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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Sandie Buchan, Director of Strategy – Sheffield ICB, Alexis Chappell, Director of Adult Health and Adult Social Care
Date:	29 June 2023
Subject:	Sheffield's Better Care Fund 22/23 Q4 and 23/25 Plan
Author of Report:	Martin Smith – Deputy Director Planning and Joint Commissioning

Summary:

Better Care Fund 22/23 – End of year template submission – 23 May 2023

The BCF 22/23 end of year reporting template was published 20 March 2023 and was required to be completed and signed off through the Board by 23 May 2023. At the Health and Wellbeing Board meeting 30 March 2023 the Board agreed that the Chair, Director of Adult Health and Social Care and the ICB Director of Strategy could sign off the BCF 2022-23 Year end template before the next meeting in June 2023 to meet the national timeline.

Approval was received on 23 May and the end of year template was send to NHS England. The end of year template is attached for information and a summary of the metrics is included in the paper.

Better Care Fund 23/25 – Planning and Narrative Plan submission – 28 June 2023

The BCF Planning Requirements and BCF Policy Framework for 2023-25 were published on 4 and 5 April 2023. The Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations. Mental health, learning disability and autism continue to be an integral area of the BCF and should be considered on an equal footing to physical health.

The Better Care Fund 2023-25 maintains the two primary objectives:

1. Enable people to stay well, safe and independent at home for longer:

2. Provide the right care in the right place at the right time:

A new 2-year plan was requested by 28 June. Due to the timescales an extra ordinary Health and Wellbeing Board Briefing session took place on 16 June 2023 to update members on the requirements of the Better Care Fund Planning Guidance 23/25. The draft plan was shared with members for comment following on from the update briefing. The plan was formally approved by the Chair on 27 June 2023 and submitted to NHS England on 28 June to meet the national timelines.

Questions for the Health and Wellbeing Board:

N/A

Recommendations for the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

1. note the submission of the 22/23 Better Care Fund Year End Template;
2. note the submission of 23/25 Better Care Fund Plan

Background Papers:

Better Care Fund Planning Guidance 23/25
Policy Guidance
My presentation to members
Year end template

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

- **Living Well**
  - Everyone has access to a home that supports their health

- **Ageing Well**
  - 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

Who has contributed to this paper?

Both Sheffield ICB and the Local Authority have contributed to the production of this document.

BETTER CARE FUND PROGRESS UPDATE

1.0 SUMMARY OF BETTER CARE FUND 22/23 and 23/25

As part of the Health and Wellbeing Board's statutory duty to encourage integrated working between commissioners, the Board has a role to oversee the Better Care Fund. On 23 May the 22/23 end of year template was send to NHS England. The end of year template is attached for information and summary in the report.

A new 23/25 2-year plan was requested by 28 June. System partners. Due to the timescales an extra ordinary Health and Wellbeing Board Briefing session took place on 16 June 2023. The draft plan was shared with members for comment following on from the update briefing on the requirements of the Better Care Fund Planning Guidance 23/25. The plan was formally approved by the Chair on 27 June 2023 and submitted to NHS England on 28 June to meet the national timelines.

The plan builds on 22/23 assured plan that was approved by the Board Chair in September 2022, noted by the Adult Health and Social Care Policy Committee in November and formally approved by NHS England on 6 January 2023.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

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

2.1 Better Care Fund Metrics – 22/23 Q4

The Better Care Fund plan was required to include stretching targets for improving outcomes against four metrics which are set nationally. The metrics are:

1. Proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)

2. Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes)

3. Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital for conditions that can typically be managed in a community setting)

4.	Improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence)

2.2 Performance against metrics 22/23 – Year End

The Sheffield Better Care Fund plan meets all national conditions and the end of year performance figures show that we meet 3/4 of the metrics.

Proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)

Actual 85%
Target 80%

This target was achieved through joint working with Sheffield Teaching Hospitals on timely discharges from hospital into reablement and intermediate care services and expanding our reablement capacity to support independence at home.

Older adults whose long-term care needs are met by admission to residential or nursing care

Actual 686
Plan 710

Team continue to review the appropriateness of every admission as part of the care reviews undertaken via Theme 4 On-Going Care. Sheffield teams are also increasing the number of planned reviews which will help prevent escalation of needs and admissions to care homes.

Unplanned Admissions

Actual 981
Plan 894

The 981 year end figure was around 10% higher than our planning numbers the increase was attributed to post-pandemic long covid impact. Teams continue to do Primary Care Networks and Community Services continue to work collaboratively to ensure people stay independent and support them to self-care through social prescribing and ensure conditions are managed in communities.

Proportion of people discharged home

Actual 97.8%
Plan 96.9

Sheffield is demonstrating a Home First approach shown through the current figures (98% of people going home).

2.3 Better Care Fund 23/25 Plan

On 4 April 2023 the Department of Health and Social Care published the 2023 to 2025 Better Care Fund Planning Requirements setting out the core requirements included the development of a narrative plan explaining current programme delivery against local objectives, explanation of local structures and governance and confirmation of agreed expenditure in compliance with the requirements of the fund.

System partners have supported the development of the attached plan that was submitted to for NHS England feedback on 23 May. The draft was shared 13th June at the Health and Care Partnership Board for noting and comment. The final plan incorporated all changes from NHS England and wider partner feedback.

The Plan for 23/25 includes over £493m of services commissioned and delivered locally. The Sheffield Better Care Fund plan continues to be co-produced by the Sheffield Place of South Yorkshire ICB and Sheffield City Council with system partners including Providers across the Health and Social Care sector, Voluntary Community and Social Enterprise Sector representatives and Local Authority wider than core adult social care areas including Locality Teams, Housing and Disabled Facilities Grant 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 which 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

The plan's submission date was 28 June 2023. Due to the timescales an extra ordinary Health and Wellbeing Board Briefing session took place on 16 June 2023. The draft plan was shared with members for comment following on from the update briefing on the requirements of the Better Care Fund Planning Guidance 23/25. The plan was formally approved by the Chair on 27 June 2023 and submitted to NHS England on 28 June to meet the national timelines.

The plan builds on 22/23 assured plan that was approved by the Board Chair in September 2022, noted by the Adult Health and Social Care Policy Committee in November and formally approved by NHS England on 6 January 2023.

4.0 WHAT NEEDS TO HAPPEN TO MAKE A DIFFERENCE IN THIS AREA?

The Better Care Fund plan and programmes are aligned to deliver the Shaping Sheffield vision of "Prevention, well-being and great care together", acknowledging that housing and the local community are an important factor to achieving this ambition.

5.0 QUESTIONS FOR THE BOARD

N/A

6.0 RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. note the 22/23 end of year BCF

2. note the 23/25 Better Care Fund Plan

Sheffield Better Care Fund 2023/25

Executive Summary

The Better Care Fund (BCF) is a key enabler in taking forward joint commissioning between health and social care in Sheffield and since its implementation has continued to evolve with the needs of the Population to include over £493m of services commissioned and delivered locally. The Sheffield Better Care Fund plan continues to be co-produced by the Sheffield Place of South Yorkshire ICB and Sheffield City Council with system partners including Providers across the Health and Social Care sector, Voluntary Community and Social Enterprise Sector representatives and Local Authority wider than core adult social care areas including Locality Teams, Housing and Disabled Facilities Grant 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 which supports our ambitions for every adult in Sheffield to have:

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- The end of their life with dignity in the place of their choice

To enable the successful delivery of our plan we continue to build upon our system working as part of the Sheffield Health and Care Partnership, https://www.sheffieldhcp.org.uk/, which allows Sheffield to engage 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. The Office for Health Improvement and Disparities – Health Intelligence Pack for Health Improvement (OHID) shows 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, including paid and unpaid carers.

The OHID pack also shows the main population risk factors for the population are smoking (13% of the adult population in 2022), and excess weight (64% of the adult population were overweight or obese in 2022). Risk factors vary significantly across the city and across different groups – for example, 55% of inpatients which pass through Sheffield's mental health wards smoke, rising to 80% of those in secure facilities. Although 25% of adults in Sheffield are obese, this rises to 40% for people with schizophrenia. 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 outcomes and ease the pressure on local health and social care services.

The diagnosed prevalence of CVD conditions including hypertension, coronary heart disease, stroke, diabetes, and chronic kidney disease show many the population are affected, yet only 15% of the eligible population have taken the opportunity to undergo an NHS Health check.

The scale of mental and emotional health and wellbeing needs in Sheffield is great. Within the Sheffield population 138,000 children, young people and adults will experience a mental health problem each year. 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 is 63%, which is over double that of the general population at 25%. There are approximately 5,500 people diagnosed with a severe mental illness in the Sheffield Population.

In addition, there are approximately 6,000 people living over the age of 65 years with dementia in Sheffield, and approximately 140 people with young onset dementia under 65 years. Work programmes are focused upon targeting risk factors, (such as smoking, blood pressure and obesity), which over people's life course could delay or prevent 40% of dementia cases, which not only improves life outcomes but would reduce the economic costs of dementia that is greater than that of cancer and heart disease combined. For example, Sheffield recently won an LGC award in the Public Health Category for the Tobacco Control Strategy, with note made of locally reallocated resources used to deliver more upstream interventions alongside core smoking cessation services. There was recognition for how the service influenced national policy and was shown as best practice of the impact of shared resources with the sector.

Sheffield GP registers record 4,714 people of all ages with a Learning Disability diagnosis. The true level of need is expected to be higher with the Sheffield Joint Strategic Needs Assessment showing the number of autistic people in Sheffield is unknown and impossible to accurately quantify but could be estimated to be between 8,500 to 20,000 people across all age groups.

