Social Enterprise sector organisations are rooted in communities, and they bring an understanding of the strengths and assets already within those communities as well as the main issues faced. They often have the trust and confidence of those least likely to access traditional health and care services and most likely to experience health inequalities.

Example Sheffield schemes that support this approach:

Model neighbourhood

One of partnership's five main priorities is to develop a model neighbourhood in the north east of Sheffield, the areas of greatest deprivation and need in the city. We will develop and deliver a plan to empower communities in north east of Sheffield to live happier and healthier lives. We will invest in VCS to help connect communities and help connect the statutory sector to join up work and target those most in need.

We'll be adopting a positive asset-based approach and building on what works in local areas, building skills and capacity so build a sustainable way to reduce health inequalities for years to come.

Improving mental health through working with VCSE

Rethink Mental Illness selected Sheffield to be one of four national sites in England to develop new models of delivering mental health care with voluntary, community and social enterprises (VCSEs).

£1m was invested over 3 years (2021/22-2023/24) by Rethink Mental Illness, supported by the Charities Aid Foundation and the Association of British Insurers and by the Sheffield Place ICB Team.

Over 100 mental health voluntary and community organisations are now signed up to the Sheffield Mental Health Alliance.

An Alliance Board has been established and it is chaired by an independent chair, and members include representatives from VCSE organisations across Sheffield.

The aim of the Alliance is to work with people who have lived experience of mental illness, to understand how services can support and improve their quality of life. Working together with organisations across the city, the Alliance will break down barriers between different agencies and tailor care to better meet the needs of people living in Sheffield. To ensure lived experience is used to inform strategic developments and transformation across the Health and Social Care in Sheffield.

The first Alliance programme – the development and implementation of Peer Support roles across Sheffield is on track to be in place from this Summer with recruitment commencing in May 2023. Our VCSE Partners are key to supporting the Better Care Fud core objectives of enabling keeping people enable people to stay well, safe and independent at home for longer and projects include:

- Working alongside Healthwatch to engage the voluntary sector - work ongoing - there has recently been a community grants launch in which voluntary sector organisations placed bids to conduct engagement activities within their local communities to develop a better

understanding of need, this will then translate into resource production and dissemination in the latter phases;
- Producing a service specific health inequalities action plan which outlines our commitment as a service to tackling health inequalities through consideration of the wider determinants of health;
- Targeted GP outreach training for low referring practices and those in areas IMD 1 or 2;
- Hosting a patient journey workshop looking at service process and delivery incorporating voluntary sector stakeholders and patients;
- Patient by experience representative on programme boards;
- Engagement with social prescribers to enhance knowledge of Long Covid and service specifics;
- Working alongside Darnall wellbeing to support their Long Covid support group;
- Working with Arts in Health to establish Long Covid specific opportunities "Singing for Lung Health" and "Mindful Painting and Drawing" with use of local assets Sharrow Community Forum and Sheffield Museums, Millennium Gallery;
- Co-location with NCSEM at either ends of the city to improve service access;
- Active engagement with Sheffield's Move More Strategy.

Housing and Health in Sheffield

Leaders within Sheffield recognised that further action was needed to integrate housing within the health and wellbeing agendas across the City and believe that no-one in Sheffield should live in a home that damages their health. Cold housing is a risk to health and those with the poorest health live in the coldest homes. People living in cold homes are far more likely to suffer from illnesses such as asthma, 'flu and bronchitis and it can increase the risk of a heart attack or stroke. 16% of properties in the private sector are estimated to have category 1 Housing Health and Safety Rating System (HHSRS) hazard1, which equates to 29,576 properties. (This is higher than in 2015 when the last study was undertaken). The total cost of mitigating category 1 hazards in Sheffield's private sector stock is estimated to be £87.1 million with £56.4 million in the owner-occupied sector, and £30.8 million in the private rented sector.

The 2 most common hazards found in Sheffield's private homes are 'risk of trips and falls' and 'excess cold'.

The number of trip and fall hazards in privately owned and privately rented homes was 16,101 (13%) and 7,387 (12%) respectively.

The number of excess cold hazards in privately owned and privately rented homes was 2,326 (2%) and 1,180 (2%) respectively. Excess cold as a Category 1 hazard signifies that, whatever the type of heating or insulation in place, the home is still not warm enough.

Cold homes have a negative effect on people's health. Cold conditions can affect respiratory and cardiovascular functioning, affect the immune system, worsen arthritis symptoms, and can increase the risk of a trip or fall. Cold homes contribute to excess winter deaths, it is estimated that 21.5% of excess winter deaths are attributable to cold homes in England.

Energy Company Obligation (ECO) is one way for vulnerable households to access funding to help improve the warmth of their home. SCC has recently launched ECO Flex. This allows us to widen the eligibility criteria to ECO which will provide millions of funding until 2026, for households who were not eligible for the grant before.

In Sheffield, around 5,500 owner-occupied and private rented properties across the city are classed as having an excess cold hazard due to a mix of financial hardship and poor property conditions. 12% of households are living in fuel poverty as a result of low income, high fuel prices and homes which are expensive to heat and run. This contributes to winter deaths, cold-related illnesses, unplanned admissions to hospital and delayed discharge, particularly in older adults.

