Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Integrated Care Board

Thursday 7 December 2023 at 10.00 am

Town Hall, Sheffield City Council

The Press and Public are Welcome to Attend

Membership

Councillor Angela Argenzio	Co-Chair Adult Health & Social Care Policy Committee, Sheffield City Council
Dr David Black	Medical Director (Development), Sheffield Teaching Hospitals NHS FT
Sandie Buchan	ICB Place Director - Strategy, ICB Place Committee
Lindsey Butterfield	Chief Superintendent, South Yorkshire Police
Alexis Chappell	Director of Adult Health & Social Care, Sheffield City Council
Councillor Dawn Dale	Co-Chair Education, Children & Families Policy Committee, Sheffield City Council
Greg Fell	Director of Public Health, Sheffield City Council
Councillor Douglas Johnson	Chair of Housing Policy Committee, Sheffield City Council
Kate Josephs	Chief Executive, Sheffield City Council
Emma Latimer	Executive Director for Sheffield, ICB Place Committee

Sheffield City Council

Kate Martin	Executive Director-City Futures, Sheffield City Council
Dr Zak McMurray	ICB Place Director - Clinical, ICB Place Committee
Yvonne Millard	Sheffield Children's Hospital
Megan Ohri	Partnership Manager, SOAR
Joe Rennie	Sheffield Hallam University
Kathryn Robertshaw	Sheffield Health and Care Partnership
Judy Robinson	Chair, Healthwatch Sheffield
Helen Sims	Chief Executive, Voluntary Action Sheffield
Rachel Siviter	Independent Chair, Sheffield Mental Health VCSE Alliance
Dr Leigh Sorsbie	PCN Clinical Representative, ICB Place Committee
Robert Sykes	Chief Operating Officer, University of Sheffield
Meredith Teasdale	Strategic Director of Childrens Services, Sheffield City Council
Salma Yasmeen	Sheffield Health & Social Care Trust

Sheffield
City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Integrated Care Board

Sheffield's Health and Wellbeing Board started to meet in shadow form in January 2012 and became a statutory group in April 2013. The Health and Social Care Act 2012 states that every local authority needs a Health and Wellbeing Board. It is a group of local GPs, local councillors, a representative of Sheffield citizens, and senior managers in the NHS and the local authority, all of whom seek to make local government and local health services better for local people. Its terms of reference sets out how it will operate.

Sheffield's Health and Wellbeing Board has a formal public meeting every three months as well as a range of public events held at least once a quarter.

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. http://www.sheffield.gov.uk/home/public-health/health-wellbeing-board

PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk . You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda. Members of the public have the right to ask questions to the Health and Wellbeing Board meetings and recording is allowed under the direction of the Chair.

Please see the Sheffield Health and Wellbeing Board webpage or contact Democratic Services for further information regarding public questions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Board meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last on the agenda.

Meetings of the Board have to be held as physical meetings. If you would like to attend the meeting, please report to an Attendant in the Foyer at the Town Hall where you will be directed to the meeting room. However, it would be appreciated if you could register to attend, in advance of the meeting, by emailing committee@sheffield.gov.uk , as this will assist with the management of attendance at the meeting. The meeting rooms in the Town Hall have a limited capacity. We are unable to guarantee entrance to the meeting room for observers, as priority will be given to registered speakers and those that have registered to attend.

Alternatively, you can observe the meeting remotely by clicking on the 'view the webcast' link provided on the meeting page of the website. If you wish to attend a meeting and ask a question you must submit the question in writing by 9.00 a.m. at

least 2 clear working days in advance of the date of the meeting, by email to the following address: committee@sheffield.gov.uk .

If you require any further information, please contact Sarah Hyde on 0114 273 4015 or email sarah.hyde@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Integrated Care Board

7 DECEMBER 2023

Order of Business

1. **Apologies for Absence**

2. **Declarations of Interest** (Pages 7 - 10)
Members to declare any interests they have in the business to be considered at the meeting.

3. **Public Questions**
To receive any questions from members of the public.

4. **Healthwatch Update.**
Verbal update.

5. **Better Care Fund Update.** (Pages 11 - 58)
Report of Alexis Chappell, Director of Adult Health and Adult Social Care, Sheffield City Council.

6. **Joint Strategic Needs Assessment** (Pages 59 - 74)
Report of Chris Gibbons. Public Health Principal, Sheffield City Council.

7. **Assessing Spending Decisions Against Our Strategy.** (Pages 75 - 76)
Report of Chris Gibbons, Public Health Principal (Sheffield City Council) and Jackie Mills (NHS).

8. **NHS Sheffield Neighbourhoods Work.** (Pages 77 - 90)
Report of Emma Latimer, Executive Place Director of Sheffield (ICB).

9. **Follow Up from Mental Health and CYP Workshops.** (Pages 91 - 96)
Report of Greg Fell, Director of Public Health, Sheffield City Council.

10. **Forward Plan.** (Pages 97 - 98)

11. **Minutes of the Previous Meeting** (Pages 99 - 102)

12. **Date and Time of Next Meeting**
The next meeting is on 28th March 2023 at 2.00pm, at the Town Hall Sheffield.

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its Policy Committees, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Standards Committee in relation to a request for dispensation.

Further advice can be obtained from David Hollis, General Counsel by emailing david.hollis@sheffield.gov.uk.

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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Alexis Chappell, Director of Adult Health and Adult Social Care
Date:	7 December 2023
Subject:	Sheffield's Better Care Fund Q2 Update
Author of Report:	Martin Smith – Deputy Director Planning and Joint Commissioning

Summary:

The Better Care Fund 2023/25 plan was formally approved by NHS England on 18 September (appendix 1). The letter confirmed that the relevant NHS funding could be formally released subject to it being used in accordance with the approved plan, and in accordance with the conditions set out in the BCF policy framework and the BCF planning requirements including the transfer of funds into a pooling arrangement governed by a Section 75 agreement. The Section 75 agreement was completed and agreed between Sheffield Council and Sheffield ICB on 30th October and signed 1st November (appendix 2).

Due to the delay in plan approval from NHS England they confirmed that the quarterly reporting would start from Quarter 2. The template was published on 26 September and completed and returned on 31 October to meet the national deadline following sign off from the Health and Wellbeing Board Chair, (appendix 3). A summary of the quarter 2 performance is within the report.

Questions for the Health and Wellbeing Board:

1. N/A

Recommendations for the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

1. Note the 23/25 Better Care Fund Q2 Performance.

Background Papers:

1. Approval letter
2. Section 75 agreement
3. Quarter 2 performance template
4. Changes to reporting requirement.
5. Links to ASC committee reports

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 BETTER CARE FUND 23/25

Introduction

The Quarter 2 template was approved under delegated authority and sent to NHS England on 31 October 2023. The template required refreshed estimates of capacity and demand for intermediate care for the Winter period (Nov 2023-Mar 2024) including:

- Updates to estimates of demand and planned capacity for admission avoidance and discharge support services
- Short narratives on assumptions, changes since the development of main BCF plans, data issues and support needs
- Estimated amount of capacity we expect to spot purchase to support discharge over Winter

The capacity and demand elements are within appendix 3.

Q2 Performance

National Conditions

Sheffield is meeting all the Better Care Fund National Conditions.

Metrics

METRIC	DEFINITION	Target	Actual	Narrative
Avoidable admissions	This indicator measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and high blood pressure. This outcome is concerned with how successfully the NHS manages to reduce emergency admissions for all long-term conditions where optimum management can be achieved in the community.	257	279	When setting this target there was an assumption that it would take 8 weeks to show full position from the previous year however it was double this time. Due to this delay we now believe our 23/24 plan is likely to be too ambitious and so we're unlikely to meet this target. There are a number of schemes which are now in place which should help to reduce the number of avoidable admissions. Virtual Ward provides a step-up pathway as an alternative to attending an acute provider. As detailed below the falls pick up service has been redesigned with partners to offer a 24 hour rounded service. There is some progress with UTI prevention alongside good hydration work, initially focused at care home settings, alongside MDT working with dietitians and MH support workers. Restore2 mini training for detection of residents at risk of admission has been rolled out. A proactive anticipatory care MDT and peer group is in place designed to work preventatively with the most at risk of

				admission cohort of the population around physical and mental health improvement. A TAP approach ensures a support network is in place which can be called upon by those who do not require hospital care and prevent an admission due to crisis.
Discharge to normal place of residence	% of people who return to their normal place following discharge from hospital	98%	98%	Sheffield is focused upon a home first where appropriate model, with limited use of beds for assessment when an alternative cannot be found. A review of the overall discharge model, alongside demand and capacity modelling, is underway with co-production for all partners, to ensure people are assessed and expedited to their correct onward destination with fewest interventions and the hand overs this involves. Use of integrated teams, MDT discussions and clear escalation and oversight is enabling the new ways of working.
Residential Admissions	Rate of permanent admission of older people per 100,000 population into care homes.	683	679	Historically the number of admissions to care homes has been low compared to other core cities, achieved through the principles of home first embedded within teams.
Reablement	The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation.	82%	85%	We are achieving 85% in this area with work underway to redesign the pathway 1 model for reablement to reduce current delays and increase the number flowing through the service.
Falls	Emergency Hospital Admissions due to falls in people aged 65 and over directly age standardised rate per 100,000	2023	Q1 - 541	A new model has been trialled and implemented in year which is delivering positive outcomes for individuals, as well as saving 100's of hours of ambulance crew time.• The city-wide alarms, level 1 pickup service has been extended it is in place between 8 am and 8pm and a commissioned a 24-hour service, to respond to the immediately fallen, this level 1 team feed into the UCR for clinical support and are working closely with Yorkshire Ambulance Service to evaluate the pathway. • The UCR 2-hour response team Is in place, this will 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 programe added 17 raizer chairs into care homes 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. Data has been provided by YAS on the number of conveyances and this will be assessed 3 months post training.

2.0 BETTER CARE FUND SCHEME UPDATES

There are a number of examples of great joint work being carried out as part of the agreed 23/24 Better Care Fund plan. Significant work has taken place including the Winter Planning and use of Adult Social Care Discharge to support the Better Care Fund deliverables. The Adult Social Care Directorate plan and performance demonstrate the improvement in data and deliverables. Some of the examples below highlight this work.

Disabled Facilities Grant

Adult Care administers and delivers the Disabled Facilities Grant (DFG). The Grant is provided from Central Government and is ringfenced as part of the Better Care Fund to fund equipment and adaptations identified by Occupational Therapists for people and children living in their owner occupied, private rented or registered provider homes.

On 7 September the Department for Levelling Up, Housing & Communities (DLUHC) has addressed Local Authority Chief Executives with its 2023/24 DFG grant determination letter. £50 million additional funding for the Disabled Facilities Grant (DFG), confirmed by the Department of Health and Social Care (DHSC), has been distributed and allocated imminently. Sheffield have received £445,752. The funds are being used to support the existing Disabled Facilities Grant activity delivered by the council alongside the initial annual allocation and a detailed report was provided to Adult Health and Social Care Committee on

8th November covering occupational Therapy, Adapted Housing and City and Wide Care Alarms (appendix 4).

Hospital Discharge

The grant conditions for the Discharge Fund stated a requirement for local areas to provide fortnightly reports on spend and capacity commissioned from this funding. As this funding is pooled into our local Better Care Fund plan, completion and submission of this return is a requirement of the BCF programme. Sheffield was also providing voluntary monthly reports on the total capacity commissioned for step-down services to support discharge as requested by The Department of Health and Social Care. On 3 November the Department of Health and Social Care confirmed in its letter (appendix 5) that fortnightly reporting on spend, and capacity commissioned from the Discharge Fund will now move to monthly following sector feedback.