For the older age groups, social isolation and loneliness is 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 2022 survey looking at the social care sector 37% of older people in receipt of social care services described themselves as not having as much social contact as they would like and regularly experiencing loneliness.

Elderly care is increasing in complexity with the local health and care services under pressure to meet need. Many older people experience multi morbidity in their health and care needs which not only increases demand on health and care services but reinforces the need for joined up care and making every contact count. The Sheffield model aims to develop preventative services alongside management of existing long-term conditions to prevent premature mortality in this cohort of the population.

While access to health and care is key to ensuring a healthy population the determinant of health in Sheffield, for example, poverty, inequality, education, work, family life also have an impact on life outcomes. A people-centred primary health and care system, including general practice at its heart, can make a significant contribution to health improvement, especially when economic resources are constrained.

Our Approach to delivering Integrated Health and Social Care for the Sheffield Population:

Sheffield continues to design and deliver a jointly commissioned experience for delivering and accessing health and social care services. This is important for the Population and the staff within the sector. Examples of how this is being achieved include:

- redesigning social work teams aligned to older person services within the city including Primary Care Networks and care home / support living teams with linked workers.
- designing and implementing a shared mental health pathway which will ensure the resources and infrastructure are available to deliver timely access to health and social care interventions at the point of need and prevent crisis.
- implementing a multi-agency safeguarding hub for adults.
- building upon existing discharge plans to develop new pathways designed to relieve the pressure upon general hospital beds, including discharge hub and joint escalation routes.
- Increasing the number of joint roles including a senior post with overall responsibility for discharge and flow.

As part of the On-Going Care BCF programme Sheffield is undertaking a joint strategic review of the city's care home market with a view to enhance the framework, considering the associated approach to workforce recruitment / retention.

The wider Sheffield system partnership has recently led developments around trauma informed care across the organisations, creating a common language and approach which is embedded within all our joint work. To support the workforce with this ambition the system offers training in large scale change and a joint leadership development scheme, helping current and future leaders solve system-wide challenges while building long lasting relationships and new networks.

To meet the rising challenges of multi-morbidity and the ambitions of the Joint Forward Plan Sheffield is working to address service duplication and underlying inefficiency in a very rigorous way to enable investment to be released to preventative and "left shift" measures. The Hewitt review makes a strong case for a greater focus on prevention, calling for a shift in resources to support this. A specific recommendation within in the review stated that ICS budgets should aim to increase spend on prevention by at least 1 per cent over the next 5 years, as well as focus the increase in the public health grant allocation in this area. Sheffield is learning from national best practice that addressing health inequalities can only be achieved through ensuring all decisions taken around the use of resources within the Health and Care system make a positive impact upon reducing inequalities.

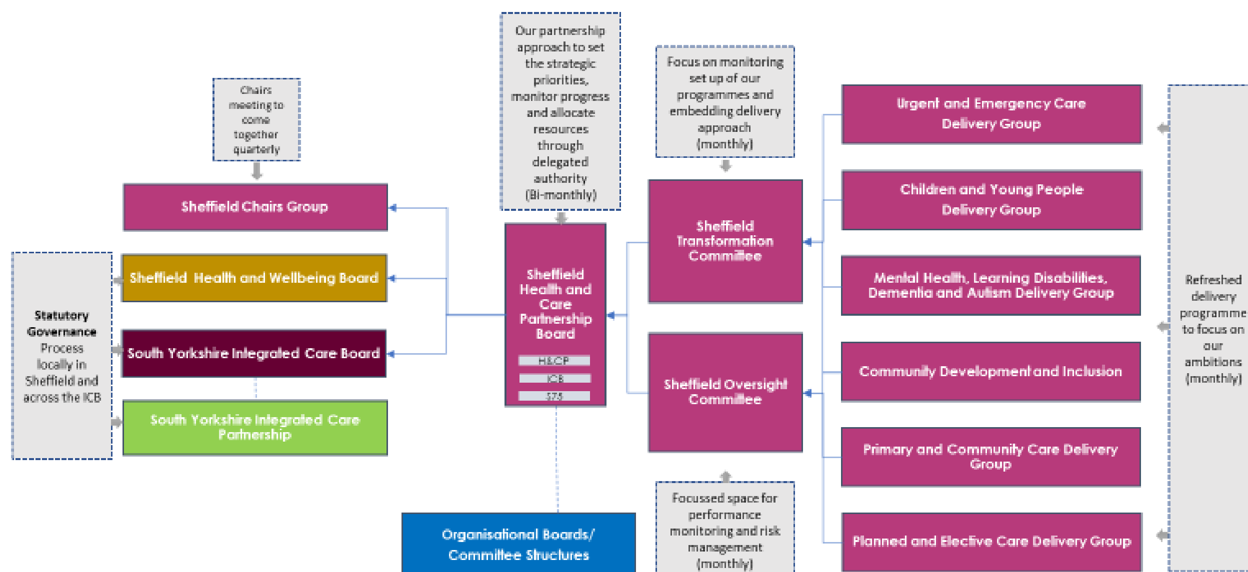
Governance and Oversight of the Sheffield BCF Plan:

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 local recovery plans. The plan also supports the South Yorkshire Integrated Care Partnership Strategy and South Yorkshire Joint Forward Plan deliverables.

To meet the requirements of the change from CCGs to a Place Led ICB, and the move from a Local Authority with a cabinet to a committee structure, the governance structure in place has been revised during 2022/23 with the aim of empowering partnership working and enhancing the transparency of decision making.

The diagram below gives an overview of the current process being tested to understand how Sheffield Place will function as part of a wider ICS in South Yorkshire.

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. The Sheffield Health and Wellbeing Board has been amended as part of the structure changes to include oversight of Adult and Children's services to support the ambition of all age pathways.

Adult Social Care Policy Committee

The new Adult Social Care Policy Committee has integrated working within its TOR, going above the previous responsibility focused upon LA services. This includes expanding their focus to include system wide targets being achieved such as hospital discharge and recognition that the whole experience of Health and Social Care is their remit. Any BCF plan and schemes have oversight and scrutiny from the Adult Social Care Policy Committee, with regular reporting, development days and briefing being provided to members.

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 focus upon priorities and appropriate use of 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 are 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. The Partnership includes Voluntary Action Sheffield, representing the VCSE sector, as equal strategic partners in the city, and Healthwatch to keep the voice of the public and patients central to our work. All 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 are governed to provide assurance of the process in place between ICB and Local Authority, delivery of the KLOE, KPIs and the BCF programmes.

The Partnership Board member organisations play an active part in overseeing and continual development of the Sheffield Place Plan. Social care is also 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 provide the right care in the right place at the right time.

The five priority areas for focus in 2023/24 are:

1. **Development of hospital discharge processes**, building on our 'home first' model 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.

More information can be found at [PowerPoint Presentation (sheffieldhcp.org.uk)]

The Sheffield Approach to Reducing Health Inequalities:

We know that people in poorer parts of Sheffield live shorter lives and have worse health from an earlier age 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 severe mental illness, learning disabilities or autism. For example, autistic adults are more likely to have chronic physical health conditions, particularly heart, lung, and diabetic conditions, despite lifestyle factors, (which increase the risk of chronic physical health problems in the general population), not accounting for this. Research through the LEDER programme has also shown that people with a learning disability and autistic people do not always receive the same quality of care as people without a learning disability or who are not autistic, and that this can contribute to health inequalities and early death.

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 as successful economies need skilled healthy people.

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. Cancer and circulatory diseases are the top contributors to the gap in life expectancy between the least and most deprived areas. The Better Care Fund programmes are enablers across health and social care with outcomes being the driver to reducing unwarranted variation.

The Race Equality Commission's Independent review into racism and racial disparities in Sheffield (June, 2022) concluded that racism and racial disparities remain significant in the lives of Sheffield citizens and that more than a 'one size-fits all' approach to tackling racial inequalities is needed across all partners. Around 19% of Sheffield population are from an ethnic minority background. They are overrepresented in many health condition groups and underrepresented in health service use, more likely to be unemployed, live in deprived areas, (38% of ethnic minority population live in the 10% most deprived areas in Sheffield), and have poorer educational attainment. The recommendations from the Sheffield Race Equality Commission are a call to action with 7 recommendations supported by Sheffield partners who have been implementing the changes with stage one being provision of the right Infrastructure to make positive changes, that are culturally and religiously appropriate. While the groundwork is time consuming it is essential to ensuring deliverability longer term.

We know that people with serious mental illnesses will die 20 years earlier than the average Sheffield population. On average men with a learning disability die 23 years earlier than men without a learning disability and for women the gap increases to 27 years. Autistic people die on average 16 years earlier than the general population. Many of these years will be within complex, expensive packages of residential care rather than how they would choose to live.

To address the challenges, we are using information about our population and trialling differential approaches to investment to address inequalities and gaps in services. For example, the People Keeping Well (PKW) BCF theme programme, lead commissioned by Sheffield City Council, is based upon a Social Prescribing community model which allocates funding using IMD scores and allows each of the 100 neighbours to design services to meet their local need. Many of the PKW services 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, seeking to avoid early involvement with services perceived to be delivered by statutory organisations. By allowing the lead to be taken by trusted partner organisations our plans and outcome metrics will create positive impact at the heart of the community by focusing upon the underlying causes of the inequity. Our emphasis upon a neighbourhood approach 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.

As articulated in the governance section of this narrative, all decisions made, including service redesign, investment decisions and resource prioritisation are assessed alongside the relevant legislative Acts, national health and social care guidance including CORE20PLUS5 targets and the local High Impact Change Model. The Place governance requires reassurance that local interpretation is applied, and all impact assessments are in place to allow fully informed changes and decision making.