Children in poor housing are more likely to have mental health problems, contract meningitis, have respiratory problems, experience long-term ill 14 health, disability, slow physical growth and delayed cognitive development, giving them a much poorer start in life. The current shortage of affordable housing is the greatest threat to health for many people if they become homeless or are forced to wait for new homes in unsuitable conditions or in places away from their social networks. There is little competition at the more affordable end of the private rented sector, which can offer poor housing conditions where vulnerable people find it impossible to ensure basic maintenance of the property. Overcrowding is also detrimental to health, in particular mental health. The shortage of affordable housing means a lack of properties for families in the social and private rented sectors.

Housing for older people

Living in a suitable home is crucially important to a good later life. Good housing and age friendly environments help people to stay warm, safe and healthy. The number of older people living with a limiting long-term illness is projected to increase by 31% between 2020 and 2040. The number of older people predicted to have an autism spectrum disorder is also projected to increase by 29% to 1,143 and people aged 65 and over living with a moderate or severe learning disability and likely to be in receipt of support services is expected to increase by 25% to 330 (source POPPI).

Approximately 65% of Sheffield's older population are owner occupiers, 30% rent from a social landlord and just 4% live in the private rented. Some older households live in homes which has been designed for older people, but many don't, and this is most likely in private sector homes. The disparity in financial resources means that the housing options and choices of older residents differs greatly by both tenure and location within Sheffield.

There are around 2,800 Older Person Independent Living (OPIL) properties in Sheffield, spread across 76 schemes. The majority (78%) of Sheffield's OPIL housing is sheltered housing and is mainly provided by social landlords as rented accommodation (80%). The Council manages 1138 sheltered properties distributed across 30 schemes. 21% of Sheffield's OPIL housing takes the form of Extra Care Housing.

More OPIL housing in Sheffield will increase housing choice for older households. However, the opportunity to improve housing conditions to support independent living remains in improving and adapting the existing homes in Sheffield. Meeting the required housing need will not be possible for the Council to achieve alone. We will use our strategic housing documents to strengthen the focus on housing and increase effort and resources to delivering better coordinated, statutory and non-statutory repair and adaptations advice and services.

The city needs more affordable homes than are currently being built, in particular for households unable to afford market price. This could include first time buyers on a low income; families seeking homes across all tenure types; vulnerable groups who need accessible or supported accommodation; or people affected by changes in the benefits system. Home improvements can significantly improve social functioning as well as physical and emotional wellbeing. For example, adequate heating systems improve asthma and reduce the number of days off school. Some private rented homes in the city have a hazard that could pose a serious threat to the health or safety of people living in or visiting the home. It is estimated that the removal of all hazards could provide £13.5 million annual savings to society, including £5.4 million savings to the NHS in Sheffield. This is not just about the quality and affordability of the bricks and mortar; we also know that homelessness is tied to some of the most significant health inequalities in our city, with homeless people having significantly shorter life expectancy than the rest of the population. Homelessness and tenancy failure can affect all groups: however, some groups are more vulnerable than others including young people, older people, people with mental health issues, people with drug and alcohol problems, people leaving hospital, care leavers, people released from prison, and former members of the armed forces.

Support is focused on preventing people from becoming homeless and helping people to resettle after a period of homelessness. We have supported a number of initiatives to wrap around services for the homeless and vulnerable this has included:

- Framework outreach embedded within acute pathways to support these patients;
- Infrastructure funding to upgrade and develop medical rooms at Cathedral Archer Project and Ben's Centre (centres for the homeless in the city centre);
- Additional peer support and transitional support to The Greens, a step-down detox service, – working with Sheffield Teaching Hospitals NHS Foundation Trust;
- Additional small grants to Cathedral Archer Project and Ben's Centre to further develop peer outreach services and ensure 1:1 support to clients to manage health conditions, ie; accessing / maintain health appointments on time and reduce do not attend (DNAs);
- Partnership work funding rough sleeper outreach nurse.

Adaptations and Disabled Facilities Grant

The DFG is managed through the Sheffield Adaptations, Housing and Health Service bringing together a team from social care and housing into one team, and the Housing, Health and Care Reference Group who work with colleagues from health services to assess peoples' living environment to ensure they promote safety, independence and enablement. A core service and support across Adult Social Care which enables and promotes independence and support the is our Occupational Therapy and Adaptations, Housing and Health Teams. The team receive 5500 applications last year which is a 22% increase in demand since pre- pandemic application levels and a reflection of the essential and core needs across Sheffield. A new model and ways of working are being embedded in the service to ensure it is accessible, sustainable and high quality.

The work includes:

- Reviewing pathways as a means of reducing areas of duplication;
- Exploration of digital self-assessment tools and video calls to enable lower risk equipment and adaptations to be assessed quickly;
- Developing more information and advice about equipment and adaptations via our information and advice hub under development;
- Developing specialist Occupational Therapists working with people with dementia, transitioning young people from children to adult services and care handling. The knowledge of these specialist workers supports better outcomes for people and a tailored response to requests from individuals and carers;
- Developing a new operating model for adult social care, which includes looking at the future design of our living and ageing well services.

The equipment contracting team, alongside our equipment provider Medequip and VCSE partner SCCCC, have created training for equipment champions who are embedded within enablement, discharge and reablement teams across the city to promote adaptations and equipment before use of care packages or to minimise additional care requirements.