The Urgent Emergency Care (UEC) Delivery Group has seen the following achievements:

- Early Pregnancy Pathway Unit pathway direct conveyance now live.
- The Winter Plan and Governance Structure has been taken to Urgent Emergency Care (UEC) Board and signed off on the 7th September.
- A three-month pilot beginning for direct conveyance for a specific cohort into Urology Assessment Unit.
- 111 clinicians can now refer into medical Same Day Emergency Care via Single Point of Access
- Discharge Programme Board started meeting in August 2023 with work underway in all of these workstreams to achieve the 'Home First' model for discharge by December 2023: Internal Sheffield Teaching Hospitals discharge workstream, Mental Health, Pathway 1, System Discharge Data and Information Visibility.
- Discharge "Let's Get This Right" event held 5th to the 7th of September where operational teams Active Recovery, Intensive Care, SPARC, Short Term Intervention Team, Social Care, Transfer of Care were supported to unblock any delays and understand the root causes of delayed discharges and escalate these early and appropriately. Key themes from the day's are being communicated to the Executive Team.

Mental Health

The Sheffield All Age Physical Health Strategy for People Living with Severe Mental Illness, People with Learning Disabilities, and Autistic People was approved on 20 September and aims to improve individuals' physical health through enabling people to have equitable and easy access to the activities and care they need. Key to the strategy is a partnership approach across the City, (appendix 6).

3.0 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.

5.0 Questions for the Health and Wellbeing Board:

1. N/A

6.0 Recommendations for the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

1. Note the 23/25 Better Care Fund Q2 update.

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Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added

Note on viewing the sheets optimally
To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed

National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

- *The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.*

- *At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.*
- *All information will be supplied to BCF partners to inform policy development.*
- *This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.*

		Checklist Complete:
Health and Wellbeing Board:	Sheffield	Yes
Completed by:	Martin Smith	Yes
E-mail:	martin.smith8@nhs.net	Yes
Contact number:	n/a	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Sheffield

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	

Confirmation of National Conditions

National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:
1) Jointly agreed plan	Yes	
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes	
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes	
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes	

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Sheffield

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	257.0	236.0	290.6	230.2	279.0	Not on track to meet target	We are able to replicate this measure locally although, because admission start date is used to identify admission in the SQL, we get a long tail on the data and it's taking far longer than expected for the monthly data to	There are a number of schemes which are now in place which should help to reduce the number of avoidable admissions. Virtual Ward provides a step up pathway as an alternative to attending an acute provider. As	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	97.8%	97.8%	97.8%	97.8%	97.97%	On track to meet target	It is challenging to replicate this measure locally. Queried on FutureNHS forum 6wks ago - reply 5wks ago was that they'd look into it, but still no further response at the time of submission. At present, using the national	Sheffield is focused upon a home first where appropriate model, with limited use of beds for assessment when an alternative cannot be found. A review of the overall discharge model, alongside demand and capacity	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,023.5	514.0	On track to meet target	We have challenges replicating the measure locally as validation, however based upon national data received Sheffield HWB is on track to meet this target.	A new model has been trialled and implemented in year which is delivering positive outcomes for individuals, as well as saving 100's of hours of ambulance crew time.•The city-wide alarms, level 1 pickup	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				683		On track to meet target	As an existing metric which retains the same calculation methodology we are confident with this target. The target is annually assessed and as a snapshot comparison Sheffield is reporting 684 against a target of	Historically the number of admissions to care homes has been low compared to other core cities, achieved through the principles of home first embedded within teams. Q1 23/24 = 699 per 100,000 pop (or 684 actual	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				82.0%		On track to meet target	As an existing metric which retains the same calculation methodology we are confident with this target. The target is annually assessed.	We are achieving 85% in this area with work underway to redesign the pathway 1 model for reablement to reduce current delays and increase the number flowing through the service.	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Sheffield

5.1 Assumptions

Checklist
Complete:

1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?

Plans have been revised to take into account changes in the pathway designs and better information from data cleansing undertaken as part of the process. The count for pathway 1 homecare and reablement has been

Yes

2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)

Demand:

Demand is being assumed as equal to discharge numbers from the acute providers onto each pathway and validated with pick up and referral numbers from the pathway providers, VCSE and IS as a reverse engineered c

Yes

Capacity:

Capacity is based upon volumes within contractual agreements where applicable. There is an expectation that the Providers return activity every two weeks and notify where demand is exceeding resources. A small poo

Yes

3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?

We have enhanced and expanded some of the services within pathway 0 where the greatest impact has been seen, moving from pilot to embedding longer term at the higher volumes. The complication is where multipl

Yes

4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?

Current concerns around level of sickness within service groups as we approach winter. This is being monitored and alternatives to mitigate service gaps explored. Recruitment continues to be a challenge in a competitiv

Yes

5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).

With support from an LGA funded consultant we are working through a "one version of the trust" data flow process. Sifting data into information that can be utilised systemwide. At this point data quality issues are bein

Yes

6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?

Many of our services are designed to be flexible across avoidance and discharge. Ideally the emphasis would be made as admission avoidance but given the system pressure for discharge the prioritisation moves resour

Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, please consider the below factors in determining the capacity calculation. Typically, this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to
support recovery, including Urgent Community Response and VCS support. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services."

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Sheffield

Hospital Discharge

Capacity - Demand (positive is Surplus)	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	-70	-70	-70	-70	-70	0	0	0	0	0

Capacity - Hospital Discharge

Service Area	Metric	Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing					Checklist
		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Complete:
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	273	273	273	273	273	438	438	438	438	438	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	6132	6432	6432	6432	6432	1893	1893	1893	1893	1893	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	53365	54121	54215	50201	55638	454	444	445	442	441	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	134	134	134	134	134	134	134	134	134	134	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	40	40	40	40	40	40	40	40	40	40	70	70	70	70	70	Yes

Demand - Hospital Discharge

Pathway	Trust Referral Source	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					Complete:
		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS) (pathway 0)	**Total**	**273**	**273**	**273**	**273**	**273**	**438**	**438**	**438**	**438**	**438**	
	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	273	273	273	273	273	438	438	438	438	438	Yes
	(blank)											Yes
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	(blank)											Yes
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Reablement & Rehabilitation at home (pathway 1)	**Total**	**6132**	**6432**	**6432**	**6432**	**6432**	**1893**	**1893**	**1893**	**1893**	**1893**	Yes
	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	6132	6432	6432	6432	6432	1893	1893	1893	1893	1893	Yes
	(blank)											Yes
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Short term domiciliary care (pathway 1)	**Total**	**53365**	**54121**	**54215**	**50201**	**55638**	**454**	**444**	**445**	**442**	**441**	Yes
	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	53365	54121	54215	50201	55638	454	444	445	442	441	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**134**	**134**	**134**	**134**	**134**	**134**	**134**	**134**	**134**	**134**	Yes
	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	134	134	134	134	134	134	134	134	134	134	Yes
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	(blank)											Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**40**	**40**	**40**	**40**	**40**	**110**	**110**	**110**	**110**	**110**	Yes
	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	40	40	40	40	40	110	110	110	110	110	Yes
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Report to Policy Committee

Author/Lead Officer of Report:
Nicola Afzal, Interim Assistant Director Ageing Well,
Ian Menzies, Assistant Service Manager Occupational Therapy and Adapted Housing
Michelle Glossop, Service Manager City Wide Care Alarms

Tel: 0114 2053722

Report of:	Strategic Director Adult Care and Wellbeing
Report to:	Adult Health and Social Care Committee
Date of Decision:	8th November 2023
Subject:	Occupational Therapy, Adapted Housing and City-Wide Care Alarms Update

Question	Yes		No	
Has an Equality Impact Assessment (EIA) been undertaken? If YES, what EIA reference number has it been given? *(1070)*	Yes	X	No	
Has appropriate consultation taken place?	Yes	X	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes	X	No	
Does the report contain confidential or exempt information?	Yes		No	X

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

*“The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended).”*

Purpose of Report:

This report provides an update regards Occupational Therapy and Adapted Housing and City-Wide Care Alarm services and the impact that has been made through the Delivery Plan agreed in November 2022.

This report details the activity underway to achieve an accessible, responsive and outcome focused equipment, adaptations service.

Recommendations: It is recommended that Adult Health and Social Care Policy Committee: • Note the Adult Health & Social Care Equipment and Adaptations and City-Wide Care Alarms performance update and progress made and notes that an Annual Report will be brought to a future Committee. • Endorse the financial recovery actions underway including a dedicated programme between November 2023 and February 2024 • Approves the updated Equipment and Adaptations Criteria. • Requests that the Strategic Director Adult Care and Wellbeing provides the Committee with updates on progress and outcomes in relation to the performance and financial spend on a six-monthly basis.

Appendices:
Appendix 1 - Updated Eligibility Criteria

Lead Officer to complete: -		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance: Kerry Darlow – Finance Business Partner Capital
		Legal: Patrick Chisholm - *Service Manager*
		Equalities & Consultation: Ed Sexton – Equalities Lead
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	
2	**SLB member who approved submission:**	Alexis Chappell – Strategic Director Adult Care.
3	**Committee Chair consulted:**	Councillor - Councillor Angela Argenzio
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	
	Lead Officer Name: Nicola Afzal Ian Menzies Michelle Glossop	**Job Title:** Interim Assistant Director - Living and Aging Well Service Interim Service Manager - Occupational Therapy and Adapted Housing Service Service Manager – City Wide Care Alarm Service
	Date: 29th September 2023	

1 PROPOSAL

1.1 Promoting and enabling individuals to live independently, safely and well at home is described in our Adult Health & Social Care Strategy which was approved by the Cooperative Executive on 16th March 2022.

1.2 As part of this Commitment, a priority is towards developing an accessible, responsive, and excellent quality Occupational Therapy and Adapted Housing Service. To deliver on the priority an improvement programme was implemented in 2022 to reduce waits whilst responding to increased demand, embed enablement, and ensuring effective pathways so that people can receive timely adaptations.

1.3 The Adaptations, Housing and Health Delivery Plan was reported to Committee in November 2022 with a further update in December 2022. Good progress has been made over the last year as highlighted in this report and this provides a foundation for further developing our Occupational Therapy and Adapted Housing Services.

1.4 Equipment and Adaptations Service Overview

1.4.1 The Equipment and Adaptations Team consists of Occupational Therapists (OT) and Occupational Therapy Assistants who visit people and complete a functional Occupational Therapy assessment to identify and recommend support people need with the tasks of daily living. The Team is all age and supports children, young adults and older adults and supports people in all types of accommodation and tenures.

1.4.2 Equipment like grab and stair rails, bath boards, stairlifts, hoists or ramps enable people to remain independent safe and well in their own homes. OT's also recommend more major adaptations such as level access showers or changing the layout of someone's home to make it easier to maintain independence for as long as possible and reduce the need for more formal care, or carer support.

1.4.3 The Royal College Occupational Therapists state that Occupational Therapy outcomes for people are maximised by early intervention within 6 weeks of people identifying an issue. Due to this, our ambition is to create a service for the people of Sheffield which works to this timescale. We believe that achieving this target will not only delivery better outcomes for people, but we will see a reduction in more expensive interventions.

1.4.3 We are ambitious in the development of the Occupational Therapy and Adapted Housing Service moving forward, recognising the enormous contribution it can make to supporting people to live as independently as possible for longer. Below are our key performance indicators in relation to Occupational Therapy assessment and the provision of equipment.

1.5 Our Performance Update

Number of people referred for equipment and adaptations (Occupational Therapy). Rolling 12 months

1.5.1 Pre pandemic the team received on average 4100 applications per year (342 per month). In 2023 we have been averaging 619 referrals per month or approx. 7,430 per annum. This presents an 81% increase in demand. The reasons for the increased demand are: -

- 21% increase from health services for occupational therapy assessments.
- 177% increase in referrals from individuals.