Addressing poverty is not purely around financial challenges facing the Population. When more support is being provided online there must be consideration to assist those 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.

As part of our offer as a city to vulnerable people, services are being reviewed to ensure they are streamlined and that every contact counts for the person. Within this cohort of citizens prevention can be difficult as they tend to find working with services 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, with 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 ASC Discharge Funding Grant was applied to supporting those individuals who were experiencing poor outcomes following discharge from hospital and frequent readmissions by joining up our service offer, training our staff around the specific needs of this cohort, embedding VCSE workers in the acute trusts to start early support for discharge and clarifying pathways to remove confusion.

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.

The Voluntary Community and Social Enterprise Sector within Sheffield:

The Voluntary, Community and Social Enterprise sector has long contributed to reducing health inequalities and improving population health in Sheffield, with many mature organisations being long standing partners to the publicly funded organisations. 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. They provide a valuable voice to strategic decision making and to reshaping how we deliver services and reach those most at risk of poor health outcomes and reduced life expectancy.

Our VCSE Partners are key to supporting the Better Care Fund core objectives of enabling people to stay well, safe and independent at home for longer. Our voluntary sector infrastructure partner Voluntary Action Sheffield is a founding member of the Sheffield Health and Care Partnership and takes a lead in coordination for the sector when developing projects to listen, map assets, bring together people and partner organisations to develop collaborative action to deliver our shared aims.

Some of the key areas VAS are co-ordinating across the system include:

- Working alongside Healthwatch Sheffield to engage the voluntary sector in voice and representation work. Healthwatch Sheffield have been delivering their SpeakUp grant programme for over 6 years. The microgrant programme is an enabling fund for small groups and organisations to hold space to share, learn and amplify citizen voice around aspects of their health and wellbeing and how they access and engage with statutory services.

- Contributing to 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 with highest indices of multiple deprivation
- Hosting a patient journey workshop looking at service process and delivery incorporating voluntary sector stakeholders and patients
- Supporting patient by experience representatives on programme boards
- Supporting People Keeping Well lead partners with social prescribing front line worker peer support and to enhance knowledge of city-wide initiatives and developing issues including cost of living information support and education around Long Covid and support available.
- 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
- Active engagement with Sheffield's Move More Strategy, to deliver community-led physical activity initiatives with VCS organisation's working in specific places in Sheffield or with specific communities of interest.

Empowering Communities – A Model Neighbourhood Approach:

One of partnership's five main priorities is to work in collaboration across the public and VCS sectors to invest in and empower communities to bring together assets across neighbourhoods to work together to tackle the greatest deprivation and need in the city. The first stage of this work is a deeper dive into understanding the needs and assets and local VCS infrastructure in a defined place; the northeast of Sheffield, to design how targeted investment develop skills generate empowered community resilience. The ultimate aim is to build an example sustainable community infrastructure that will create health and wealth in communities for years to come and be a model to be rolled out across the city.

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. As we near the end of the identified funding period 100 mental health voluntary and community organisations are now signed up to the Sheffield Mental Health Alliance, with a representative Board established and chaired by an independent chair.

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, an understand what matters to them in their care. 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 established programme has been the development and implementation of Peer Support roles across Sheffield and on track to be in place from this Summer.

Health Creation through the Sheffield VCSE sector:

The health and care system has invested via grant into the VCSE sector, none more so than during the Covid-19 pandemic. More information can be found at the following links.

- COVID19-VCS-report.pdf (vas.org.uk)

- [Capacity through crisis: The Role and Contribution of the VCSE Sector in Sheffield During the COVID-19 Pandemic | Sheffield Hallam University (shu.ac.uk)]

Grant funding has been used to allow flexibility in delivery and commissioning in the sector. The nature of the money is short term and usually linked to specific work programmes. It is evident that through providing long term stable funding, VCSE partners can recruit highly skilled individuals and lever in other monies and assets to continue to support people, communities and green space of Sheffield. There is currently work underway to understand how contracts can be amended to retain flexibility but ensure longer term stability in the current financial environment of transformation for efficiency.

Some of the locally funded system programmes include:

- Age UK Sheffield is running nature for wellbeing sessions. These sessions provide a social opportunity for people, improving their health and wellbeing by connecting attendees and developing their knowledge and understanding of nature. One of the attendees, who lives alone, is widowed and has significantly deteriorating health, recently celebrated her 88th birthday with the other members. This lady has been part of the group for the past 2 years, including meeting over zoom during lockdown, and said that the group had been a lifeline to her over the past few years.
- Darnall Well Being, enable a Diabetes Peer Support group in collaboration with Primary Care Network specialists. This group reaches out to the community, to raise awareness and educate people to manage Diabetes. Beneficiaries and participants are from mixed ethnic backgrounds, genders and the current age range of participants is 26 to 80 years old, all of whom have been diagnosed with Type 2 diabetes or are borderline.
- Manor and Castle Development Trust, have a Men’s Group. The group is a space for men to meet and socialise, encouraging resilience and independence through experiencing a variety of activities, which range from cooking, creative pastimes, adult learning, talks around mental health, physical activities and workshops on scamming awareness.
- Zest, are supporting a Multicultural women’s group, which is co-produced with women in the local community, from a range of different ethnic backgrounds. The group have run activities ranging from crafts, meals, celebrations and had talks from local organisations, such as Shelter.
- The Terminus, have a craft group and chairobics sessions, host the local covid memorial event, have recently opened a local allotment with sessions, healthwalks in the local area, a women’s conversation club, and a growing and very successful men’s football programme via their partner, Sheffield FC.
- SOAR, in partnership with three PCNs have a team of Welfare Coaches who regularly secure significant awards and arrears for local people, a team of Wellbeing Coaches who run several social cafes, menopause cafes, exercise/gym sessions, and run a very successful annual community grants pot (Let’s Build Health grants).

Housing and Health in Sheffield:

As with all large cities the provision of appropriate housing is a continual challenge. Leaders within Sheffield recognise the interdependency between housing and health outcomes and that further action is needed to integrate housing within the health and wellbeing agendas across the city. No-one in Sheffield should live in a home that damages their health.

The housing strategy embodies the Sheffield Joint Health and Wellbeing priority that ‘Everyone has access to a home that supports their needs’.

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. This exasperates with age and existing underlying conditions. 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.

Within Sheffield 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.

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 eligibility criteria to ECO to be widened which will provide £m's of additional 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.

There are challenges accessing suitable accommodation for vulnerable adults, including those with SMI, who may present with a risk of harm to themselves or others. This contributes to challenges to supporting people to live well in the community and challenges across the UEC system.

Housing and Health for older people in Sheffield:

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 be autistic 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).

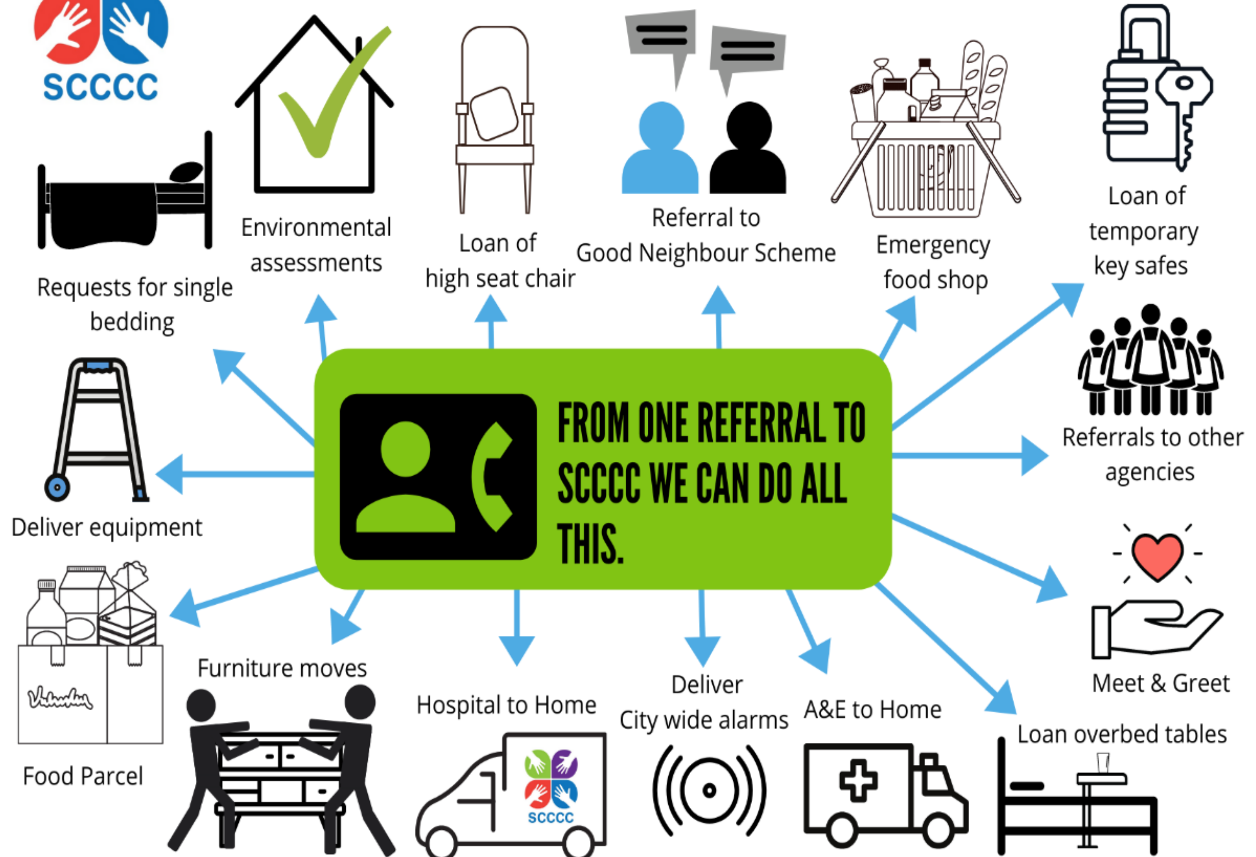
Approximately 65% of Sheffield's older population are owner occupiers, 30% rent from a social landlord and just 4% live in the private rented. Some older households live in homes which has been designed for older people, but many don't, and this is most likely in private sector homes. The disparity in 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 1,138 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.