Where homes cannot be adapted or are not suitable to house the equipment required by the individual the wider housing team based at the council will work to identify alternative accommodation to enable rehousing. The team make use of extra care accommodation while rehoming takes place to ensure safety and ensure discharges are not delayed for those in a hospital setting.

For those individuals who are more vulnerable, homeless, rough sleeping, drug and alcohol dependent or with complex needs, mental health or learning disabilities third sector partners are involved in the reviews and remain in contact for up to 12 months to ensure correct placements and appropriate use of adaptations and equipment. Organisations such Thrive, Salvation Army, Humankind, Shelter, Cherry Trees and Adullam work with colleagues from South Yorkshire Housing, SCC and the NHS to deliver this additional wrap around support.

This team are also looking at how we manage adapted properties in the social sector as part of the Allocations Policy review. Our future approach will:

- Strengthen relationships with internal stakeholders – working together to get the right information and streamline processes;
- Allow us to create more detailed property adverts which will lead to increased, and more appropriate, bids;
- Match properties quicker;
- Better match properties according to needs;
- Reduce the resource time that OTs need to visit a property as the details will already be recorded.

Supporting Unpaid Carers

Unpaid Carers are an essential part of our health and social care systems and play a key role in our communities by providing care and support to some of the most vulnerable in our society. Unpaid Carers are the glue, which hold our health and social care systems together for the person they care for.

Within Sheffield the Carers services are commissioned by Sheffield City Council as part of their lead role for contracting prevention, support and people keeping well services, many of which are with the voluntary and charity sector. A Delivery Plan was refreshed in 2022 to build on activities within the carers strategy (please see the action plan for more details), deliver upon 'living the life you want to live' which is Sheffield's vision for adult social care 2022-2030, our youth service strategy and an inclusion strategy that are important for young carers and parent carers. It also enabled a response to the learning on the impact of the pandemic on unpaid carers.

During the past year the support to carers services have been reviewed, redesigned and recommissioned. This has allowed a more holistic approach to identifying carers, meeting the needs of carers and to a contract which is driven by outcomes rather than contacts. This was following engagement with service users and staff who identified a particular need to support wellbeing and mental health of unpaid carers.

The main offer to Carers' is commissioned with the Sheffield Carers Centre as a familiar face in the city. Individuals in need of support do not always feel able to be open with a statutory organisation until the point of crisis. They undertake the Carer Assessment, a requirement of the Care Act 2014, which is designed to understand the role of the carer and signpost to resources tailored to the individual's circumstances.

The Health and Care Partnership highlighted the need to enhance the service for young carers, many of whom support relatives who access our Better Care Funded Services. The follow short video highlights the importance of ensuring their needs are understood and their outcomes defined and met as part of our framework planning. https://youtu.be/I4fzMOWGErQ. Sheffield Young Carers are commissioned to specifically support those caring for parent's with a substance addiction where adverse childhood experiences could shape the future life of the young carer. More information can be found on their website Sheffield Young Carers | Dedicated to helping young carers across Sheffield.

As part of the BCF Theme 4 – Mental Health - a carers wellbeing course is also commissioned from Sheffield Health and Social Care FT. This course aims to provide support to family and friends who are adult carers and want to learn ways of managing their own mental and physical wellbeing. The short course helps Carers learn and develop new skills which help build resilience to cope with the demands of a caring role as well as meet a network of people with similar life experiences to draw upon at the end of the sessions.
Alongside the specific services there are other ways in which carers are supported by the city. For example, funded within our BCF PKW Theme programmes, attendance at community groups such as coffee mornings or craft clubs can offer breaks in the day or week to allow carers to undertake normal activities away from their caring responsibilities. Dementia cafes can allow

carers to leave their loved ones in a safe space while they go shopping or focus time on themselves. The BCF On-Going Care Theme specifically commissioned packages of respite care can allow a long duration vital break from responsibilities that carers need to avoid deterioration in their own health and wellbeing. Those packages are funded by the local authority IBCF funding except for respite packages for clients with learning disabilities which are commissioned by ICB Sheffield Place.

Support for carers is an area highlighted within the developing outcomes framework and a team are currently undertaking a review of these services to understand where they can be enhanced or where gaps have emerged due to the impact Covid-19 has had on many smaller community-based voluntary organisations.

Develop the care market to support Market Sustainability for Health and Care in Sheffield

Sheffield's Market Shaping Statement is informed by the consultation and engagement behind the Adult Social Care Strategy, re-modelling of Homecare, commissioning strategies for Working Age Adults and Mental Health, and the engagement with providers in the Fair Cost of Care exercise. It provides providers with our intentions and standards and provides a starting point from which to engage further with our communities, our providers, and our partners to inform and influence a number of more detailed Market Position Statements that give both the purchasers and providers of care information on the needs and demands for different types of care and support, and the commissioning intentions to shape and change the market to meet these needs. The Sheffield market oversight and sustainability plan sets out our approach to meeting its sufficiency needs and duties for adults with additional needs in the City. It describes our approach to commissioning and how Sheffield will fulfil its role to facilitate and shape a diverse, sustainable, and quality market, as well as identifying the key challenges and risks to achieving this and our approach to overcoming them to ensure that our local care market is sustainable.

The plan considers the extent to which care and support markets in Sheffield are sufficient and stable, meeting quality standards, and providing value for money.