1.5.2 In response to the increased demand, inflationary costs, and cost of living costs set against ongoing financial pressures it has meant a focus on developing new models and ways of working to meet our ambitions of being a response and enablement focus service.

1.5.3 A programme is underway, supported by change resource and recruitment to a Principal Occupational Therapist with ambitions to complete the following over the next year:

- Building collaborative models of working and reviewing pathways with partners as a means of reducing areas of duplication.
- Implementing use 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 the Sheffield Directory.

% Equipment provided within timescale once assessment competed (Emergency = same day, Urgent = next day, standard = 5 day)

1.5.4 At August 2023, 99.7% people receive equipment within timescales. This is an increase from 98% people in 2021.

1.5.5 Equipment is provided through a provider which is jointly contracted through the Council and South Yorkshire Integrated Care Board. The Equipment Criteria was approved at Committee in December 2022 to ensure fairness and equity of approach regards provision of Equipment.

Number of people awaiting an Occupational Therapy Assessment (Based on average referral rate per month and aim that assessment completed within 28 days)

1.5.6 At the end of the lockdown in July 2021 there were over 2900 people waiting for an occupational therapist assessment some of which had been waiting for over 18 months from our Equipment and Adaptations team.

1.5.7 As of Oct 2023, there are 1300 adults on our waiting list with the majority waiting for 4 months or less. This is set against the 81% increase in demand noted above, which demonstrates the improvement activity is taking effect as our responsivity to referrals is increasing not decreasing despite increase in demand.

1.5.8 To continue to reduce waiting list so that people can be assessed within 28 days, the service has implemented: -

- Use of temporary agency support and limited overtime to escalate pace of reducing backlogs, with a target set that the waiting list will be down to 500 by April 2024. This then provides a foundation for our priority throughout 2024 to 2025 to reach a position of no waiting list.

- A new duty system where an Occupational Therapist triages each application to enable a risk-based approach to assessment and provision of equipment and to enable the high volumes of requests for smaller pieces of equipment to be responded to quickly. The duty triage system started in November 2022 has been further enhanced since August 2023 using ideas from a benchmarking exercise with other areas to inform ways this could be more effective.

- 5 additional staff have been given a development opportunity to work within the Equipment and Adaptations service using proportionate assessments to further reduce the waiting list. These staff started in Oct 2023.

1.5.9 Benchmarking other Local Authorities has evidenced that while Sheffield has a waiting list, the number of people waiting over 6 months is very low in comparison with others.

<u>% People Referred Who Need Equipment and Adaptations (Our Early Help & Enablement Offer)</u>

1.5.10. The focus of Occupational Therapy is on early help and enablement which means in practice that only 17% of people referred need adaptations or equipment and with that 83% need no further support after referral. Before the pandemic this was 11% but our assessment is that the effects of the pandemic have increased individuals need.

1.5.11 The early help offer includes the team providing a range of information and advice and early enablement interventions and practical solutions to support independence.

1.5.12 It’s planned that our responsivity increases, waits continue to reduce our focus from April 2024 is further leading and implementing our approach to enablement and independent living to support the continued shift towards earlier intervention and prevention and building a collaborative first contact model in line with our operating model agreed at Committee in November.

1.5.13 In addition, its planned to continue to implement and develop specialist Occupational Therapists working with people with dementia and people with a learning disability building on our work in delivering support to young people in transition.

1.5.14 The knowledge of these specialist workers supports better outcomes for people and a tailored response to requests from individuals and carers and builds the approach to early intervention and enablement being embedded across all of Adult Care activity.

1.5.15 The developments described within this paper support a positive staff culture – to quote staff from the Occupational Therapy and Adapted Housing service enablement and reablement work with people – is what we do. We are all committed to clearing our back logs so that we can move to an enablement way of working which enables people to achieve the outcomes and lives that's important to them.

1.6 Use of the Disabled Facilities Grant

1.6.1 Adult Care administers and delivers the Disabled Facilities Grant (DFG). The Grant is provided from Central Government and is ringfenced to fund equipment and adaptations identified by Occupational Therapists for people and children living in their owner occupied, private rented or registered provider homes.

1.6.2 The Service works closely with the Council's Housing Asset Management Service. The Housing Asset Management Service that delivers adaptations to Council Tenants is not in scope of this paper or discussed.

1.6.3 Delivery and use of the DFG is governed by legislation in the Private Sector Housing Policy, the Housing Grants, Construction and Regeneration Act 1996, the Disabled Facilities Grants Delivery: Guidance for local authorities in England (2022) and the Private Sector Housing Policy. The Private Sector Housing Assistance Policy, agreed in January 2020 and reported to November 2022 Committee provides guidance on use of the Grant.

1.6.4 *Number and amount of Grants Provided*
In 21/22 the DFG spend on Critical need Accelerated Adaptations Grants (AAG) was £400k, but this spend has now grown to £1.2 million.

Year	Number of grants awarded
2018/19	594
2019/20	578
2020/21	380 due to covid
2022/23	551
2023/24 to Oct 23	219

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1.6.5 *Number of discretionary payments provided by Strategic Director*

Year	Number of grants awarded	Number exceeding £10,000 discretion
2019/20	43	2
2020/21	280	45
2021/22	533	119
2022/23	592	81
2023/24	219	130

In addition, there have been 12 DFG grants awarded with an additional discretionary top of £20,000 to date in 2023/24 to meet needs.

1.6.6 The process for accessing an adaptation is as follows:

- An Occupational Therapist identifies the need and makes a recommendation to the DFG team for allocation.
- A visit will be made, and a means test of finances is carried out unless the applicant is a child.
- A decision about the approval of the grant and agreed work is communicated.
- Contractors are procured using the framework and a date is agreed.
- Completed work is signed off by an Officer prior to the contractor being paid.

Disabled Facilities Grant Budget Position

1.6.7 The total amount of Disabled Facilities Grant available is £6.2m this is made up of £0.65m b/f from 22/23, the 23/24 annual allocation from central government of £5.1m plus an additional £0.5m announced this summer. Spend to the end of September 2023 is £3.1m with a forecast outturn of £7.1m.

1.6.8 As reported to Committee in November 2022, the DFG team were only able to deliver critical need adaptations to children and adults during the pandemic. This subsequently resulted in both a waiting list, which is being addressed as noted above and a DFG underspend.

1.6.9 As the waiting list reduces, the demand continues to increase and building and construction costs continue to increase due to cost of living and inflationary costs, this has caused a pressure on the budget and due to this it's been important to therefore to maximise funding available through the Grant to maximise availability.

1.6.10 The DFG underspend was historically used to support the Integrated Community Equipment Loans Medequip contract to support hospital discharge, and to City Wide Care alarms to support digital transfer of alarm systems. The use of the underspend discontinued in 2022, as reported to Committee to ensure maximum funding is available.

1.6.11 Due to the budget pressure the following mitigations will be fully implemented by way of a dedicated programme between October 2023 and February 2024:

- All requests for use of the mandatory DFG grant for major adaptations which will be over £50k are subject to scrutiny by Strategic Director and Operations Director.
- The use of AAG prioritised to where the costs of providing the adaptation is less than the ongoing care costs would be.
- A review of the discretionary payments, systems, and processes to maximise use of grant and efficiency of delivery.
- A review of the joint equipment provision, systems and prescribing arrangements as a partnership with health and providers.

1.6.12 The Eligibility Criteria for Equipment and Adaptations is used to ensure equitability and transparency in provision of adaptations. The Criteria has been updated to provide clarity over funding routes and this is provided at appendix 1 for approval today.

1.7 City Wide Care Alarms Service

1.7.1 Our Emergency Care Alarm Service allows people to get help when they are in difficulty. It helps people to remain safe, secure, and independent in and around their homes. Our service provides individuals, family, and carers reassurance that if there is a problem, help is available 24 hours a day, every day. The service supports 8,107 people annually.

1.7.2 Anyone aged 18 or over who lives in Sheffield can use the service. This includes:

- older people
- people who live alone
- people who have recently left hospital
- people with a disability
- people with medical conditions

1.7.3 The service is inspected by the Care Quality Commission (CQC) and has been rated as Good. We also have accreditation through the Technology Services Association (TSA) Technology Safe Provider Accreditation and are working to become Outstanding.

1.7.4 The service retrieves and recycles equipment wherever possible and has no current waiting list of people waiting for a unit to be installed.

1.7.5 The service has developed an innovative project with Yorkshire Ambulance Service focused on emergency response and falls prevention and currently receives funding from Yorkshire Ambulance Service and ICB to deliver the programme. It’s aimed to complete a self-evaluation to provide the foundations to further build upon this programme in 2024.

1.7.6 People pay a monthly charge of £21.42. Additional sensors charged extra. There is a current customer debt of just over £250,000 which is due to rise.

1.7.7 As noted above the City-Wide Care Alarms have a £0.1million pressure as the DFG underspend is no longer used to fund the service. The service is moving from analogue to digital early 2024 which has an increased cost.

1.7.8 To mitigate this pressure, a review programme is underway to consider options to reduce this pressure which includes income generation, building on the Yorkshire Ambulance Service project which has attracted funding into the service and a dedicated debt recovery project. It's planned to bring proposals to a future committee for decision.

2 HOW IS THIS WORK CONTRIBUTING?

2.1 This work the Safe and Well and Active and Independent Outcomes that are set out in the Adult Care Strategy in several ways.

- Equipment and Adaptations delivers increased quality of life by enabling people to remain or increase independence, live safely and well in their own homes for as long as possible, plus helping to prevent hospital admissions and long-term care.
- Thriving neighbourhoods and communities as more disabled people will be able to maintain living in their own home and participate more fully in their communities.
- Better health and wellbeing as more disabled people will have the Adaptations equipment and/or assistive technology to maintain their independence and prevent ill health.
- Tackling inequalities as more disabled people can utilise Adaptations equipment and/or assistive technology to overcome obstacles and achieve their potential.

2.2 This work also supports a broad range of strategic objectives for the Council and City, and is aligned with existing policies and commitments, including:

- *Councils Delivery Plan* – Under the priority Adult Social Care.
- *Our new ASC Operating Model* - this aligns to that new arrangement by reimaging a living and ageing well service. .
- *Adult Care Workforce Development Strategy*[12]: a vision of 'developing our people in a joined-up way to deliver holistic, person-centred and integrated care'.
- *Ethical Procurement Policy*[16]*:* driving ethical standards and increasing social value for the city through procurement.

3. HAS THERE BEEN ANY CONSULTATION?

3.1 A crucial element in the successful promotion of independent living and reablement is the increased involvement in people receiving, and staff directly delivering care, in the development of all key parts of the plan.

Throughout the sector, we know that involving and coproducing these makes them more likely to be successful.

3.2 An overall approach to coproduction and involvement is also a key element of the ongoing delivery plan, ensuring that the voice of citizens is integrated into all major developments ahead.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 Equality Implications

4.1.1 As a Public Authority, we have legal requirements under the Equality Act 2010, collectively referred to as the ‘general duties to promote equality’. Section 149(1) contains the Public Sector Equality Duty, under which public authorities must, in the exercise of their functions, have due regard to the need to:

1. eliminate discrimination, harassment, victimisation, and any other conduct that is connected to protected characteristics and prohibited by or under this Act.
2. advance equality of opportunity between those who share a relevant protected characteristic and those who do not.
3. foster good relations between those who share a relevant protected characteristic and those who do not.

4.1.2 The proposal described in this report is consistent with those requirements. It aims to develop a more efficient and person-centred approach and, as referenced in the Consultation section above, to ensure citizens’ voices and experiences help to inform and develop the processes.

4.2 Financial and Commercial Implications

4.2.1 The budget for the Equipment Contract with Medequip is made up of £2.5m NHS SY ICB funding, £1.22m SCC funding and up to £2.04m of refund income for items of equipment which have been returned.