One of Sheffield's key VCSE partners, Sheffield Churches Council for Community Care, is an multi award winning charity that has been supporting over 65's in Sheffield since the 1970's with free service to older residents who are living, often alone, in their family homes and struggle to navigate the complexity of services available.

A full list of these services can be found on their website - What we do (scccc.co.uk). Their staff include trained therapists who enable frail and vulnerable older people to remain at home and supported by their local community for as long as possible. This includes being a central signposting function to help people navigate and access the complexity of the Health and Social Care System. The following diagram explains their role for these individuals.



As part of their offer they deliver a particular scheme focused upon vulnerable older people who are unable to sufficiently heat their home details of which can be found at [Heat helpers (scccc.co.uk)].

Housing Review for vulnerable and homeless In Sheffield:

The city needs more affordable homes than are currently being built, 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. Sheffield is running a number of initiatives to wrap around services for the homeless and vulnerable including:

- Framework outreach embedded within acute pathways to support these patients at discharge
- 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 e.g., accessing / maintain health appointments on time and reduce do not attend (DNAs) and preventing admission
- Partnership work funding rough sleeper outreach nurse

Sheffield has recently been announced as one of the six locations for The Prince of Wales and The Royal Foundation's new Homeward Programme which aims to end homelessness within five years in those areas. The Prince of Wales and The Royal Foundation launch UK-wide programme to end homelessness | The Royal Family The launch of the programme began with visit by The Prince of Wales to the identified hub on the 27th June 2023.

Adaptations and Disabled Facilities Grant:

Sheffield Council is a single tier Metropolitan authority and as such has the total responsibility for the Disabled Facilities Grant which is included in Theme 7 of the Sheffield Better Care Fund Plan.

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. This team supports the core aims of the BCF and the housing strategy through physical adaptations to property such as through the installation of stairlifts, ramps, wet rooms and extensions. This can help to reduce the impact of frailty and disability and to support people to live independently. Through this type of intervention, the Disabled Facilities Grant is being used to reduce health inequalities and maximise safety and independence.

The Disabled Facilities Grant can be used across all tenures of property and is used predominantly to meet the housing needs of older and disabled people. The Adaptations Service offer advice about new build properties or schemes to ensure that they are going to meet the needs of people in the future. The Disabled Facilities Grant is used to prevent falls and prevent hospital admission and discharge which prevents decline in health and increase in care and support needs.

The adaptations team receive 5,500 applications last year which is a 22% increase in demand since pre-pandemic application levels and a reflection of the pressures within essential and core needs across Sheffield. In 2022/23 £8.3m was spent in this area, with £3m of local funding added to the DFG allocated to Sheffield. This was in part to meet the backlog in demand caused by delays during the pandemic but also driven by the increasing costs of adaptations, equipment and staffing costs.

To mitigate the financial risk a new model and ways of working are being embedded in the service to ensure it is accessible, sustainable and high quality but within the recurrent funding available. 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, 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, CherryTrees 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.
- Create more detailed property adverts which will lead to increased, and more appropriate bids by those requiring housing.
- Match properties more quickly to individuals and their needs.
- Reduce the resource time that OTs need to visit a property as the details will already be recorded.

Supporting Unpaid Carers with Sheffield:

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 and are often prioritising others above themselves.

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. The Carers' contract is within theme one of the Sheffield BCF Plan and is scheme 1 in tab 6 of the planning template.

A Delivery Plan was refreshed in 2022 to build on activities within the Carers' Strategy (please refer to 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 Covid-19 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 parents 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. Additional support via the Sheffield Young Carers' Centre was added as part of the schemes funded by the ASC Discharge Grant where a particular need to support new young Carer's following an adult was being discharge from an acute setting was identified. The scheme also included training for staff in the health and care system in how best to support the Carer.

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 meeting a network of people with similar life experiences to draw upon at the end of the sessions.

Alongside the specific services there are local options such as attendance at community groups, coffee mornings or craft clubs funded by PKW which can offer breaks in the day, help create a network of others who understand their position, or to allow carers to undertake normal activities away from their caring responsibilities. The development of community dementia services and PKW dementia link workers services have meant that there are more dementia-specific and dementia-friendly groups across the city. 937 people with dementia attended their local groups in 2022-23, with 1,580 people receiving 6-monthly dementia wellbeing / check-in phone calls.

The BCF On-Going Care Theme specifically commissioned packages of respite care which can allow a long duration vital break from responsibilities that Carers need to avoid deterioration in their own health and wellbeing. Those packages lead commissioned by the local authority, with the exception of respite packages for people with learning disabilities which are lead commissioned by ICB Sheffield Place.

Development of 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 gives Providers our intentions and standards and provides a starting point from which to engage further with our communities, and our partner organisations. This will 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 joint action to continue to secure a sustainable health and care market, and to drive improvements through a model of co-production. 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
- 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, in part funded by BAF and ASC Discharge Funding, to test new models of delivery which reduced reliance upon statutory care hours 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.

One example of listening and understand the challenges facing communities who receive home care is that of SACMHA with its primary focus in the African Caribbean community. They have worked with Healthwatch as part of a system review of Home Care from the African Caribbean Perspective. The recommendation from this review have been incorporated into the new home care model for the city.

Enabling the people of Sheffield to stay well, safe and independent at home for longer:

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):

The Sheffield Team Around the Person model has received national recognition for its ability to deliver tailored care across the pathways, from admission avoidance, living with life limiting conditions, to discharge and end of life care. 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), social care, voluntary and private organisations, 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. This integrated TAP model was designed to co-ordinate personalised support for individuals, who are involved with multiple services, and are at risk of escalating needs. It is closely linked to our mental health transformation work streams.

The TAP team are currently awaiting the outcome of being shortlisted for two national awards around innovative work in personalised care. (MJ Award and Nursing Times). This is on the back of being asked to present their work at NHS Confed EXPO Agenda (nhsconfedexpo.org).

TAP Case Study:

Introduction:
Female (30's) living with quadriplegic cerebral palsy and a severe leaning disability. Physical health needs required round the clock support including medication, nutrition and airways. Informal daily support is by her ageing parents, who have complex health needs themselves and increasingly a formal care package meets her needs, but relationships with the Provider are not ideal and the family are losing trust with statutory support. TAP services were asked to support the family in crisis and over 11 different services/agencies were involved in care.

Intervention:
The TAP service created an impartial safe space for the family to voice their concerns and design 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 understanding not just what needed to happen, but they wanted to happen.

TAP appointed an advocate focussed on her aims and objectives forming her care, including periods of respite and attendance at a day service as Carer relief. Due to the team of professionals, TAP had built she was fully supported to deal with her mother's death and grieving, including contingency for the informal support from her father. She particularly enjoyed her time in respite and had expressed a wish to live more independently longer term. With access to the right professionals and a slow build up her time in a respite facility this became her primary residence.

Impact of Intervention:
Due to TAPs intervention the 'what matters to you' personalised approach was taken, demonstrating that a change in provision would suit her needs and could be tailored to meet

both health and wellbeing needs. She now has positive relationships outside of her family dynamic and had professionals she could rely on for support of her longer term needs.

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 daughter's 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. We spoke 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".

Transforming Community Mental Health Services in Sheffield:

Throughout 2022 and 2023, SHSC and SYICB Sheffield Place clinical and operational leads have engaged with people with learning disability, their family Carers and other stakeholders to create an enhanced community model for the small cohort of people within the learning disability population with moderate to severe learning disability, alongside behaviours that are challenging to support and/or with comorbid autism mental health needs.

Analysis of admissions over the last 5 years would suggest that we may only need capacity for 1 to 2 people to be admitted to specialist learning disability inpatient provision in a 12-month period, rather than requiring the commissioned 7 bedded inpatient unit at Firshill Rise. This is a significant positive improvement compared to when there were 26 people within long stay inpatient care and 12 people in secure care at the start of the Transforming Care programme in 2015, most of whom had been there for many years, and there were frequent admissions required during any 12-month period.

Some of the reasons for this improvement and changed pattern of demand includes:

- Work through the Transforming Care Programme on admissions avoidance conducted by SY ICB Sheffield Place Commissioners/Senior Nurse Lead, Local Authority Commissioners/Social Workers and clinicians working in SHSC's specialist learning disability services.
- The implementation of Dynamic Risk Registers.
- Improved coordination and oversight of patient pathways across agencies.
- Collaborative work with Sheffield Place ICB led by the Local Authority on residential care and accommodation.