Sheffield is already taking action to continue to secure a sustainable health and care market, and to drive improvements. These include:

- Digital Strategy;
- Technology Enabled Care programme;
- Workforce Development Strategy;
- Delivery of the Individual Support Funds pilot;
- Living and Ageing Well;
- Homecare transformation programme, including procurement of the Care and Wellbeing service, our new delivery model for homecare and a Test of Change project to inform mobilisation of the new contract and focus our collective efforts on the areas with most positive impact for people;
- Strategic Review of residential care, including the development of a co-produced support programme for the sector and commissioning strategies;
- Development and tender of a new MH Support and Independence framework;
- Tender for the Adults with a Disability Framework;
- Enhanced Supported Living Framework.

Over the past year the homecare market both internal and external to the council has undergone a period of transformation, which has increased the number of hours available from council services by 500 from January 2023 and stabilised the homecare market in advance of a new ten-year enablement focused contract going live from September 2023. Alongside this, resources have been put in place in relation to care at night and assessment and care management which has also led to a reduction in delays for those reasons and waits for access to services.

Reducing health inequalities and enabling people in to stay well, safe and independent at home for longer

We know that people in poorer parts of Sheffield live shorter lives and have worse health than those in more affluent areas. We also see similar disparities affecting groups with specific shared characteristics, such as people from Black, Asian, Minority Ethnic and Refugee backgrounds, or people with learning disabilities. These differences and disparities are the health inequalities that exist in our city, and that we see as unacceptable.

inequality is not simply bad for those who are most disadvantaged, it is bad for everyone. This is because in unequal societies, social cohesion is poor, skill levels are low, businesses find it difficult to start up and sustain themselves, support services struggle to meet the challenge of rising demand, and environments are often degraded. Inequality is linked to lower levels of educational attainment, social divides and poverty, which in turn affect everyone's futures because successful economies need skilled healthy people.

We are using information about our population and a differential approach to investment to address inequalities and gaps in services. For example, the People Keeping Well (PKW) BCF theme is commissioned by the Council on behalf of both the ICB and Council and is one of Sheffield's approaches to Social Prescribing. One of the core funding streams is distributed based on deprivation of the city, for example, each of the 100 neighbourhoods is allocated money weighted by the IMD score. PKW, and our community dementia programme, are delivered wholly by the VCSE via community partnerships, of which there are 17 around the city. Local intelligence tells us that those with protected characteristics, people who belong to health inclusion groups and those living in the most deprived communities are disproportionate users of unplanned services. Our plans and metrics will impact positively on this as we focus on the underlying causes of this inequity. In particular our emphasis on neighbourhood approaches will enable a greater understanding of the needs of communities to allow services and interventions be tailored and personalised around those who most need them.

All decision, as well as local authorities' priorities s around service redesign, investment and resource prioritisation are taken to ensure full compliance with the Priorities and Operational Guidelines regarding health inequalities under the Equality Act and NHS actions in line with CORE20PLUS5.

The common theme which emerges when reviewing these communities is a high level of poverty. These groups of the populations are also prone to digital exclusion with high levels of digital illiteracy. The ICB Sheffield Place are leading on a Digital Roadmap which explicitly addresses digital inclusion, digital literacy and digital poverty. Using the network of organisations within the Health and Care Partnership there are plans for the primary care estate in Sheffield to recognise and support digital inclusion in some of our most excluded communities. The primary care hubs projects being developed as part of the ICS Wave 4B Capital Programme in three primary care networks, City Centre, and SAPA5 and Foundry in the north of the City, will include facilities to enable digital access to health and other services for the local population. A similar approach is being taken in our plans to re-develop void space in LIFT and NHS Property Services premises within the City.

The ICB Sheffield Place and Council have jointly funded a pharmacist post embedded with the Better Care Fund Joint Commissioning Office to support the most vulnerable housebound people in our city, particularly people who are in receipt of social care packages to support them at home. Due to multiple long terms conditions, these patients have complex medication regimes which they may struggle to manage. Non health qualified social care staff and family carers may need additional support to help them with medication, and interventions such as specialised feeding techniques, due to lack of knowledge and confidence. The purpose of this post is to provide pharmacy expertise to support carers, so as to improve patient safety (reducing medication errors) and improving access and experience, eg; for people with dementia, physical disabilities. This project was deigned to address feedback from vulnerable people and their carers.

As part of our offer as a city to vulnerable people the services are being reviewed to ensure they are streamlined and that every contact counts for the person. Within this cohort of citizens prevention is difficult as they find working with services to be intimidating or repetitive and will wait until the point of crisis before making contact.

As part of a wider focused approach to early help and prevention the review is looking at the needs of the homeless population, those who require advocacy support to navigate services, or who find they aren't able to cope alone and their health needs are deteriorating at an early age. During the last twelve months work has progressed to establish multi-organisational and multidisciplinary teams to support homeless and rough sleepers including outreach nurses and dedicated mental health specialist to work with people on personalised outcomes.

The HALT drug and alcohol services is being redesigned to expand the outreach and identification elements of the service so we can support more people earlier and maximise the potential benefits for service users.