4.2.2 The budget is a risk share budget with the NHS SY ICB picking up 67% of costs and SCC picking up the remaining 33% net of any recharge to the DFG.

4.2.3 The current outturn position is that SCC is forecast to be £507k overspent at Month 6 which means the SY ICB contribution is forecast to be £1,012k overspent bringing the total overspend to in the region of £1,519k against the budget of £3.72m.

4.2.4 As mentioned, the total amount of Disabled Facilities Grant available is £6.2m this is made up of £0.65m b/f from 22/23, the 23/24 annual allocation from central government of £5.1m plus an additional £0.5m announced this summer.

4.2.5 The current forecast commitments against this capital funding is £7.1m. There is an allocation of a historic one-off Social Care Capital Grant that will mitigate this overspend. However, in future years there will only be the allocation received from government in year available to deliver against DFG works as all reserves will have been exhausted. The allocation is expected to remain at the level of 2023/24 £5.1m p.a.

4.2.6 There is already £1.7m of work identified to be funded by DFG in 2024/25. The current trend is for new requests for work to be received at a rate of £400k per month. If this level of demand continues then total costs to DFG (including staffing recharges) will be £5.5m creating a £0.4m pressure. Any increase to numbers of assessments has the potential to worsen this position.

4.3 Legal Implications

4.3.1 The core purpose of adult health and social care support is to help people to achieve the outcomes that matter to them in their life. The Care Act 2014 sets the Council's statutory power to direct the provision that:

- promotes wellbeing
- prevents the need for care and support
- protects adults from abuse and neglect (safeguarding)
- promotes health and care integration
- provides information and advice
- promotes diversity and quality.

4.3.2 Beyond the Act itself the obligations on Local Authorities are further set out in the Care Act statutory guidance issued by the government. By virtue of section 78 of the Act, Local Authorities must act within that guidance.

4.3.3 The Care Act Statutory Guidance requires at para 4.52 that "… Local authorities should have in place published strategies that include plans that show how their legislative duties, corporate plans, analysis of local needs and requirements (integrated with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy), thorough engagement with people, carers and families, market and supply analysis, market structuring and interventions, resource allocations and procurement and contract management activities translate (now and in future) into appropriate high quality services that deliver identified outcomes for the people in their area and address any identified gaps". This report evidences the continuing strategy to ensure these obligations are met within the Adaptations, Health and Housing services.

4.3.4 The proposals set out in this report will also assist the Council in meeting its statutory duty under the Housing Grants, Construction and Regeneration Act 1996. As set out in the main body of the report the Council, where the DFG statutory eligibility criteria and conditions are met, is required to pay a DFG. The guidance to local authorities also advises

that ‘Authorities should decide the most appropriate forms of assistance to best address the policy priorities they have identified.’

4.4 Climate Implications

4.4.1 The review the equipment contract will include a review of how we increase recycling of equipment and adaptations which will in turn reduce landfill and waste. No significant climate impact to consider.

4.5 Other Implications

4.5.1 From 2008-09 the scope for use of DFG funding was widened to support any Council expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). Article 3 of the RRO enables housing authorities to give discretionary assistance, in any form, (e.g., grant, loan or equity release) for the purpose of improving living conditions, allowing the Council to use DFG funding for wider purposes which may be more appropriate for individuals than mandatory DFG allows.

4.5.2 This provides an opportunity for a more flexible use of the DFG fund to address issues on a wider preventative basis which cannot be covered using the mandatory scheme. However, under the RRO, any new forms of assistance must be set out in an approved policy. The Council Assistance Policy sets out all the forms of assistance it provides under the RRO. Therefore, any assistance using DFG funding will need to be set out in the Assistance Policy.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 The alternative options considered were:

5.2 Don’t complete a delivery plan for equipment and adaptations performance and financial recovery. This would not provide the assurances required to ensure that we are striving towards a high performing and financially sustainable service.

6. REASONS FOR RECOMMENDATIONS and ONGOING APPROACH

6.1 The performance updates and focused delivery plan gives a structured approach to the promotion of independent living as well as how the service is addressing waiting lists and impact of the pandemic. It will also provide greater accountability and transparency of how we will do this.

6.2 Asking for regular updates and refreshes of the plan will keep the Committee, wider stakeholders, and the public the ability to hold the Council to account for progress and provide an additional mechanism to input to future development.

Department of Health & Social Care

Hospital Discharge Programme
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

3 November 2023

NOTIFICATION OF CHANGE TO DISCHARGE FUND REPORTING REQUIREMENTS

The Department of Health and Social Care is grateful for the key role local authorities are playing, in partnership with integrated care boards, in deploying the 2023/2024 Discharge Fund. This is enabling a larger number of supported discharges, allowing people to receive the right care in the right place more quickly.

The grant conditions for the Discharge Fund currently state a requirement for local areas to provide fortnightly reports on spend and capacity commissioned from this funding. As this funding is pooled into your local Better Care Fund plan, completion and submission of this return is also a requirement of the BCF programme. Local areas have also been asked to provide voluntary monthly reports on the total capacity commissioned for step-down services to support discharge.

We have taken note of sector feedback on the frequency of these reports and the resource pressure it puts on local areas. We have therefore decided that the fortnightly reporting on spend and capacity commissioned from the Discharge Fund will now move to monthly, aligning with the voluntary monthly reporting. The purpose of this change is to allow for greater resource for completing monthly reports on total capacity commissioned for step-down services to support discharge.

The updated reporting template will be uploaded to the Better Care Exchange as soon as possible. Please note that it will collect the same information but for the longer period of a calendar month. The reporting periods will be as follows:

Period Covered	Return Due Date
Nov-23	11-Dec-23
Dec-23	15-Jan-24
Jan-24	12-Feb-24
Feb-24	11-Mar-24
Mar-24	08-Apr-24

The last reporting deadline for the existing template will be 13 November and this will cover two weeks up to 5 November 2023. The new monthly return will cover the period of 1 to 30 November and will be due on 11 December 2023. This means the first five days of November will be double reported which is unavoidable as we make this transition.

We also intend to publish the new monthly reports every quarter, and we will confirm when this will begin in due course. Local areas should consider whether there is any commercially sensitive information in their plans and inform us if there is anything that should be removed prior to publication. We will ensure everything we publish is GDPR compliant.

If you wish to object to these changes, please do so in writing by 13 November, responding via the Better Care Fund inbox (england.bettercarefundteam@nhs.net). If we do not receive any objection by this date, we will assume you are content with these arrangements.

Kind regards,

Ben Dyson
Director, Hospital Discharge Programme
Department of Health and Social Care
39 Victoria Street, London, SW1H 0EU

Sheffield Physical Health Strategy for People Living with Severe Mental Illness, People with Learning Disabilities, and Autistic People

2023 - 2028

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To note:

There are 4,714 patients of all ages with a Learning Disability diagnosis *recorded* on Sheffield GP registers. However the actual number will significantly higher as it is estimated that approx. 2.16% of adults, and 2.5% of children, have a learning disability.

There are approx. 5,540 people diagnosed with a severe mental illness in Sheffield (excluding those in remission) *(NHS England defines 'severe mental illness' (SMI) as anyone diagnosed with schizophrenia, bipolar disorder or other psychosis or is having lithium therapy)*

The Sheffield Joint Strategic Needs Assessment states the number of autistic people in Sheffield is unknown, and could be between 8,500 to 20,000 people (all ages).

Introduction

- In 2019 Sheffield's NHS organisations, Voluntary and Community Sector partners, and Sheffield City Council agreed our first citywide Sheffield Physical Health Improvement Strategy, through which we have worked together to help people living with severe mental illness, people with learning disabilities, and autistic people to live longer and to have healthier lives.
- In 2022, we started the process of reviewing and updating the strategy. This included asking people with lived experience and their carers for their views about what has helped with their physical health over the last three years, what the challenges have been, and what the priorities for action over the next three years should be. This feedback has been through a survey on the strategy, review of recent consultations such as the Autism Strategy engagement, the Health Experiences engagement by Disability Sheffield, the "What Matters to You" engagement, and feedback from providers. It has helped to shape the ambitions in this 2023-28 Strategy.
- This document outlines our shared vision and ambitions for the next five years.
- It also includes appendices which show highlights of what has been achieved in the last three years (2019-2022) through working together across our organisations and most importantly with people with lived experience, and also our high level delivery plan.
- This strategy sits alongside a range of other related strategies and plans, including:
  - The Sheffield Mental Health and Emotional Wellbeing Strategy
  - Sheffield's Joint Health and Wellbeing Strategy
  - Sheffield's Joint Strategic Needs Assessment
  - Sheffield's Autism Strategy
  - Sheffield Learning Disability Strategy
  - Sheffield Adult Social Care Strategy
  - Learning from the Lives and Deaths of People with Learning Disabilities and Autistic People Programme
  - Start for Life Sheffield Early Years Strategy 2023-2028
  - Sheffield Special Educational Needs and Disabilities Inclusion Strategy 2020-2025
  - SCH Learning Disability and Autism (LDA) Strategy
  - NHS South Yorkshire Five Year Joint Forward Plan
  - SCH clinical strategy 2022-2027
  - The internal workplans and strategies of all partner organisations (relating to physical health for people living with severe mental illness, people with learning disabilities, and autistic people)
  - NHS England's Five Year Forward View for Mental Health

Vision

Our Vision for Sheffield is that people of all ages with severe mental illness, people with a learning disability and people who are autistic will live longer and healthier lives, because of improvements in their physical health and reduction (or early identification) of avoidable physical illness.

How will we achieve the vision?

- NHS organisations, Sheffield City Council, and community and voluntary sector partners will work together on three key ambitions (see later in document).
- At the heart of our work will be a focus on: Promotion of Wellness; Prevention of Illness; Earliest Intervention; Recovery; and, Living Well. We want to help the people of Sheffield live long, healthy and fulfilled lives.
- We will recognise that (as set out in Sheffield's Joint Health and Wellbeing Strategy) that poor health and wellbeing are inequitably distributed across our city. We also know that most of the solutions are not to be found within NHS and social care services alone.
- We will involve and listen to people with lived experience and their family carers, to ensure that their expertise and experiences influence the work that we do.
- We will connect to wider programmes and public policy which tackle poverty and inequity, such as housing, education and skills.
- We will recognise the value of the contribution made by the voluntary, community, social enterprise sector and faith and community groups.
- We will look at ways to increase opportunities for person centred care, so people will get more control over their own health and more personalised care when they need it.

Why do we need a Physical Health Strategy for people living with severe mental illness, people with learning disabilities, and autistic People?

Please note: some of the information on this page may be distressing

- These are three different groups of people, but they share inequities in terms of physical health and disparity in health outcomes. For too many people this means living for many years with a long-term physical health condition and with reduced quality of life, as well as on average a dramatically reduced life expectancy.
- Deaths are mostly from preventable causes and in part due to physical health needs being overlooked. “Diagnostic over-shadowing” can be a contributing factor through which symptoms of physical ill health are mistakenly attributed to the person’s learning disability, autism or mental illness.
- The average life expectancy for someone with a long-term mental health illness is at least 15-25 years shorter than for someone without and it is estimated that for people with severe mental illness, 2 in 3 deaths are from physical illnesses that can be prevented.
- On average men with a learning disability die 23 years earlier than men without a learning disability and for women it’s 27 years earlier.
- Autistic people die on average 16 years earlier than the general population (and more than that for people who have a learning disability).
- Research through the LEDER programme has also shown that people with a learning disability and people who are autistic 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.
- Many of those who have severe and enduring mental illness in adulthood are diagnosed when they are children or young people.
- Due to the combination of lifestyle factors and side effects of antipsychotic medication, there is a high incidence of cardiovascular disease causing premature death in people with severe mental illness (15-25 years).
- Over-prescribing of psychotropic medicines for adults and children with learning disabilities and autism leads to serious problems with physical health.
- There are higher rates of respiratory disease linked to eating and swallowing problems for people with learning disabilities, and to increased smoking rates for people living with severe mental illness. Smoking is the leading preventable cause of early death and health disparities among people with mental illnesses.