We have proposed that through investment into the clinical professionals within the specialist learning disability service, the new model will provide:

- A single pathway into one Community Learning Disabilities Team (CLDT), which will provide standard and enhanced interventions, determined by need
- A central point of access for all referrals into the service, with a greater emphasis on a coordinated community multidisciplinary team (MDT) approach to better assess and manage risk

- An improved MDT offer to stabilise and reset care plans/manage titration of medication through increased clinical and support staff, including nursing, speech and language therapists, occupational therapy, psychiatry, dieticians, physiotherapy, and other therapists
- Extended operating hours during the week with additional on call clinical advice and support over the weekends
- A more consistent application of the national programme to Stop Over Medication of Patients with a learning disability/autism (STOMP)
- The introduction of more evidence based and coproduced outcome measures
- Improved prevention and early intervention when a person with learning disability is experiencing a deterioration in their emotional wellbeing, mental health or behaviour that is challenging to support.
- Increased support available to families and paid carers to help to manage behaviour that is challenging to support without the need for the person to be removed to inpatient services

The Sheffield Ageing Well Programme:

The Sheffield Ageing Well programme runs in collaboration with Theme Two of the Better Care Fund – Active Support and Recovery and is a specific work programme aimed at the most frail and vulnerable of our current older generation. There is a focus on:

- promoting a multidisciplinary approach to care.
- 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.

To deliver these ambitions, the NHSE driven programme is split into the following three workstreams:

Urgent Community Response (UCR)
Enhanced Health in Care Homes (EHiCH)
Anticipatory Care (proactive 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 core20plus communities and inclusion groups.

Sheffield is ensuring effective waiting list 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 urgent community response, virtual wards and hospital at home, without stripping the workforce from other areas of the system where they are required.

Our joint plans include greater use of technologies to support care at home and enable independence, alongside specific work on improving access to dietetics and falls prevention.

The programme includes services that support the BCF metrics on falls such as:

- Following a successful evaluation of a Winter falls intervention, the city-wide alarms, level 1 pickup service has been extended from the beginning of May 2023 and provides a 24-hour

service to respond to the immediately fallen at home. The response team work closely with the UCR team who provide clinical support and there is a collaborative approach with Yorkshire Ambulance Service on the monitoring and evaluation of service outcomes.
- 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 Raizer 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 Raizer 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.

The Ageing Well programme has been working in collaboration with partners across all city organisations to consider the approach to Enhanced Health in Care Homes. This has included a focus on:
- Workforce development
- Hydration and nutrition support
- Management of dysphasia
- Falls - including management of the immediately fallen and falls prevention
- Management of the deteriorating individual with early identification of need.
- Multidisciplinary working
- ReSPECT planning for care home residents

The programme has sought opportunities to collaborate, including provision of training to care homes in partnership with St Luke's ECHO and Yorkshire ambulance Service. The team have also collaborated across SYICB, with sharing of practice and resources to deliver 'Good Hydration!' to care homes, reducing duplication and silo working across our footprint.

In view of personalised proactive care approaches, as well as Team Around the Person (see page 14), the programme is delivering a citywide roll out of ReSPECT personalised care planning. ReSPECT is a process that creates personalised recommendations for a person's clinical care in emergency situations in which they are not able to decide for themselves or communicate their wishes. ReSPECT plans have now replaced DNACPR in the city. This development will support ensuring that we deliver 'what matters' to an individual, ensuring they receive the care they want in the place of their choosing, where clinically appropriate. It will encourage open dialogue between health professionals and the individual, ensuring that conversations about their wider care wishes outside of DNACPR are clearly documented, improving cross organisational communication. This will potentially also reduce conveyance to hospital for care home residents, and hence reduce deaths in acute hospitals, as many may choose to have end of life care provided within their care home by people they are familiar with.

Further proactive care has been delivered via focussing on falls prevention. Work has included:
- Development of a Sheffield Falls screening tool embedded in "What Matters to Me" shared across services; voluntary, council and health.
- Development of a self-assessment falls tool that can be used by clients and staff.
- Training of staff in the voluntary sector on Falls risk awareness and self-assessment.
- Training of staff across the pathway to enable delivery of falls strength and balance programmes.
- Mapping of the current pathway for falls Rehabilitation in the city.

- Engagement with staff and residents in council housing to describing the anticipatory care needs of over 60s to prevent falls

Early falls prevention is key in order to reduce pressure on urgent response services and acute care. Following the extensive networking, scoping, and testing that is being undertaken, there is an ambition to deliver a 'Team Sheffield' falls plan by autumn 2023, for the city to consider next steps in view of Falls prevention.

The Sheffield Ageing Well programme has an emphasis on developing services, redesigning existing pathways and making embedded improvements to meet the needs of our community in a way that can be sustained beyond March 2024. Future proofing our approach to Ageing Well will need to be considered by the city going forwards to ensure we:

- Continue to build a partnership network in Sheffield, to deliver 'what matters' to our population and the workforce who serve them, ensuring an embedded structure for delivery of Sheffield's key strategic priorities today and into the future.
- By doing this we will realise the ambition to create a city collaborative that enables greater integration and therefore efficiency and effectiveness, aiming to build capability and capacity in the community across health and social care, the Voluntary Community Sector and the independent sector, in order to deliver improved quality and better outcomes for people in Sheffield.

The preventative BCF Themes, PKW and AS&R, include team which have a dual focus upon discharge support and avoidance. Flexible capacity allows the teams to meet discharge demand to enable flow as well as delivering inpatient admissions avoidance. The aim is for more upfront avoidance work to reduce the requirement for discharge interventions. Work programmes include Urgent Community Response, Enhanced Health in Care Homes and Anticipatory Care which complement the wider Ageing Well system offer. More detail can be found on the HCP website The Sheffield Ageing Well Programme - Sheffield Health and Care Partnership (sheffieldhcp.org.uk)

In addition, there has been localised short term targeted investment to support additional capacity within falls pathways, community dietetics, mental health, including advocacy support to vulnerable individuals through the advocacy hub at Citizen's Advice, and within long term condition pathways to support recovery and remedial actions required following successive lock downs through the pandemic and evidence of significant de-conditioning within some populations.

Personalised Care in Sheffield:

Our vision within Sheffield is for care to be person-centered 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 through to End of Life Care pathways.
- **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.

An example of this in action is thatthe Community Mental Health Framework sets out a requirement for us to discontinue the use of the Care Programme Approach in favour of a more person centred and flexible approach to the delivery of care. This is heavily built around the use of Patient Reported Outcome Measures which will be in place before April 2024

Personalised care examples in Sheffield:

There are some excellent examples of teams and services working in a person-centred multi-disciplinary way across Sheffield which can be seen in the narrative within this document. Other examples include:

- 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.
- 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 in individual work programmes 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 as part of the BCF outcome framework.

Working in multidisciplinary teams in Sheffield 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

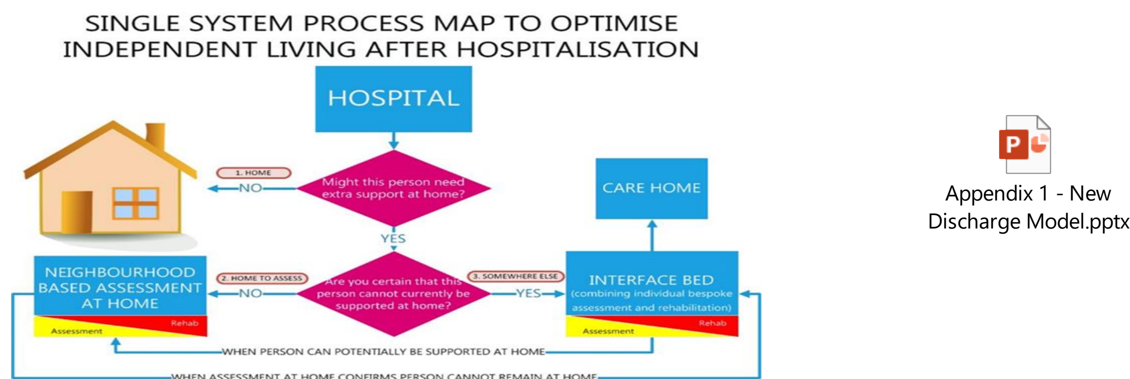
Primary Care Network (PCN) footprints. This will allow staff to be part of the network and to understand the needs of the population, working within their network to achieve tailored health and social care. This has meant reorganisation within our statutory partner services and commissioning structures 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.

Our Sheffield Discharge Model – A New Systems Approach:

Despite the transformational changes made to the Sheffield Discharge Model pathways since the start of the Covid-19 pandemic it continues to be an area of pressure for the system. To continue with this on-going process of improvement a partnership group has been established across Sheffield City Council Adult Social Care, Sheffield Teaching Hospitals, Sheffield Health and Care Trust and Sheffield Place Integrated Care Board 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 Discharge Model will apply to the needs of people across acute and mental health inpatient services. The Sheffield Health and Care Board received the Approach-to-Discharge-Pathways-Redesign.pdf (sheffieldhcp.org.uk) that provides an overview and describes our unique Place challenges, work proposed and underway.

Similar work has been done before within frailty pathways as part of 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. Initial work has been undertaken within the acute hospital with equivalent standards for mental health inpatient services at the design phase.

The model is depicted below and adapted from the model proposed by John Bolton for people over 65:



Support the redesign of discharge in the system the governance and oversight has been reviewed to ensure correct oversight by the new Place Boards and Committees. These include:

- 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 continue to exceed the national average and the funding available.
- Joint Up Leadership: A joint leadership post has been established between Sheffield City Council Adult Care and Sheffield Teaching Hospital to build capacity to implement our new model and establish a shared leadership approach to discharge across the City.
- Moving Assessment into Community: Redesign of pathways and service delivery in our Care and 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.

Capacity and Demand within the Sheffield System:

Current demand and capacity modelling includes the transformational changes in the pathways and the move towards more VCSE input into the structure. This was undertaken as a test of change during the Covid-19 pandemic and expanded using ASC Discharge Funding in 2022/23.