As part of the Better Care Fund On-Going Care Theme are programmes which commission services for our older citizens who live in care homes, who are some of the city's most vulnerable people with complex health and care needs, often with multiple frailty, and including people nearing the end of life. We have used our Better Care Fund to provide enhanced support to improve the health status of people in care homes, for example dietetics and speech and language therapy to address swallowing issues and improve nutritional status, as well as work on falls prevention (upskilling care home workers).

The learning from working closer with Providers during the Covid-19 pandemic and the fair cost of care exercise are being embedded within the in-year retendering of home care and care home services to ensure a balanced, sustainable offer across the city designed to meet the differing needs in each network. The aim is for the homecare provider footprints to mirror those of primary care networks to cement the relationships and allow seamless services to be offered which can be response to demand in a timely manner and help deliver the requirements of our active support and recovery programmes.

Team Around the Person (TAP)

To support our Mental Health Better Care Fund Theme we have developed Local Care Coordination Centres across the City based on the Team Around the Person (TAP) process. The TAP process supports the integration of health (physical and mental) and social care, reduces demand on the acute/statutory services and supports individuals to build their capabilities and resilience. The process focuses on preventing wellbeing problems from becoming more serious, promotes independence and reduces the need for acute hospital and residential care services. TAP was designed to support the integration of health (physical and mental) and social care and to help co-ordinate personalised support for individuals, who are involved with multiple services, and their needs are at risk of escalating. It is closely linked to our mental health transformation work streams.

TAP Case Study:
Introduction:

Sally is a female in her 30's living with quadriplegic cerebral palsy and a severe leaning disability. When we met Sally and her parent's they had major concerns for Sally's future. Sally had a spinal rod, displaced right hip, and was experiencing tonic colonic seizure (epilepsy). Sally required round the clock support. Due to dysphasia medication (given orally), dietary and fluid intake needed to be monitored due to the risk of aspiration, a continuous positive airway pressure (CPAP) machine was used through night due to sleep apnoea. Sally lived in the family home and received informal support from her ageing parents – however, both Sally's Mother and Father had considerable health issues and due to unfavourable prognosis' became completely dependent on Sally's formal care package to meet her needs. Over a period of several months the family relationship with the care agency completely broke down following several issues and

disputes on the appropriate level and quality of the care their daughter was receiving. The care agency gave notice to withdraw, and the family lost trust in the other supporting services. When the referral came to TAP the family were at a loss of who to turn to for help, at a time when their entire family was in complete crisis they felt let down. Over 11 different services/agencies were involved in Sally's care.

Intervention:

The TAP created an impartial safe space for the family to voice their concerns, they were able to get to the heart of the issues and listen to what Sally wanted, and how she wanted her future to look. Using an integrated approach, the team worked with all the involved agencies and organisations responsible for Sally's care to help rebuild trust, and ensure all services were on the same page. Once they had formed this team around Sally, they were able to create a collective action plan that detailed the plan for Sally and her family, taking in to account not just what needed to happen, but also what Sally and her family wanted to happen.

TAP appointed an advocate for Sally to ensure everyone was focussed on her aims and objectives. Her care plan was moved to another provider and support was increased. Sally also began periods of respite and attendance at a day service to allow for her mother and father to manage their own health needs. The family were supported to access additional help following a terminal diagnosis for Sally's mother, and Sally was able to utilise the advocate to ensure she received the right bereavement support she needed when her mother sadly passed away. Due to the team of professionals, they team had built around Sally she was completely supported during this period. Once Sally was receiving the right care and support, and the family relationships with services was repaired, the TAP continued to support the family to look at future proofing support. We discussed contingency with Sally's father, and how Sally's needs may be met in the future. Sally had particularly enjoyed her time in respite and had expressed a wish to live more independently. With access to the right professionals Sally was able to build up her time in her favourite respite facility, and become a permanent resident, receiving the right support.

Impact of Intervention:

Due to TAPs intervention, Sally's care needs were completely met in a way that she wanted them to be. One of the biggest concerns for Sally and her family was Sally being taken into care and placed somewhere that didn't meet what she needed, but due to collaborative working, and involving Sally and her family in conversations we were able to tailor something that was perfect for what Sally needed. We saw an improvement in Sally's health, and wellbeing, she was much happier, and the family felt far less pressure during what was an incredibly difficult time for them all. Sally built positive relationships outside of her family dynamic and had professionals she could rely on for support. We future proofed Sally and were able to look at the long term needs she had, and how we could ensure they were met with as little upheaval as possible. Sally's newfound independence continues to grow, and she is looking forward to considering holidays and trips and experiences she felt completely unable to before.

Family member quote:

"I would just like to thank you and your colleagues and the rest of the TAP for their invaluable advice and input into the transition process and delivery of the change in my daughter's transition to independent living".

"Without your assistance I would not have been able to navigate my way through the process, especially after being widowed during the transition. It made it doubly reassuring for me to know I had someone I could call on whenever I needed help or just someone to talk to about my concerns (and hopes) for my daughters future and you provided that vital support in abundance. Thank you once again, from the bottom of my heart, for all your help and kindness during this very difficult time. I called on S yesterday and she says she is very happy with her new independent life. I'm sure she's living her best life and I'm making the most of my time too so your help for us both cannot be underestimated".

Quote from advisor:

"For me this case shows that treating the person, not the condition or situation gives them the very best chance not just for basic needs to be met, but for a holistic change for the better, that impacts not just the person but their wider support".