Why do we need a Physical Health Strategy for people living with severe mental illness, people with learning disabilities, and autistic People? (continued)

Please note: some of the information on this page may be distressing

- People living with severe mental illness in the UK are more likely to have common risk factors for being overweight, such as reduced access to healthy food, lower incomes and health conditions that limit their mobility. In addition, they have risk factors not typically faced by the general population, such as weight gain related to psychiatric medication and admission to inpatient wards with few opportunities to be physically active. For example, diabetes is 2–3 times more common among people with Severe Mental Illness than the general population.
- Autistic adults are more likely to have chronic physical health conditions, particularly heart, lung, and diabetic conditions, however lifestyle factors (which increase the risk of chronic physical health problems in the general population) do not account for the heightened risk among autistic adults.
- Diagnosis of dementia, hypertension and cancer is a priority within NHS South Yorkshire Integrated Care Board Five Year Plan, and the plan highlights that because people with serious mental illness and people with learning disabilities are more likely to have physical ill health, this means that early detection and prevention are key for these groups of people.
- Gastrointestinal disorders are nearly eight times more common among children with autism than other children.
- Epilepsy is more common in people with a learning disability and with autistic people than in the general population. Autistic adults who also have a learning disability have been found to be almost 40 times more likely to die from a neurological disorder relative to the general population – with the leading cause being epilepsy

- 78.5% of people on the Sheffield Severe Mental Illness register (4,348 people) had a measurement of weight/BMI in 2022/23. 80% of these (3,041 people) were identified as needing weight management support/intervention due to a high BMI.
- The prevalence of epilepsy in Sheffield is at least 2x higher for patients with autism (and no Learning Disability) than the general population, and more than 17x higher for patients with Learning Disability.
- Approx. 9.6% of people aged 14+ on GP Learning Disability registers also have a diagnosis of diabetes. 11% have a diagnosis of hypertension.

What have people with lived experience of learning disabilities, severe mental illness and autism told us?

These quotes are from people with lived experience and their family carers, shared with us through:

- Responses to our 2023 physical health survey
- The Health Experiences for people with learning disabilities and autism report (Disability Sheffield, 2022)
- Sheffield Autism Strategy consultation (2022-23)

Thank you to everyone who has contributed their views and experiences, which have helped to inform this strategy

Still particularly in the primary care sector there is poor understanding of the impact of mental illness on physical health - often things get missed because of this.

What do we need? Proactively doing a physical health MOT on those with SMI - twice a year - and chasing up those who do not come in for them. We are often too mentally ill to self-care.

Carers and family members need support and should be valued as experts and partners.

Adequate mental health care would go a long way towards improving our physical health too. Same goes for social care - e.g. forcing people to live on microwave meals of course leads to worse physical health, as does lack of support to access sport and leisure activities

I need support with exercise, like someone to go with me the first time

I need help and encouragement to go to my appointments

I have to remind people a lot that I have Autism, especially at hospital

I need targeted friendly sessions and more disabled changing facilities.

What would help me is for doctors and nurses to be trained how to cope with people with learning disabilities and autism; it would be good for doctors and nurses to know what it's like in our shoes

My daughter has not experienced any good examples of health care. She is 16 years old, has autism and it feels like the services are waiting for her to turn 18

I have no access to subsidised gyms, pools, supervised walks or anything else which is what is needed to improve my physical health, on top of my SMI and to keep my weight down.

There is an inability or unwillingness of NHS services to make reasonable adjustments for accessing medical care - e.g., long waits in intolerable environments when attending appointments, important information provided verbally only and rushed

Some examples of progress to date (and what we still need to achieve)

See appendix one for more details of progress against the 2019-2022 strategy

New health and outreach roles are providing practical support for people to receive and access health checks and support with healthy living activities (including with Sheffield Mind, Primary Care Sheffield, Disability Sheffield, Sheffield Mencap and Gateway, Sheffield Teaching Hospitals, SHSC).

Between Mar 2022 to Apr 2023, 79% of people in Sheffield with a LD received their annual health check (85% excluded declines) - a total of 3,382 people. Only 1,440 had their health check in 2018/19, so this is an increase of 1,978 people.

The percentage of people with LD aged 14+ with a Health Action Plan recorded following their health check has more than doubled over the last year. This was 84% in 2022/23 compared to 41% in 2021/22.

As at the end of March 2023, 61% of people with SMI had received their Annual Physical Health Check in the previous 12 months – a total of 3,367 people; more than three times the number of people who had their check in 2018/2019 (1,102 checks; 18.5%).

75% of people with LD had their flu vaccination in 2022-23 – compared to 58% of people vaccinated (or exempted) in 2021-22.

Approx. one third of people on SMI registers are eligible for a flu vaccination due to long term health conditions – in 2022-23, 72% received their flu vac in Sheffield - compared to approx. 63% vaccinated (or exempted) in 2021-22)

Amongst service users on SHSC's Acute Mental Health Wards, smoking prevalence has reduced from 66% in 2016/17 to 55% in 2022. *(Citywide smoking rate: 13.3%, 2022).*

Primary Care data shows smoking rates for patients aged 18+ with severe mental illness has reduced from 37.9% (2018) to 35.8% (May 2023). However, this is still much higher than the average Citywide smoking rates (13.3%, 2022).

Sheffield was successful in being awarded a place on the NHSE national project to pilot annual health checks to autistic adults. 100 health checks are being completed in 2023 in Sheffield as part of the project.

More people with a learning disability have been helped to take part in the NHS bowel and breast screening, which will reduce the risk of dying from bowel and breast cancer.

Hundreds of health and care staff have received additional training (e.g. Training for Providers in Recognising the Deteriorating Patient; LDA Speak Up training and SMI health check training for GP surgeries; Health Passport Awareness Training for hospital staff; NHS Cancer Screening Awareness Training).

Our three key ambitions (or commitments) for 2023-2028

1. People will have equitable access to healthy living and wellbeing activities and support in their community.

This will contribute towards the Promotion of Wellness; Prevention of Illness; Earliest Intervention; Recovery; and Living Well

2. People will have equitable access to the physical health care and interventions that they need.

This includes GP and hospital appointments/care, national screening, dental care, pregnancy/maternity care, and vaccinations.

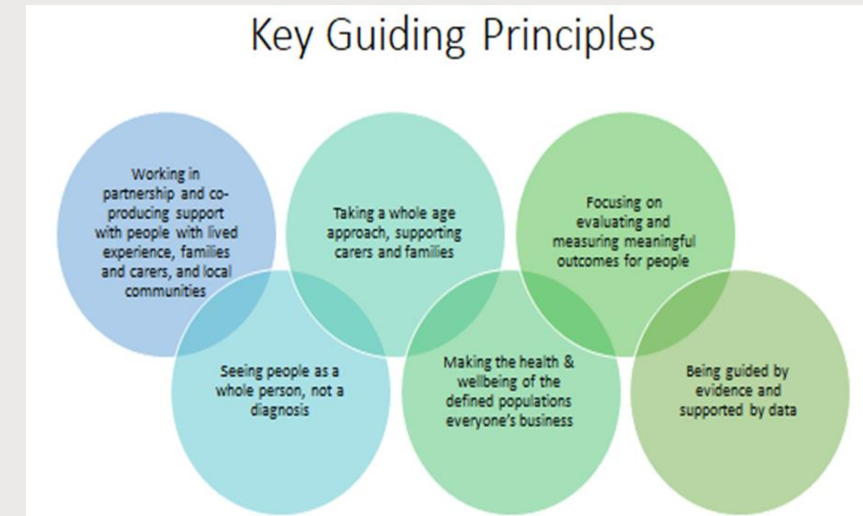
3. People who receive health and care services to help with needs related to their mental illness, learning disability, or autism, will (as part of this care) be supported with their physical health.

See APPENDIX TWO for more details about the three ambitions

Cross-cutting considerations that we will work towards across the three ambitions…

As partners we will -

- Extend our strategy to encompass all ages (recognising that the 2019-22 strategy was adults focused) and that we will need additional work to ensure that Delivery Plans are consistently all age. We will also ensure that there is sufficient focus on supporting older people.
- Consider and raise awareness about the appropriate use of the Mental Capacity Act to support good decision making where people are not able to make decisions themselves.
- Recognise that family carers need support to and that their role and expertise should be valued.
- Identify opportunities to embed good practice about personalised care across the services and projects relevant to the strategy.
- Consider opportunities for working across South Yorkshire, where this will add value to our work.
- Build on the progress achieved in our 2019-2022 Strategy, which will include that where we have already delivered projects that have improved outcomes for one of our populations (e.g. people with Learning Disability), we will now consider if this can be extended to our other populations (e.g. people with Severe Mental Illness).
- Better understand and meet the needs of all our different communities (across all Protected Characteristics) and identify ways to improve care and outcomes and address additional health inequalities. Equality Implications for individual projects and any commissioning activity associated with the refreshed strategy will be assessed throughout the duration of the strategy.
- Work with professionals to support the recognition of, responding to and learning from safeguarding incidents and reviews which involve people with SMI, Learning Disabilities and Autism to ensure inequalities in provision of services are addressed appropriately
- Continue to consider the impact of poverty and cost of living challenges on healthcare and healthy living.
- Align Physical Health Strategy activity with our citywide focus on prevention of admission to hospital.
- Improve information sharing and good communication between services.
- Share learning where health inequalities are being addressed, providing examples and tools to support changes of approach and adjustments made.
- Deliver our ambitions in the context of our shared **guiding principles (opposite).**



Sheffield Physical Health Strategy (SMI, LD, Autism), 2023-2028
Plan on a Page

1. Children, young people, and adults (including older adults) will have equitable access to healthy living and wellbeing activities and support in their community. We will -

1.1 Improve access to community healthy living and physical activity opportunities, groups and facilities

1.2 Reduce smoking; Improve oral health; Improve access to nutritious food and reduce obesity

1.3 Increase recognition and referral for support for (unpaid/informal) carers and [parent carers

1.4 Improve how the needs of different communities are understood and met (Across all Protected Characteristics and across Geographical Area)

2. Children, young people, and adults (including older adults) will have equitable access to the physical health care and interventions that they need. We will -

2.1 Improve reasonable adjustments and Accessibility of Information across health providers

2.2 Increase prevention, identification and support (management) of long term health conditions

2.3 Improve skills/awareness/training of health and care staff

2.4 Increase quantity and quality of annual health checks and health action plans (including through better information sharing between organisations)

2.5 Improve accuracy of patient registers and flagging to health services (and the additional support this enables)

2.6 Increase National Cancer Screening

2.7 Increase adult and childhood vaccination rates

2.8 Provide better mental health, learning disability and autism care when people visit hospital for a physical health cause, including through the use of Health Passports

2.9 Review if people experiencing pregnancy/maternity are receiving the reasonable adjustments that they need when accessing pregnancy/maternity physical health care

3. Children, young people, and adults (including older adults) who receive health and care services to help with needs related to their mental illness, learning disability, or autism, will (as part of this care) be supported with their physical health. We will -

3.1 Support care staff to detect (and respond to) when people's physical health is deteriorating

3.2 Ensure young people receive good physical health support during the move from children's to adults services.

3.3 Support the physical health of people receiving support from social care services, working with partners to promote physical health.

3.4 Continue to develop physical health offer of the Primary Community Mental Health Service

3.5 Improve the physical health for patients within community and inpatient mental health and learning disability services

How will we will monitor our strategy?