The focus is upon supported discharge to home with wrap around care, limiting where appropriate, bedded facilities as an alternative location which requires a secondary discharge to home.

Additional work is underway to review the requirements for winter 2023 and understand the implementation of the new home care tender and care home strategic review into 2024/25.

The key element of the redesign as described in the narrative above, and further explained by the paper which can be found on the HCP website links, is to ensure that capacity is available to meet demand and remove or reduce unnecessary delays for those waiting for care and support to leave hospital. We have embedded the learning from a number of schemes that were implemented during winter including schemes that trialled alternative support and resources where work force recruitment and retention proved difficult. This included support for people to return home building capacity within the community and the team around.

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 which will be reallocated from savings elsewhere in the pathway redesign.

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 result of the issues outlined above, the system is incurring 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.

The new model design includes a change to the central discharge hub and management structure for discharge which aims to facilitate removal of this inefficiency and streamlines people to the appropriate setting, ensuring best use of resources and maximising outcomes for individuals.

In May 2023 the Executive Leads overseeing the Sheffield Better Care Fund plan met with a team representing the Better Care Fund Support Programme who, alongside ECIST, have offered to support Sheffield with implementation of their discharge model. Potential support from the DHSC Better Care Fund Improvement Team is being scoped to understand where this resource could be beneficially deployed.

Adult Social Care Discharge Funding – Utilisation in Sheffield:

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 revised plans included within the 2023/25 BCF planning, funding identified in 2023/24, £7.172m, and indicatively £11.787m in 2024/25, has been reviewed by system partners into proposed schemes focused into areas which appraised well from 2022/23 and support the overall longer-term redesign of discharge pathways from both acute and mental health settings.

One of the reasons identified for delayed discharge and tested in 2022/23 to continue recurrently related to patients with complex medication and feeding regimes, who rely on familial carers or non-qualified care provider staff who are aren't confident to take responsibility without support. As part of this new discharge model SY ICB Sheffield Place and Sheffield City 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 to return home with their medication and specialist feeding techniques where patient safety is a concern.

High Impact Change Model for the Sheffield System:

The principles around the High Impact Change Model are embedded in all decision and discussions around system flow. The model has been reviewed, assessed and update to reflect changes within Sheffield and the wider discharge conversations.

A programme of transformation of discharge support was approved by our HCP board in May 2023 with the focus including develop of areas in our HICM which required further improvement in the previous model. The summary of progress against areas for improvement identified in 2022-23 include:

- **Change 2:** Monitoring and responding to system demand and capacity. Work has been progressed to capture capacity to meet demand across all pathways including consolidated reports which show capacity to help plan discharge dates and actions to improve delays in packages of support. The programme to transform discharge support has commenced with priority actions set out to improve capacity to meet demand ahead of winter 2023. This along with actions already in place to reduce the backlog will help ensure capacity meets demand. New governance around the remedial actions required are established with escalations and oversight via the UEC board.
- **Change 5:** Flexible working patterns. There are still challenges to fully establishing 7 day working across the system to support discharge due to variations is working patterns and hours across the range of community services. The discharge hub does operate 7 days a week, however other services are not able to yet work to full capacity and meet demand 7 days a week. As part of the development of the transfer of care hub and the redesign of discharge support being reviewed with the intention to make recommendations for improvement to support further development. Learning from

actions already implemented to improve discharges along with the recommissioning of home care, VCS support and additional resources will help progress this at pace.

The 2023/24 High Impact Change Model is attached below:

High Impact Change Model Action planning

In Summary:

The Health and Care System in Sheffield has gone through a period of change due to organisational restructures, changes within senior staffing and governance process alongside implementation of transformation programmes. The Better Care Fund Programmes and the Joint Commissioning Office Team have provided the stability to facilitate these transitions.

The initial focus has been to develop a collaborative Sheffield culture structured around communities and support for individuals, with personalisation at the heart of decisions to minimise inequalities and maximise outcomes for citizens. Individuals, as well as organisation, come together to co-produce plans as partners irrespective of their legal status or funding source. Factors wider than pure health and social care, such as housing, education and employment, are taken into account when decisions are being made.

While challenges, particularly around hospital discharge, persist in the City there has been significant progress to face the complex issues as a collaborative rather than individual elements of a system jigsaw. Rather than fire-fighting today's issues we are working to reduce inefficiencies, remove barriers and ultimately provide long term sustainable services which are future proofed to deliver best possible outcomes for our population.

Paper **B**

Sheffield Partnership Place Plan
Proposed Priorities
April 2023

Page 33

Introduction and Purpose

Purpose: To provide an overview of the **proposed** key priorities for delivery across Sheffield Place Partnership over the next 18- 24 months.

Introduction and Background

We have come together across Sheffield to review our Partnership governance over recent months. The role and priorities of the following delivery boards have also been reviewed to focus on the needs of our communities across Sheffield.

- Urgent and Emergency Care
- Children and Young People
- Mental, Health, Learning Disabilities and Autism
- Community Development and Inclusion
- Primary and Community Care
- Planned and Elective Care

In February, we came together to discuss the priorities for each of these groups, and recognised that there was a need to identify our top 5 priorities that the Partnership need to collaborate on over the next 18-24 months.

As we have been developing our plans for Sheffield, we have had the publication of the South Yorkshire Integrated Care Strategy, the launch of the 2023/4 operational planning process and the NHS joint forward plan. The Provider Collaboratives and Alliances Plans will need to be reflected through our work.

The following slides set out the proposed approach for delivering our priorities and a broader view of the work we will continue to deliver. It is acknowledged that accountability for different elements of our Place work is being led by other areas such as the Acute Federation and the Place Partnership would require sight of progress in these work programmes and how they relate to the delivery of the Sheffield Place ambitions.

We are keen that our focus continues to be on the areas which have the greatest impact for the people of Sheffield.

***Our partnership vision is** for our **health and care services** to be **integrated**, joined up, and seamless; to **reduce and remove inequalities in health outcomes and access** to support, by playing our full role as **anchor organisations** in our city, and to do all this in a way that **involves people, their experiences and our communities** at the centre of our work.*

Our vision

Sheffield Place - Strategy and Planning

Since the establishment of the Integrated Care Board and the Integrated Care Partnership in July 2022, we have been supporting the development of the Integrated Care Strategy across South Yorkshire, which provides us with a significant opportunity to drive forward our ambitions for the people of Sheffield. As we develop our Place Plan, it is important for us to consider the delivery of our broader strategy and plans as we focus our collective efforts on the key priorities, our delivery group work plans and the enablers through our framework.

South Yorkshire Integrated Care Strategy

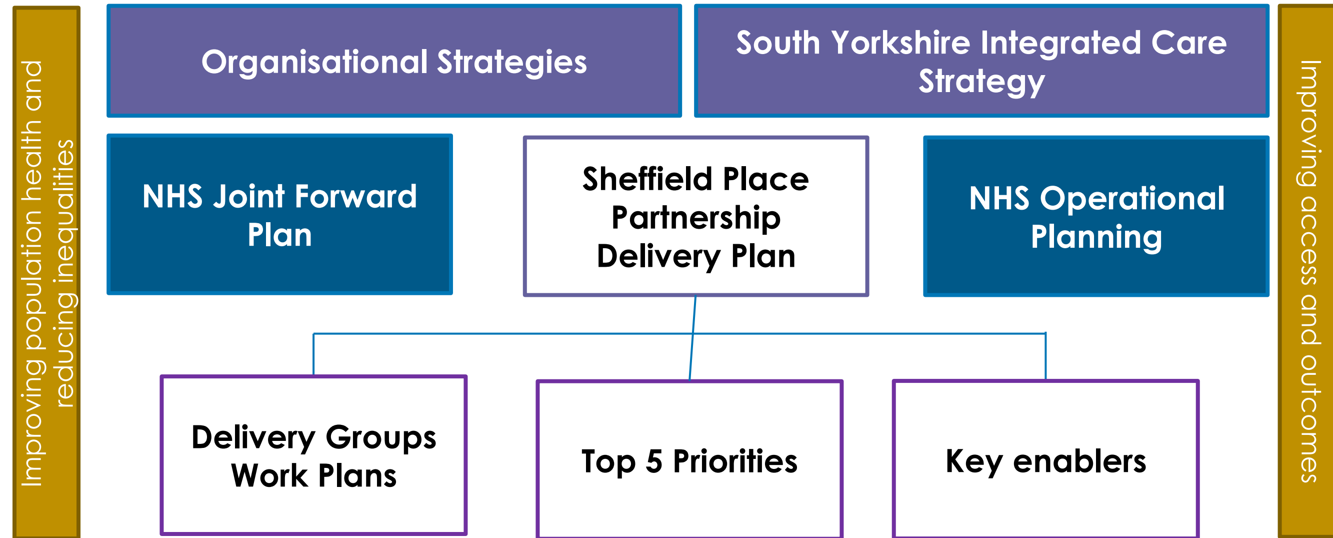
The Integrated Care Partnership, the joint committee of the ICB and Local Authorities in South Yorkshire have developed the Integrated Care Strategy where collectively we have agreed a set of goals, bold ambitions and joint commitments. This builds on our Health and Wellbeing Strategies in each of the four Places. In South Yorkshire we will continue to contribute to the delivery of these through our Place Partnership Plan.

NHS Joint Forward Plan and Operational Planning

The development of the NHS Joint Forward Plan is underway, across the ICB and Trusts across South Yorkshire, this will set out our delivery plans across South Yorkshire for the NHS contribution to the delivery of the Integrated Care Strategy. The first year of this plan will align with the annual operational plan where there is an immediate focus on improving access and quality across services.