Ageing Well

The Ageing Well programme has specific work areas aimed at the most frail and vulnerable of our current older generation and split into three workstream.

Urgent Community Response (UCR)
Enhanced Health in Care Homes (EHiCH)
Anticipatory Care

Sheffield partners are taking preventative and proactive approaches in the community whilst also ensuring responsiveness to escalating need and crisis management and include transforming community services to improve timely access for all, especially those with greatest needs, our core20 plus communities and inclusion groups.

We know that we must have effective waiting list management and case management, productivity and efficiency, maximising use of technology and expansion plans. Developing a robust community workforce is vital to enable integration vertically into pathways to and from acute care, and horizontally into community pathways with primary care, social care and VCSE partners. Working together supports delivery of proportionate levels of care according to individual needs and affordability.

Teams are workforce planning for community sector expansion and ongoing training include advanced practice, joint working with PCNs, and building skills to support increased acuity in community settings linked to expansion of virtual wards and hospital at home.

Our joint plans include greater use of technologies to support care at home and enable independence and specific work on improving access to dietetics and falls prevention. We have a number of services that support the BCF metrics on falls such as:

- The city-wide alarms, level 1 pickup service has been extended it is in place between 8 am and 8pm and a temporarily commissioned a 24-hour service, to respond to the immediately fallen, this level 1 team feed into the UCR for clinical support and are working closely with Yorkshire Ambulance Service to evaluate the pathway.

- The UCR 2-hour response team to support level two fallers , those able to stay at home but at risk of admission due to medical deterioration , often an acute infection , that caused the fall.

- The UCR service offer is open to all care homes, to ensure that residents have access to 2-hour response, to avoid conveyance where appropriate.

- A push model from 999 into UCR is being tested, this will include level 1 and 2 falls as clinically appropriate.

    - The ECP service is the main responder to level two falls in the city, the team have access to the 2-hour UCR response team to support management of the deteriorating patient, preventing admission.

    - The ageing well team has purchased 17 raizor chairs and is delivering a training plan to enable care homes to manage level 1 falls within the care home using the I stumble tool and the razor chair. The ambition is to decrease long lies in care homes and conveyances to hospital. This is supported by the respect training and a what matter to me approach.

Personalised Care

Our vision within Sheffield is for care to be person-centred at all points of contact. The key to wellbeing and improving quality of life lies in people's ability to be able to live a life they have reason to value. This may be achieved by drawing on their own strengths and networks or by being connected to the assets and resources in their local communities and the wider city.

As a city our basis of together is true collaboration, people, communities and organisations, to build places and services that support and sustain these assets and resources.

This means changing how we do things in Sheffield so that people and communities to have greater control of what matters to them and can see how they can influence their care. We are designing a model that is:

Asset based: knowing that people and communities are resourceful. Building on what skills are already there. Focusing effort on searching out and developing strengths. An example of this is capture within the embedded document which shows the City's approach to building, supporting and maintaining resilient communities.
Population Health driven contributions to the design of services to meet the current needs of the demographic as well as to extrapolate expected future need requirements and to ascertain if any impact is being evidenced of preventative work already in place.
Enabling and Engaging: making it easier for people do for themselves, or 'work with'. Avoiding 'doing to' unless absolutely essential (we recognise that there are situations where 'doing to' is most appropriate). The ethos of "What matters to you" is embedded across our health and social care partners with the lead for the city being a GP who also holds a role within our main provider FT. This has allowed the message to be a key part of the PCN and locality development with ARRS social prescribing and our People Keeping Well services applying the principle.
Personalised: any support is tailored to the person's context to help build capabilities. This means we must be able to understand people's strengths and where they need additional support and a personalised response. This is also linked to the Ageing Well workstreams, enhanced care in care home, the falls prevention service, community AHP services and End of life,
System Focused: we look at the whole picture as a city, for example strategy development, policy choices, service redesign, recruitment procedures; and use coproduction, connections, and community knowledge and expertise to improve quality of life and wellbeing for everyone. The aim is for one consistent message is shared across all our meetings, partners and staff groups to ensure the culture in Sheffield is reflective of the overall strategic vision and system priorities. Alongside the core BCF and HCP structures sub-groups with representation from across the partners are held to support this aim. For example, the Workforce, Culture and Leadership and Community of Interest Group, NEY Personalised Care Board has representation behalf of SY ICB and Sheffield Compassionate City Board.

Personalised care examples

There are some excellent examples of teams and services working in a person-centred multi-disciplinary way across Sheffield. An example of this is the Citywide Prevention Programme led by Sheffield City Council who are working with Providers, Service Users and Statutory services to co-produce plans ensuring that every contact counts for the individual. Another examples funded through BCF schemes is the Twice Weekly Escalation Meeting, with representation from all system partners tailoring discharge packages to an individual's circumstances when leaving secondary care and the wrap around support for end of life and bereavement support where statutory partners work with VCSE and St Luke's Hospice to ensure personal choice and dignity in death as part of our compassionate city promise. Focus now is to build on that success by building a culture of personalised care and asset-based approaches across the city driven by senior leadership across the city and the development of a city-wide strategic personalised care programme.