- We will have a **delivery plan** which will be overseen by **our cross organisational Physical Health Improvement Group.** The delivery plan will include key actions from the Equality Impact Assessment and themes arising from the engagement on the refresh of the strategy.
- This group will report to the **Mental Health, Learning Disabilities, Dementia and Autism (MHLDDA) Delivery Group**. These groups have a range of partners on them, working together and these partners will help to progress and monitor delivery plans.
- Some actions and projects will be **monitored directly by the organisations involved in the strategy**.
- Some actions and projects will be **monitored by boards and groups that have cross organisation oversight for particular citywide areas of interest** (for example smoking cessation).
- We will gain assurance and feedback from **people with lived experience and their (informal/family) carers** on the progress that the strategy is making and to guide next steps.
- We will gain assurance and feedback from the **organisations and networks that work with and support people** of all ages with severe mental illness, people with a learning disability and people who are autistic on the progress that the strategy is making and to guide next steps.

NHS Sheffield Clinical Commissioning Group

NHS England

healthwatch Sheffield

Sheffield City Council

HEALTH AND WELLBEING BOARD PAPER

Report of: Chris Gibbons

Date: Dec 2023

Subject: Update of Joint Strategic Needs Assessment

Author of Report: christopher.gibbons@sheffield.gov.uk

Summary:

The JSNA provides a high level overview of health need in Sheffield and has served as one of the core pieces of evidence on which the Health and Well Being Strategy is based.

The production of the JSNA is a requirement of the HWBB. This paper describes the update and details the high level summary section of the JSNA, which forms one part of the four part JSNA. The JSNA for Sheffield is structure in four key parts. The first, the attached document (draft), provides a high-level overview of the key health indicators, places these in the context of recovery from the Covid-19 pandemic, and outlines some of the strategic priorities for the city's health and wellbeing.

The second is the data available on our Local Insight Platform. This web tool gives the latest data and analysis for communities and services, with up-to-date open data matched to the areas multiple sectors and organisations work in. It combines the ability to map data at MSOA level and produce custom dashboards to compare and rank areas within the city, the region, other Core Cities and nationally.

The third is the Picture of Health Toolkit which replaces much of the statistical analysis and infographics contained in the current Sheffield JSNA website with a more user-friendly interface based on PowerBI.

The fourth part is an updated A-Z web page which provides definitions and links to key strategies, data sources and other documents grouped by topic. This will be going live in January 2023.

Update of The Joint Strategic Needs Assessment

1.0 SUMMARY

1.1 The JSNA provides a high level overview of health need in Sheffield and has served as one of the core pieces of evidence on which the Health and Well Being Strategy is based.

1.2 The production of both is a requirement of the HWBB. This paper describes the update of both and gives some summary headlines of the JSNA.

2.0 Update of the Joint Strategic Needs Assessment

2.1 The production of the Joint Strategic Needs Assessment (JSNA) is a statutory requirement of the Health and Well Being Board (HWBB). This has been led by the PH Intelligence team within SCC. Over the course of the pandemic capacity has been exceptionally constrained for anything other than covid epidemiology and surveillance.

2.2 The Sheffield JSNA is well established and has historically been a very well regarded piece of work by all that use it.

2.3 **The structure of the Sheffield JSNA** aims to provide over-arching information on the current and future health and wellbeing needs of Sheffield people. It provides the evidence base for the joint health and wellbeing strategy and the context for all other health needs assessment for the City. The online site contains a range of specific pieces of public health analysis, an overview of health at neighbourhood and ward level, DPH reports. It is split broadly into 7 chapters (population, communities of interest, economic, social and environmental impact on health, maternal, child and young people's health, disease and disability, commercial determinants of health).

2.4 **Maintaining the JSNA** in that form with the current demands on the intelligence team's time is problematic and it is increasingly out of date. As we update it, the JSNA has become shorter, punchier (and perhaps more widely read and used), makes more use of third-party tools and products to reduce duplication of effort and, critically, easier for the team to produce. This will free up more time to do more detailed needs assessment work where required to answer more bespoke questions.

2.5 **The update** is described here:

- Finalisation of a slimmed down summary of the JSNA.
- Production of a simple A-Z of all public health intelligence and insight tools on the JSNA website and elsewhere
- Using the Picture of Health tool to replace the need for an update of the specific chapters on the current JSNA website.
- More emphasis given to the local insight tool Sheffield Local Insight website to point users to data for specific geographies.
- Greater link to the Public Health Outcome Framework the fingertips tools. We will be framing this as the health and wellbeing outcome framework for the city. From these users can get readily accessible outcomes data on many topics across a number of domains (NHS and Care, health improvement, wider determinants, health protection, headline indicators).

Part One – Strategic Summary

JSNA for Sheffield

A Joint Strategic Needs Assessment (JSNA) is a comprehensive analysis undertaken by local authorities and health partners to identify the current and future health and social care needs of a population. JSNAs involve collating data on demographic trends, health outcomes, and social determinants. This assessment aims to provide a holistic understanding of the community's well-being, helping policymakers prioritize resources, plan services, and address specific health inequalities. JSNAs play a crucial role in informed decision-making, fostering collaboration between various stakeholders, and ensuring that health and social care services are tailored to meet the unique needs of the population.

The JSNA for Sheffield is structure in four key parts. The first, this document, provides a high-level overview of the key health indicators, places these in the context of recovery from the Covid-19 pandemic, and outlines some of the strategic priorities for the city's health and wellbeing.

The second is the data available on our Local Insight Platform. This web tool gives the latest data and analysis for communities and services, with up-to-date open data matched to the areas multiple sectors and organisations work in. It combines the ability to map data at MSOA level and produce custom dashboards to compare and rank areas within the city, the region, other Core Cities and nationally.

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The fourth part is an updated A-Z web page which provides definitions and links to key strategies, data sources and other documents grouped by topic. This will be going live in January 2023.

JSNA For Sheffield 2023- Strategic Summary

This section of the report gives a broad overview of health in Sheffield. More detail can be found in the Local Authority Health Profile produced by OHID at https://fingertips.phe.org.uk/ and on the Global Burden of Disease GBD Compare website athttps://vizhub.healthdata.org/gbd-compare/

Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable

Recent trends: – Could not be calculated → No significant change ↑ Increasing & getting worse ↑ Increasing & getting better ↓ Decreasing & getting worse ↓ Decreasing & getting better ↑ Increasing ↓ Decreasing

Benchmark Value
Worst 25th Percentile 75th Percentile Best

Indicator	Period	Sheffield			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Life expectancy and causes of death									
Life expectancy at birth (Male, 3 year range)	2018 - 20	–	-	78.6	78.4	79.4	74.1		
Life expectancy at birth (Male, 1 year range)	2021	–	-	78.9	78.0	78.7	72.3		82.9
Life expectancy at birth (Female, 3 year range)	2018 - 20	–	-	82.4	82.2	83.1	79.0		
Life expectancy at birth (Female, 1 year range)	2021	–	-	82.0	82.0	82.8	78.6		36.0
Under 75 mortality rate from all causes	2021	–	1,705	380.5	394.9	363.4	625.1		205.7
Under 75 mortality rate from all cardiovascular diseases	2021	–	368	83.2	86.8	76.0	133.9		9.6
Under 75 mortality rate from cancer	2021	–	561	126.6	131.0	121.5	189.8		75.8
Suicide rate	2019 - 21	–	168	11.0	12.5	10.4	19.8		4.8
Killed and seriously injured (KSI) casualties on England's roads	2021	→	235	148.6*	110.8*	95.6*	469.8		31.2
Emergency Hospital Admissions for Intentional Self-Harm	2021/22	–	825	143.3	146.7	163.9	425.7		47.9
Hip fractures in people aged 65 and over	2021/22	–	540	546	546	551	741		
Injuries and ill health									
Percentage of cancers diagnosed at stages 1 and 2	2020	→	806	53.6%	50.6%	52.3%	43.7%		%
Estimated diabetes diagnosis rate	2018	–	-	77.3%	81.9%	78.0%	54.3%		5%
Estimated dementia diagnosis rate (aged 65 and over)	2022	→	4,507	70.3%	63.1%	62.0%	50.3%		
Admission episodes for alcohol-specific conditions - Under 18s	2018/19 - 20/21	–	60	17.0	27.2	29.3	83.8		7.7
Admission episodes for alcohol-related conditions (Narrow)	2021/22	–	2,842	562	533	494	840		251
Smoking Prevalence in adults (18+) - current smokers (APS)	2021	–	-	13.3%	14.1%	13.0%	22.0%		6.6%
Behavioural risk factors									
Percentage of physically active adults	2020/21	–	-	68.1%	65.2%	65.9%	48.8%		76.5%
Percentage of adults (aged 18 plus) classified as overweight or obese	2020/21	–	-	63.9%	66.5%	63.5%	76.3%		
Under 18s conception rate / 1,000	2020	→	133	14.8	16.5	13.0	30.4		2.7
Smoking status at time of delivery	2021/22	↓	-	9.4%	12.0%	9.1%	21.1%		3.1%
Baby's first feed breastmilk (previous method)	2018/19	–	-	71.7%	56.4%	67.4%	43.6%		
Child health									
Infant mortality rate	2019 - 21	–	61	3.5	4.4	3.9	7.5		1.2
Year 6: Prevalence of obesity (including severe obesity)	2021/22	↑	1,570	25.3%	24.9%	23.4%	34.0%		
Deprivation score (IMD 2019)	2019	–	-	27.1	26.0	21.7	45.0		5.8
Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	2020	–	-	19.9%	25.5%	24.5%	42.1%		
Inequality in life expectancy at birth (Male)	2018 - 20	–	-	10.9	10.7	9.7	17.0		
Inequalities									
Inequality in life expectancy at birth (Female)	2018 - 20	–	-	8.7	8.8	7.9	13.9		
Children in relative low income families (under 16s)	2020/21	↑	28,029	26.4%	25.2%	18.5%	42.4%		6.2%
Children in absolute low income families (under 16s)	2020/21	↑	24,060	22.7%	21.5%	15.1%	39.2%		5.2%
Average Attainment 8 score	2021/22	–	265,585	46.1	46.9	48.7	39.2		
Wider determinants of health									
Percentage of people in employment	2021/22	→	290,200	75.8%	74.3%	75.4%	62.9%		.1%
Homelessness: households owed a duty under the Homelessness Reduction Act	2021/22	–	3,403	13.8	12.0	11.7	29.9		4.4
Violent crime - hospital admissions for violence (including sexual violence)	2018/19 - 20/21	–	890	45.7	47.3	41.9	116.8		12.0
Excess winter deaths index	Aug 2019 - Jul 2020	–	250	15.7%	16.6%	17.4%	50.2%		0.7%
New STI diagnoses (excluding chlamydia aged under 25) per 100,000	2021	↓	-	193	285	394	2,634		103
TB incidence (three year average) New data	2018 - 20	–	130	7.4	5.9	8.0	43.1		0.6

The health of people in Sheffield is varied compared with the England average. Sheffield is one of the 20% most deprived districts/unitary authorities in England and about 23.2% (23,095) children live in low income families. Life expectancy for women is lower than the England average.

Life expectancy is 9.6 years lower for men and 8.8 years lower for women in the most deprived areas of Sheffield than in the least deprived areas.

In Year 6, 21.6% (1,334) of children are classified as obese, worse than the average for England. The rate for alcohol-specific hospital admissions among those under 18 is 16 per 100,000, better than the average for England. This represents 18 admissions per year. Levels of GCSE attainment (average attainment 8 score) and smoking in pregnancy are worse than the England average. Levels of breastfeeding are better than the England average.

The rate for alcohol-related harm hospital admissions is 736 per 100,000, worse than the average for England. This represents 3,816 admissions per year. The rate for self-harm hospital admissions is 167 per 100,000, better than the average for England. This represents 1,010 admissions per year. Estimated levels of physically active adults (aged 19+) are better than the England average. The rate of new sexually transmitted infections is better than the England average. The rate of killed and seriously injured on roads is worse than the England average. The rates of statutory homelessness, violent crime (hospital admissions for violence) and under 75 mortality rate from cardiovascular diseases are worse than the England average.