Our golden threads

Throughout our strategy and plans we all have a focus on improving the health of our population and reducing inequalities across the city. We have as a partnership focussed on this in the development of our delivery plan, and this will be central to our approach. In developing our priorities it has been key for us to consider how we maximise our impact as a partnership for the benefit of our communities.



We have undertaken a process to develop the priorities of the delivery groups and alongside this have identified proposed 5 key priorities for the partnership. The following slides set out how we have assessed these priorities including an outline of how we would deliver against these and what success would look like.

Sheffield Place Plan - Identifying our Top 5 Priorities

To identity the top 5 priorities, we have undertaken an assessment of our key challenges and our aspirations as a partnership. Through the following lenses, this has enabled us to develop the proposed priorities, linking to a strong evidence base to support us in onward delivery.

Considerations when identifying our Priorities

National requirements and local strategies

- Focus on our role in the delivery of the 31 Operational Planning Objectives
- The development of the NHS Joint Forward Plan
- National strategies and plans for specific sectors
- Provider Collaboratives and Alliances
- Sheffield's Health and Wellbeing Strategy
- Embed the Core20plus 5 to reduce healthcare inequalities and focus on the needs of our most deprived communities

Improving performance and focussing on access and outcomes

- Focus on areas where we have long standing challenges in achieving national performance requirements and identify areas where collectively we have a role
- Specific key areas of challenge include;
  - Discharge from hospital,
  - same day access to care,
  - mental health crisis support and
  - C &YP Neurodiversity

Listening to the needs of our communities

- Focus on what have heard through listening exercise(s) to understand the needs of patients and the public
- Engagement with our diverse communities to inform and shape these priorities
- Need to actively address equality and inclusion in our work
- Help us support patients and public partners to have a meaningful and positive experience

Focus on Health Inequalities

- Assessed the population health needs of our communities
- Utilised health outcomes and wider determinant's of health as an indicator for these priorities
- Ensure we support the most deprived communities across Sheffield, with a focus on the north east of the city
- Focus on the bold ambitions of the ICP
- Embed an approach to co-produce a neighbourhood model with our communities

Partnership working

Where best we can jointly maximise our impact for the benefit of our communities

Proposed Top 5 Priorities

Discharge and Neighbourhood Home First	Same Day Access to Care	Mental Health Crisis Support	C&YP Neurodiversity	Building a Model in North East Sheffield

Sheffield Place Plan - Proposed Priorities

To support discussion, we have set out below the reasons for identifying these priorities, objectives and importantly how this will support our communities along with where we will deliver this work – across our delivery groups in some instances.

	Discharge and Home First	Same Day Access to Care	Mental Health Crisis (all age)	Neurodiversity	Building a model neighbouhood
Why is this a priority	Significant challenges in our discharge pathways which has an impact on hospital flow and patient experience.	Ssignificant challenge in levels of presentation in ED, ambulance handover delays and demand on primary care along with levels of occupied beds.	Challenges in achieving core standards due to increase in demand and presentation in ED for people in crisis that impacts on experience and outcomes and an opportunity to deliver alternative models of support.	The neurodiversity service has received more than double the number of referrals compared to 18/19 and 19/20. increasing demand which has a significant waiting time for patients.	To address the health inequalities experienced by communities residing in the north-east of the city, where we have the highest levels of deprivation and poorer outcomes
Objectives	To work together to reduce delays in discharge ,implement home first principles across the city including roll out of the optimum model for D2A, including acute, community and adult social care.	To develop a new model for same day care that delivers the national ambitions and enables our communities to access the right service based on need	To ensure there is 24/7 access to mental health crisis support for children, young people and adults	To work jointly to improve waiting times to access services as well as ensuring we have a variety of support offers for patients post diagnosis	To work with our local communities in the north east of the city to develop a neighborhood model which best supports their needs
How will this support our communities	Improve patient experience and outcomes through appropriate and timely discharge and recovery in patient's own homes.	Will result in shorter stays for patients and unnecessary delays in leaving hospital, this will also support us to improve access in ED and primary care on the day improving flow.	Delivery of a more person-centred, responsive and supportive service whilst improving the response times to age-appropriate services to those in mental health crisis	Faster diagnosis and support for children, young people and their families improving experience and outcomes.	Improve health outcomes, patient experience and the overall health and wellbeing for our local people

Delivery Groups

- Urgent and Emergency Care
- Primary Care and Community
- Mental Health, Learning Disabilities and Autism
- Community Development and Inclusion
- Planned and Elective Care
- Children and Young People

Our golden threads

- Improving population health and reducing inequalities
- Focussing on access and outcomes

Proposed Priorities: Summary of key deliverables and benefits

The following table sets out the potential deliverables and associated success measures for each of our areas.

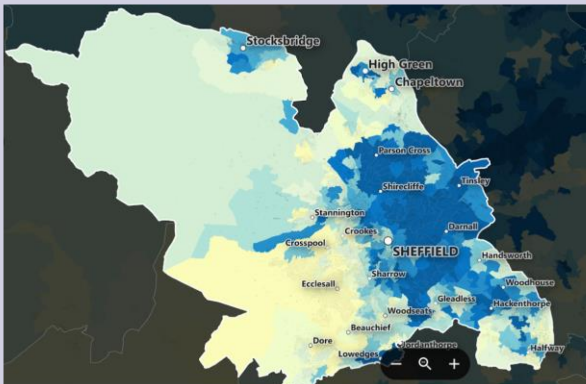
	Deliverables	Measuring success
Discharge and Home First	• Ensure all partners adopt the home first principles • Agree and deliver by November 2023 the optimum model for Discharge to assess across the city • Target investment for discharge at schemes that support and sustain sustainable D2A • Re-procure Domiciliary Care provision that supports 'independence' not 'dependence' • Increase virtual ward capacity to support discharge and avoidable admission • Evaluate and invest in Voluntary sector support for discharge where value is demonstrated.	• Increase in residents who return to normal place of residence after hospital discharge (BCF) • Increase in older people with reablement support • Reduction in length of stay in hospital (BCF) • Carers satisfaction • Decrease in unplanned admissions for chronic ambulatory care sensitive conditions (BCF).
Same Day Access to Care	• Develop a new model for same day urgent care across the city (Primary Care, Extended Access, Walk In Centre, GP collaborative, ED) • Improve navigation and signposting across the city access • Improve knowledge of urgent care pathways (staff and patient). • Improve ambulance handover processes, reducing handover delays • Work with community services to enhance opportunities to avoid admission, ensure effective use of SDEC and consider future model of SPA for Urgent Care • Ensure high quality local Directory of Service to ensure we Reduce conveyances to ED	• Improved access points to urgent care pathways across the city; • deliver and then maintain the new 2023 (ambulance handover and ED performance) • Reduction in ambulance handover delays • Patient and carer satisfaction • improving patient experience • reducing hospital admissions • Avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and de-conditioning for patients • Sustainable model of Primary care
Mental Health Crisis Response (all age)	• Reduce inequalities in access, experience and outcomes of crisis care amongst different groups, and to co-design alternative provision which is tailored to their needs and preferences • Staffing models for these types of services must include peer support workers and will require partnership with voluntary sector providers of all sizes • Development of local care crisis pathways, cross –sector.	• Improve older adults' experience and access to services • Improve access, in line with NHS standards • Increase in range of complementary services • Decrease in crisis ED attendance • Improved patient experience • Improved outcomes
Neurodiversity	• Designing an approach to Identify and assess neurodivergent people's needs in a more holistic way focussed on the whole person and embedding a personalised care model • Implement the national objective to reduce reliance on inpatient care, while improving the quality of inpatient care • Focus on developing preventative programmes of work, by co-designing with those with lived experiences and their carers • Identify alternative community support provision, building on the progress to date	• We will reduce waiting times for access to diagnostic services • Improved diagnosis rates • Increase in commissioned VCSE services for support to those with a diagnosis • Improved patient outcomes for those with co-morbidities • Improved patient and carer satisfaction
Building a Model Neighbourhood (further information slide 7)	• We will prioritise resources in the north east of Sheffield and bring partners from multiple sectors together with communities to overcome the social determinants, to improve health outcomes. • The model will be co-designed with our local communities, ensuring we are embedding their views in designing the key elements of the neighbourhood with all agencies • Initial design to be developed and continued co-design approach to be identified	This will support us to improve health outcomes, satisfaction, experience and improve the overall health and wellbeing for local people alongside addressing the wider determinants of health.

Health and Care Needs – Building a model neighbourhood

We have summarised below elements of the population health and wider determinants of health facing our communities focussing on the most deprived communities in north east Sheffield.

Sheffield Health and Care Needs

- Sheffield is ranked as the 57th most deprived local authority in England, out of 317
- Five (out of 345) lower super output areas in Sheffield are within the 1% most deprived in England, an increase from three in 2015
- Around 19% of the Sheffield population are from a BAME background
- 30% of the BAME population live in the 10% most deprived areas in Sheffield, which is above the citywide average of 23%
- The map demonstrates the **differences in deprivation across the city**, with the most deprived communities in **the east.**



Our North East Sheffield Communities

93,749 total population	**3,749 unemployed**
Diverse Population	**High Digital Exclusion Index – 35,877.2**
<50% own their own homes	**47,980** receive universal credit
High levels of reported poor health	Young population **– 25.6% aged 0-15**
Lower life expectancy	**45,406 economically inactive**

https://sheffield.communityinsight.org/dashboard/

Building a Model Neighbourhood

Our approach

- **We will co-design a model neighborhood**, working across health and care partners, to address the needs of our communities living in north-east Sheffield
- Develop a plan with associated resource allocation to drive forward our ambitions in partnership with our communities.

What Does Success Look Like?