The Active Support and Recovery Better Care Fund Theme also focuses upon services to enable flow and avoiding inpatient admissions. Work programmes include Urgent Community Response,

Enhanced Health in Care Homes and Anticipatory Care as part of the wider Ageing Well system offer.

Working in multidisciplinary teams at place or neighbourhood level considering the vision set out in the Fuller Stocktake

To enable delivery of the outcomes and the system desire to achieve transformational change across all services there has been a decision to work towards alignment of services to the Primary Care Network (PCN) footprints. This will allow staff to be part of the network and to understand the needs of the population, working within their network to achieve tailored health and social care. This has meant reorganisation within our statutory partner services and commissioning structures as well as re-procurement of services from independent sector providers such as home care and care home packages to align with the PCN boundaries.

The first stage of the process has been to align the teams within SCC delivering social work provision, enablement services, Short Term Intervention Team (STIT) which delivers reablement, care home support teams to PCN or neighbouring PCN areas, depending upon the volume of workload in each network. This is being enhanced by on-going work to build stronger relationships with GP practices and the social prescribing and ARRS roles within their staff. This will also allow previously generic citywide teams to be more tailored and specialised to the needs and outcomes expected within each network.

Our model for support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence

Our collective ambition across health and care services in Sheffield is to prevent admission and readmission to hospital where possible so that individuals can live independently and well at home. Prevention is our preferred and local approach in Sheffield.

Where individuals do require a period in hospital our collective ambition in line with the introduction of the Health and Care Act 2022 is that we make discharge personal where individuals and their families have good experiences during their stay in hospital, experience a positive, safe, and timely discharge and feel involved in planning for discharge.

Partners across the city agree on and are committed to the principle of 'home first' and optimising on-going care and support through timely out of hospital assessment. To continually improve our delivery of services, a partnership approach has been adopted across Sheffield, reflected through our approach to Adult Health and Social Care Strategy, Delivery Plan Better Care Fund, Tackling Inequalities and Improving Outcomes, the Future Design of Adult Social Care.

Various programmes of improvement work to support integration have taken place over recent years and in February 2020, approval was given for the redesign and transformation of intermediate care and new models of care to support care outside of hospital. Subsequently, approval was provided in February 2023 by the Adult Health and Care Policy Committee to undertake a further review of the model and improvement plan. The link to the report is here: https://democracy.sheffield.gov.uk/documents/s57438/8.%20Report%20to%20AHSC%20Committee%20-%20Hospital%20Discharge%20and%20Urgent%20Care%20Delivery%20Plan.pdf.

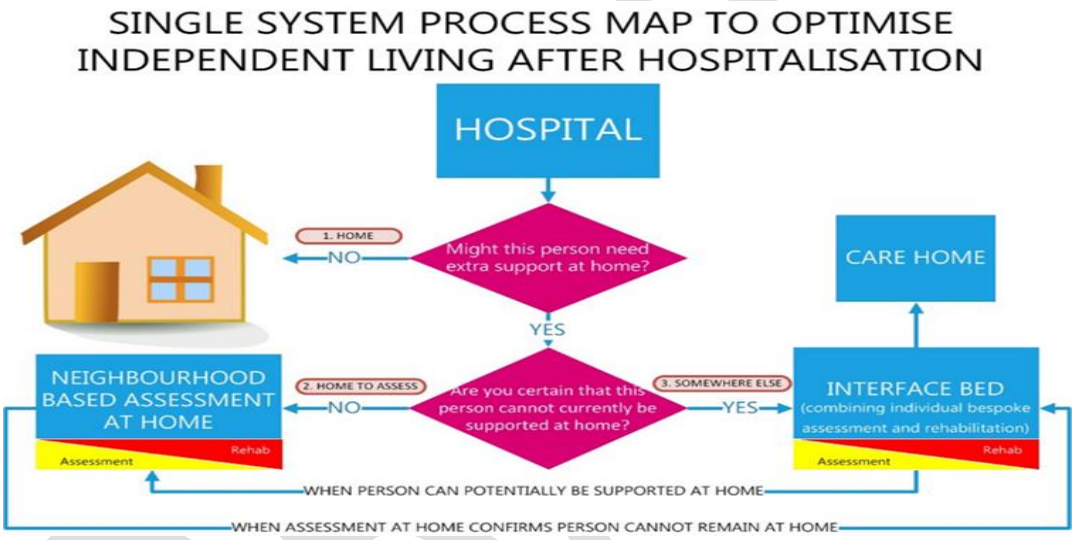
Our Sheffield Discharge Model – A New Systems Approach

As a partnership across Adult Care, Sheffield Teaching Hospitals, Sheffield Health and Care Trust and Sheffield Place Integrated Care Board we are working to understand our performance, demand pressures and have agreed a model which will enable people to return home from hospital when they are well. The Sheffield Health and Care Board received the Approach-to-Discharge-Pathways-Redesign.pdf (sheffieldhcp.org.uk) that provides an overview of the discharge work.

Under the model a minimum of 95% of people over the age of 65 who are admitted to hospital would be able to go home with:

- Pathway 0 – a minimum of 50% able to go home with minimal or no support, led by Sheffield Teaching Hospital;
- Pathway 1 - 45% can go home with support from community service (social care/health), led by Adult Care;
- Pathway 2 – around 4% will need short term rehabilitation in a bedded setting (step down) led as a partnership between Sheffield Teaching Hospital, ICB and Sheffield City Council;
- Pathway 3 - only 1% should require long term residential or nursing care home.