The major causes of death and disability are detailed in the Global Burden of Disease data for Sheffield, the most recent data available are from 2019. It is important to note, a very large proportion of these deaths and causes of illness and disability are preventable or at worst delayable.

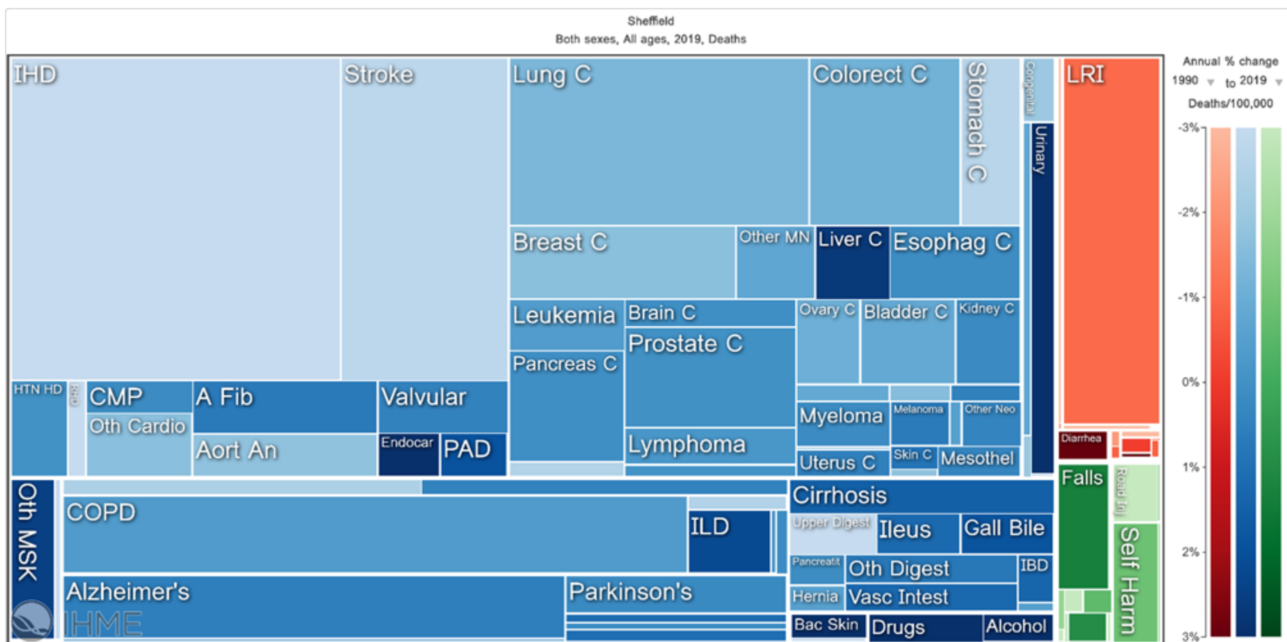


Figure 1 GBD treemap of causes of death, both sexes, all age, rate per 100,000 2019, Sheffield

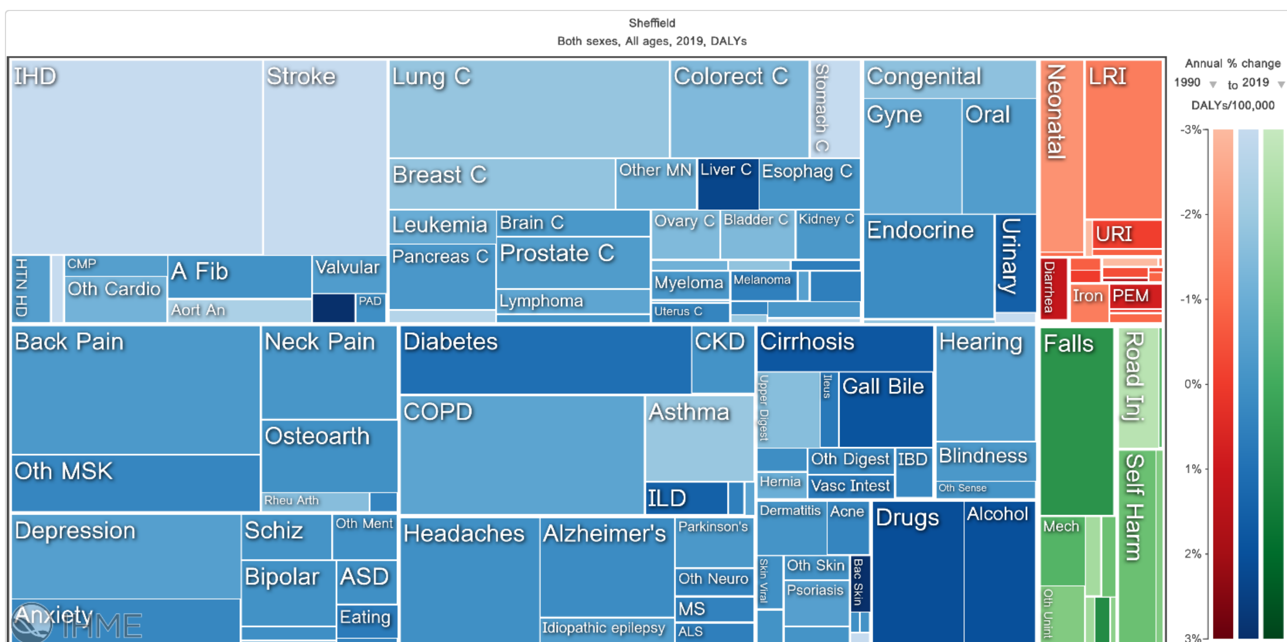


Figure 2 Disability Adjusted Life Years (DALYS) for major causes of morbidity, all ages, both sexes, Sheffield 2019

The tree maps shown in Figs 1&2 detail the major causes of death and morbidity which have remained broadly constant since 1990, with significant progress made on smoking, diet and lipid modification as well as some advances in diagnosis meaning that CVD and some cancers have seen a drop in rates for both mortality and morbidity. Worsening trends for Sheffield are shown in darker shades, and are consistent with the findings of the Lancet Commission which explored the changing health needs of the UK population. Figure 3 sets out how some of those key burdens of illness have changed for men and women over a 20 year time period for the UK, despite risk factors remaining relatively constant (Fig 4).

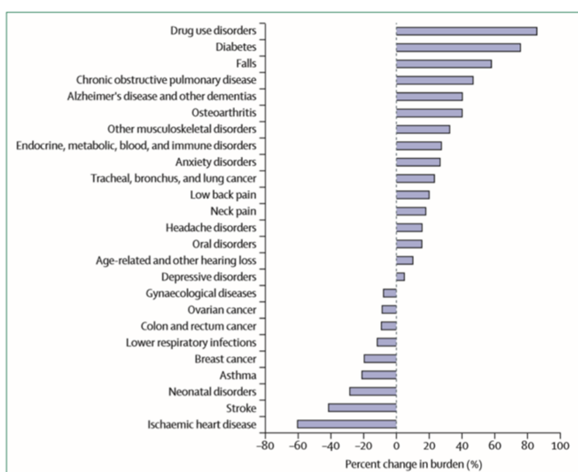


Figure 5: **Percentage change in burden due to the top 25 causes of DALYs in women in the UK, 1990–2019**
Source: Global Burden of Disease. DALY=disability-adjusted life year.

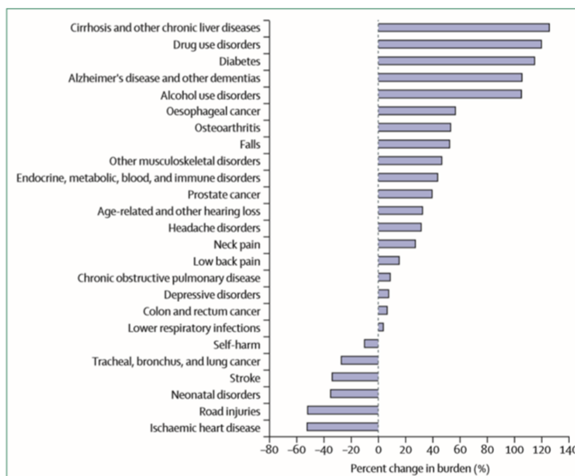


Figure 6: **Percentage change in burden due to the top 25 causes of DALYs in men in the UK, 1990–2019**
Source: Global Burden of Disease. DALY=disability-adjusted life year.

Figure 3 McKee et al. 2023 Lancet Comission

It should be noted that for some changes the % change is from a low baseline (for example Drug Use Disorders) and for others, whilst the percentage change is not as large, the magnitude in epidemiological terms is enormous (for example diabetes). Another important hidden issue in the data is that there is a growing burden on working age people, with the percentage change evident in chronic liver diseases in men for example being indicative of this phenomena. There is also interaction between risk factors and health outcomes are often a result of the cumulative effect of multiple and overlapping risk factors. Tobacco consumption is a risk factor for cancer and cardiovascular diseases, and high blood-pressure a risk for heart disease and stroke, but tobacco consumption also causes and worsens high blood pressure, for example.

The data shown in the charts in figure 4 further emphasises that ill health and its main drivers are amenable to prevention and intervention. There is a temptation to view this data and reduce the risk factors and the burden of ill health to a simplistic and false narrative about poor individual choice and a lack of 'personal responsibility' for health. Commercial actors and media outlets sympathetic to this narrative encourage policy to be shaped around the individual and education to make 'informed decisions' about commodities that are addictive, harmful, and heavily promoted. This detracts from investment in upstream interventions which have much greater benefit to population health (see Defining and conceptualising the commercial determinants of health - The Lancet 2023 for more detail). Of particular concern is the rising trend in Type 2 diabetes, which remains a substantial public health issue. Type 2 diabetes, which makes up the bulk of diabetes cases, is largely preventable and, in some cases, potentially reversible if identified and managed early in the disease course. However, all evidence indicates that diabetes prevalence is increasing, primarily due to a rise in obesity caused by multiple factors. Preventing and controlling type 2 diabetes remains an ongoing challenge. It is essential to better understand disparities in risk factor profiles and diabetes burden across populations, to inform strategies to successfully control diabetes risk factors within the context of

multiple and complex drivers. Much of this will depend on better regulation of the food system, particularly food choice architecture, advertising, and lobbying by national government.