- Improved health and wellbeing
- Happy healthy people
- Strengths based approach to co-design
- Increased levels of employment
- Supporting people to achieve educational attainment
- Supporting local businesses and drive forwards social value
- Personalised service models addressing

Embedding an approach of co-production and working together to maximise our approach to addressing the needs of local communities

Enablers to delivering our Place Plan

To support us to achieve our objectives we will require a focus across the following areas to ensure we are able to deliver the plan and the associated benefits.

Embedding a compassionate leadership model

Compassionate leadership involves a focus on relationships through careful listening to, understanding, empathising with and supporting other people, enabling those we lead to feel valued, respected and cared for, so they can reach their potential and do their best work.

The approach helps to promote a culture of learning, where risk-taking (within safe boundaries) is encouraged and where it is accepted that not all innovation will be successful, this will support us to drive innovation through the work of our teams.

Listening to the needs of our communities

As part of the Compassionate Leadership Model and through our local approach, we will build in continuous engagement and involvement with our communities to best support our work.

This will include co-production of building a 'Model Neighbourhood' and will be a focus throughout all of our delivery plans.

Across all of our priorities we have included a measure of improved patient experience, this will be key for us alongside embedding further detailed listening exercises.

Allocating resources

To be able to deliver our ambitions, we will need to address the longstanding challenges on how resources are allocated.

We have identified funding to support the reduction in health inequalities, and we must continue as a partnership to address some of our biggest challenges with the required investment to address needs of local communities.

We will co design a set of principles for how we allocate resources to those areas most in need

Focus on workforce and digital throughout all of our work

We will need to be informed by high quality, current information for each of the key areas as well as across our partnership. This includes information we hold individually as organisations being shared across the partnership, where this is helpful, along with collectively measuring our approach.

The longstanding challenges across workforce will require focussed work, and we will embed this through the development of each of our plans.

Summary and areas for discussion

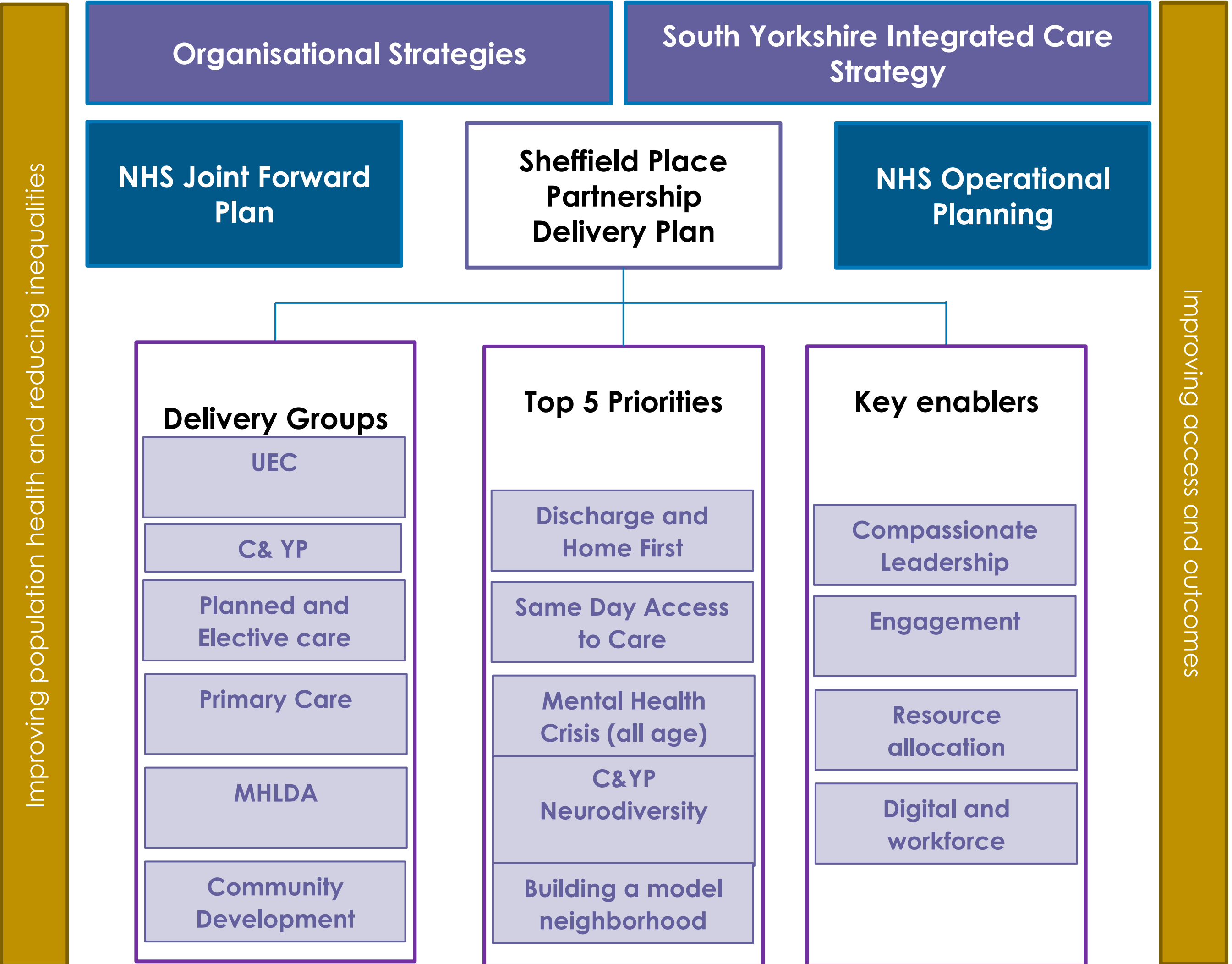
We have set out the key considerations, assessment of priorities and a summary of the areas of focus for the next 18-24 months for the Sheffield Health an Care Partnership.

Proposed next steps:

- To develop the plans aligned to each priority area and create a detailed plan alongside a plan on a page for each area
- Launch work programmes, building on the progress to date within each of the delivery groups.
- Agree periodic reporting to the board

The Partnership Board is requested to discuss the assessment of priorities and discuss:

- Consider the five key priorities and whether these are the right areas of focus for us
- Discuss the deliverables and success measures, and share comments on how we can further develop these
- Discuss the key enablers and consider agreeing to developing a detailed framework to embed these in our partnership approach



Appendix

South Yorkshire Integrated Care Strategy

As part of our role in developing the South Yorkshire Integrated Care Strategy, we have contributed to developing a series of goals, outcomes, bold ambitions and joint commitments, which all drive our collective vision. This is central to developing our Place Plan, ensuring our key deliverables support us to deliver on our ambitions.

Everyone, in our diverse communities, to live happier healthier lives for longer
South Yorkshire Integrated Care Strategy, Vision

South Yorkshire Integrated Care Strategy

Our goals

- **Healthier Life for Longer**
- **Fairer Outcomes for All**
- **Access and Quality**

Shared Outcomes

- Children and young people have the **best start in life**
- People in **South Yorkshire live longer and healthier lives** and the **physical and mental health and wellbeing** of those with the greatest need improves the fastest
- People are supported to live in **safe, strong and vibrant communities**
- People are **equipped with the skills**

Bold Ambitions

- **Early Years and School Ready**
- **Acting Differently on Prevention**
- **Fair Inclusive Sustainable Economy**
- **Value and Support our entire Workforce**

Joint Commitments

- **Bold, visible and collaborative leadership**
- **Identifying, recognising and tackling systemic discrimination including a focus on anti racism**
- **Reallocation of resources to where there is most need**
- **Joined up service delivery and support**
- **Listening and co-production with people and communities**
- **Create a culture of learning and innovation**

Our **Sheffield Place Plan**, will support us to deliver the above, as part of the **Integrated Care Strategy**, for the **local population of Sheffield**.

The above has been central to the development of our plan.

Operational Planning – Delivery focus

Area	Priority	Where
1. Urgent and emergency care*	(1a) Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (1b) Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 (1c) Reduce adult general and acute (G&A) bed occupancy to 92% or below	UEC Alliance and Places
2. Community health services	(2a) Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard (2b) Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	UEC Alliance and Places Places and Primary Care Alliance
3. Primary care*	(3a) Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need (3b) Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 (3c) Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 (3d) Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Primary Care Alliance and Places Primary Care Alliance and Places Primary Care Alliance and Places Primary Care Alliance
4. Elective Care	(4a) Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) (4b) Deliver the system- specific activity target (agreed through the operational planning process)	Acute Federation
5. Cancer	(5a) Continue to reduce the number of patients waiting over 62 days (5b) Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days (5c) Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Cancer Alliance
6. Diagnostics	(6a) Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% (6b) Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Acute Federation
7. Maternity*	(7a) Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury (7b) Increase fill rates against funded establishment for maternity staff	LNMS
8. Use of Resources	(8a) Deliver a balanced net system financial position for 2023/24	South Yorkshire CFOs
9. Workforce	(9a) Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	All building blocks
10. Mental Health	(10a) Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) (10b) Increase the number of adults and older adults accessing IAPT treatment (10c) Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services (10d) Work towards eliminating inappropriate adult acute out of area placements (10e) Recover the dementia diagnosis rate to 66.7% (10f) Improve access to perinatal mental health services	MHLDA
11. People with a learning disability and autistic people	(11a)Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 (11b) Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	MHLDA
12. Prevention and health inequalities	(12a) Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 (12b) Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% (12c) Continue to address health inequalities and deliver on the Core20PLUS5 approach	Place and Prevention Programme

- UEC Alliance
- Places
- Primary Care Alliance
- Acute Fed
- Cancer Alliance
- LNMS
- CFOs
- MHLDA
- Place and Prevention Programme