Similar work has been done before within frailty within the Right First Time Programme and demonstrated that it can be done with impressive results and as then, this will require system wide support; recognising that the benefits if we get it right are many and widespread. Previous learning has demonstrated that the importance of eliminating the "queue" cannot be overestimated if we are to realise all the benefits associated with the D2A model.
The model is depicted below:



Appendix 1 - New Discharge Model.pptx

A key element of the new model is about increasing social care community capacity to enable pathway 1 to be realised effectively. To this end, NHS England Capacity Modelling Guidance was used as a reference to inform development of a sustainable position and a two phased approach towards increasing and right sizing community capacity to effectively enable timely discharge + referencing the capacity and demand modelling.

To enable effective governance arrangements, the following have been put in place as below:

- Joined Up Governance - Strategic governance and scrutiny will be undertaken through the Adult Health and Care Policy Committee and the Health and Care Partnership. Tactical and operational oversight arrangements are in place to enable local collaboration and delivery upon the model.

- Joint Action Plan – A joint action plan to enable implementation of the new model. It's aimed that this will also act as our winter plan to enable timely and effective preparation for winter 2023.

- Joint Monitoring and Management of Risk – our joint governance and oversight of the action plan will enable us to jointly manage the programme and financial risks, particularly if homecare hours required for discharge exceed the 34,000 hours funded by Sheffield City Council per week.

- Joint Up Leadership - A joint leadership post has been established between Sheffield City Council Adult Care & Sheffield Teaching Hospital to build capacity to implement our new model and establish a shared leadership approach to discharge across the City. This post is funded by Sheffield Teaching Hospital.

- Moving Assessment into Community – Redesign of pathways and service delivery in our Care & Wellbeing Services to enable assessment to take place in the Community, streamline pathways and ways of working and establish a homecare provider collaborative of commissioned and council run homecare to utilise our community-based support effectively and efficiently.

Challenges

The challenge to maintain and increase capacity in care to meet demand have been exacerbated by the pandemic and the ongoing challenge of managing IPC in both acute and community settings temporarily impacts on flow due to the closure of wards and community settings.

Over the past year the homecare market both internal and external to the council has undergone a period of transformation, which has increased the number of hours available from council services by 500 from January 2023 and stabilised the homecare market in advance of a new ten-year enablement focused contract going live from September 2023. Alongside this, resources have been put in place in relation to care at night and assessment and care management which has also led to a reduction in delays for those reasons and waits for access to services.

Whilst most patients admitted to hospital return home with no additional support, some people including our frail and vulnerable and those with specific physical and mental health conditions do require additional care and support to return home. This can come from a range of services such as short-term support with rehabilitation at home or in a care setting, help to recover and or help to adjust following a period of ill health.

The resources and processes required to provide an assessment at home on the day of discharge and provide the right level of care and support short term at home in the model proposed will require additional resourcing to meet the targets proposed. Currently packages of care must be determined and secured whilst someone is still in an acute setting, with the assessment taking place in the days following their discharge.

The ‘Assess to Discharge’ approach means that there are delays whilst a date to return home or move on is secured, there is then the potential for over subscribing the type or level of support required and an overreliance on statutory support. If support is not reviewed within the days or first couple of weeks this can build a reliance of a service for the wrong reasons.

As a system we are currently faced with several challenges when trying to discharge people who require additional support:

- We have delays within discharge pathways that mean people are unable to be discharged in a timely way when they no longer require an acute bed;

- There are process inefficiencies in the system which means that individuals referred to community services are not ready for discharge, which loses homecare hours to the system;

- These delays and inefficiencies mean people do not have positive experiences of discharge and this in turns impacts on our admission to hospital settings;

- Delays within hospital pathways mean that discharge cannot be proactively planned accurately;

- Lack of confidence – historical lack of trust and confidence across community and acute staff, which then impacts on integrated operational activity and working;

- Lack of proactive planning of discharge results in lack of timely communication to community providers regarding capacity/resource requirements which in turn results in further delay.

As a result of the issues outlined above, the system is allocating very significant amounts of additional resource to support "holding" patients in the wrong setting, which creates a high risk of deconditioning and deterioration in our most vulnerable jeopardising their ability to return home, demoralises our extremely tired and stretched workforce and provides a poor experience for patients and their families.

Adult Social Care discharge funding

The funding, £7.172m in 2023/24 and indicatively £11.787m in 2024/25, has been included in allocations at commissioning organisations to allow longer term planning, support recruitment which enhances capacity, and to add to overall stability while discharge pathways are reviewed, redesigned, and simplified to allow activity flow across the health and social care system.

The schemes implemented with non-recurrent funding during 2022/23 were wide ranging and used as a test of change for all areas where the population could experience a breakage in the discharge process resulting in a delay in returning to their usual place of residence.

The initial planning for 2023/25 builds upon the appraisal of these schemes but is more focused into areas which support the overall longer-term redesign of pathways. This includes identifying funding of £2.2m for homecare packages and support assessors and reviewers to provide additional capacity and stability to hospital discharges during the implementation of the new contract where existing clients will be transitioning between Providers.

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High Impact change model

The high impact change model has been updated and is attached below:

High Impact Change Model Action planning