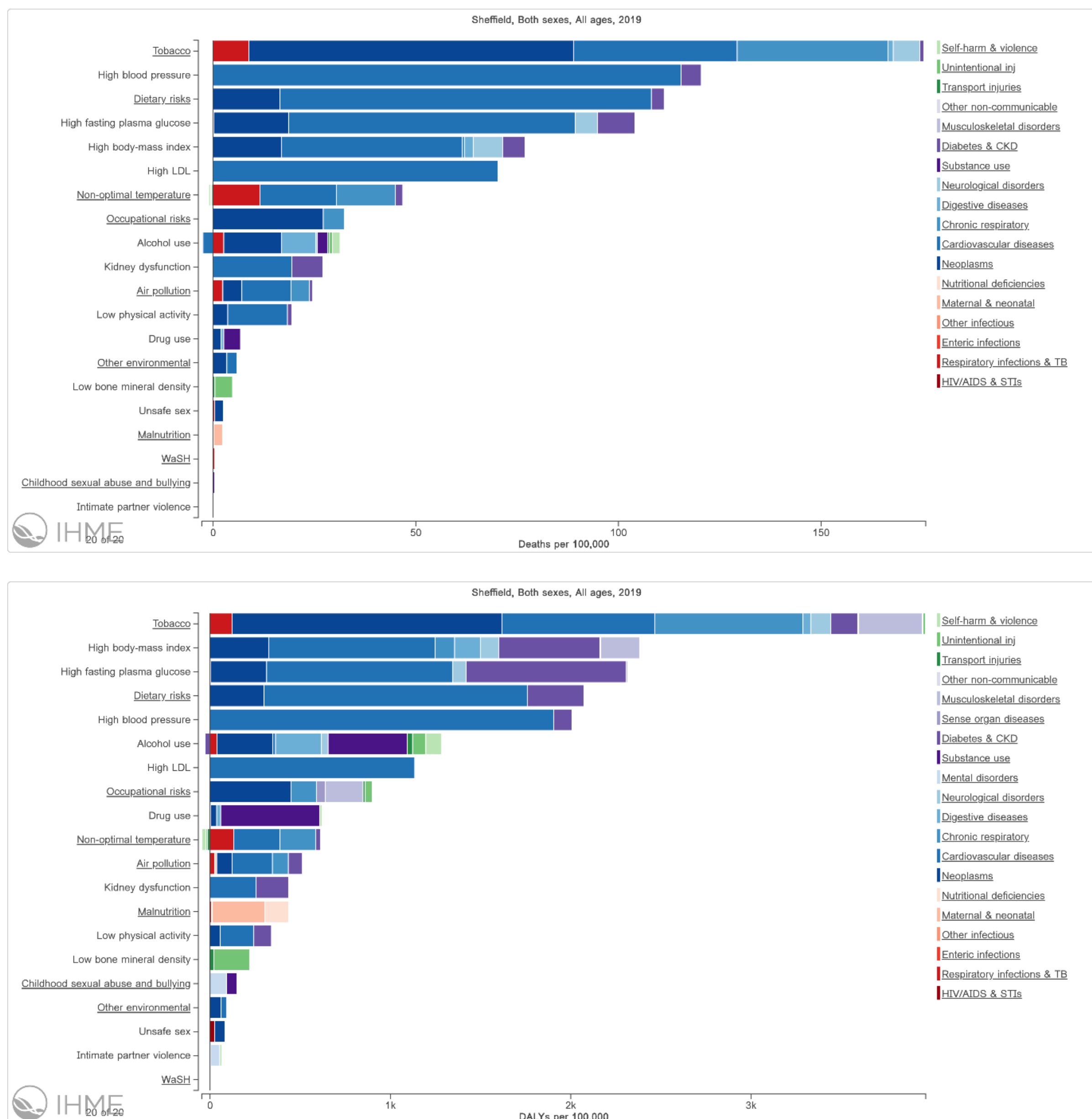
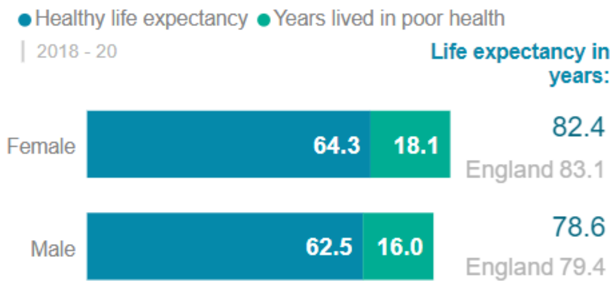


Figure 4 Risk factors for death (top) and morbidity (bottom), all ages, both sexes, Sheffield 2019

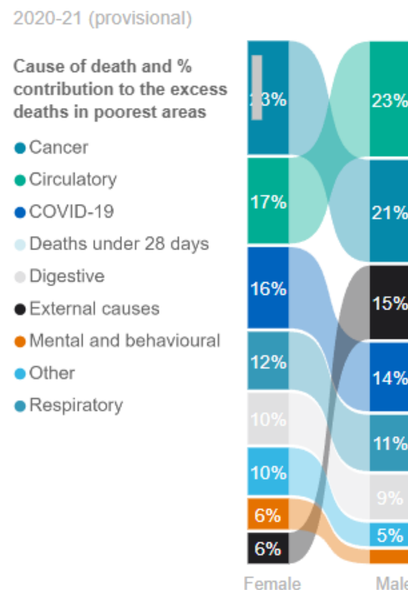
Since 2011, increases in life expectancy slowed after decades of steady improvement. In 2020, the Covid-19 pandemic caused a sharp fall in life expectancy larger than at any time since the Second World War. Health measures such as childhood immunisations, the introduction of universal health care, medical advances in treating adult diseases such as heart disease and cancer, and lifestyle changes including a decline in smoking had increased life expectancy over many years. Healthy life expectancy has also increased over time but to a lesser degree than life expectancy, so for many people more years are spent in poor health. Recent data for both life expectancy (LE) and healthy life expectancy (HLE) suggest that for much of the population historic gains are slowing down, and for those living in the most deprived areas the trend is worsening. Around 30%

of the life expectancy differences between the richest and poorest areas are due to differences in the prevalence of cardiovascular and respiratory diseases, which are preventable conditions.

Healthy life expectancy and years lived in poor health



Diseases that contribute most to the gap in life expectancy between the least and most deprived areas, by sex



Life expectancy gap by deprivation

Inequality in life expectancy at birth by deprivation:
Life expectancy gap in years (slope index of inequality)

In Sheffield, life expectancy and healthy life expectancy direction of travel are a similar shape to the national data but the numbers are worse relative to England. What is particularly concerning is that the overall data masks considerable inequality at a local level, with people living in the most deprived areas of this city experiencing both shorter lives but a greater proportion of their lifetime in poor health relative to people in the least deprived neighbourhoods (Fig 5). A baby born in Firth Park can expect to live a third of a shorter life with poor health, with a large proportion of that in working age. A baby born in Carterknowle and Millhouses will live a seventh of a longer life with poor health.

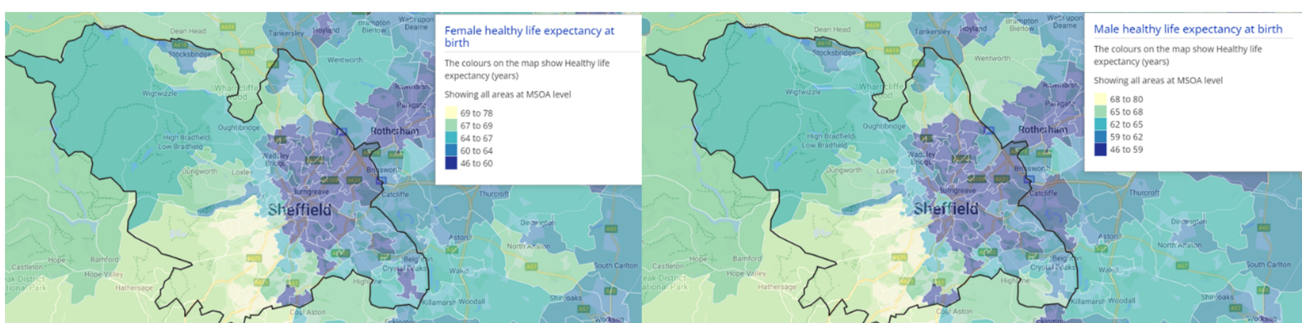
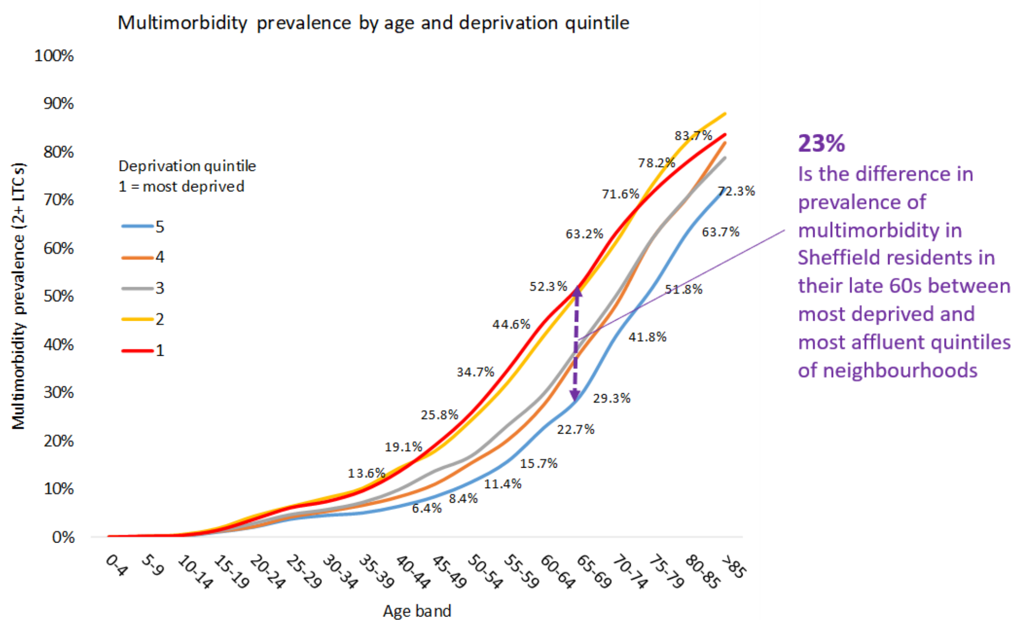


Figure 5 HLE for men and women, Sheffield

The gap in healthy life expectancy matters to both the NHS & social care, with rising demand largely from preventable non-communicable diseases (NCDs) and long term conditions (LTCs)with earlier onset in some populations. It also matters to the economy because of lost productivity on account of poor health at earlier ages. It is also, fundamentally, an issue of social justice.

Underpinning this variation is the growing problem of multimorbidity (MM). This was first well documented in Scotland (Barnett on multi morbidity in Scotland. Lancet 2012) but similar work has been done in many

places in England over recent years (Somerset, Sheffield, Bradford) and the story is broadly the same. The key metric is a 10-15 yr difference in onset of MM between most and least deprived areas. Or at any given age 15% difference in prevalence of MM across that spectrum of inequality.



The principal impact of socioeconomic deprivation on the development of LTCs is to bring forward the age at which they develop and accumulate. There is an approximate doubling of the prevalence of multimorbidity in most deprived relative to most affluent neighbourhoods. And this is true at all ages following the onset of LTCs. This is where NHS and social care demand comes from and represents the biggest single shift in epidemiology of non-communicable diseases in the last 3 decades. Ever more efficient systems to address demand will not address this problem. Multi morbidity or frailty is not "inevitable". It's constituent parts are largely preventable. From the Lancet Commission paper on health need: **"Meeting the challenges of the future will require an increased focus on health promotion & disease prevention, involving a more concerted effort to tackle the multiple social, environmental, and economic factors that lie at the heart of health inequalities"** – and are driving the increase in MM and declining HLE.

Despite the growing recognition of multimorbidity's importance in driving demand for healthcare services, there is evidence that resource allocation in the healthcare system has not caught up with an increasingly complex, multimorbid population. Data from the Lancet shows that funding for single specialty consultants rose considerably compared with that allocated to GPs in the ten years from 2008-2018 with the latter actually falling over the same period.

The Covid 19 Pandemic

COVID has had a significant impact on the health and wellbeing of the Sheffield population. The severity of this impact, and its unequal nature, are inseparable from the health of the city population in the years prior. The trend of flatlining life expectancy and healthy life expectancy his was well documented in Marmot 10 years on (Feb 2020), by Barr documenting the Impact of LA spending cuts on Life Expectancy (and by definition HLE), and by Bambra writing on the long term trends in life expectancy over 2 decades . In addition to the short term hit from covid LE is now decreasing in many places. As of 27th October 2023, over two-

thousand deaths have been recorded with Covid-19 mentioned on the death certificate as a cause. In 2020-2021 Covid-19 was responsible for around 15% of the gap in life expectancy between the most and least deprived areas of the city (Fig. 6).

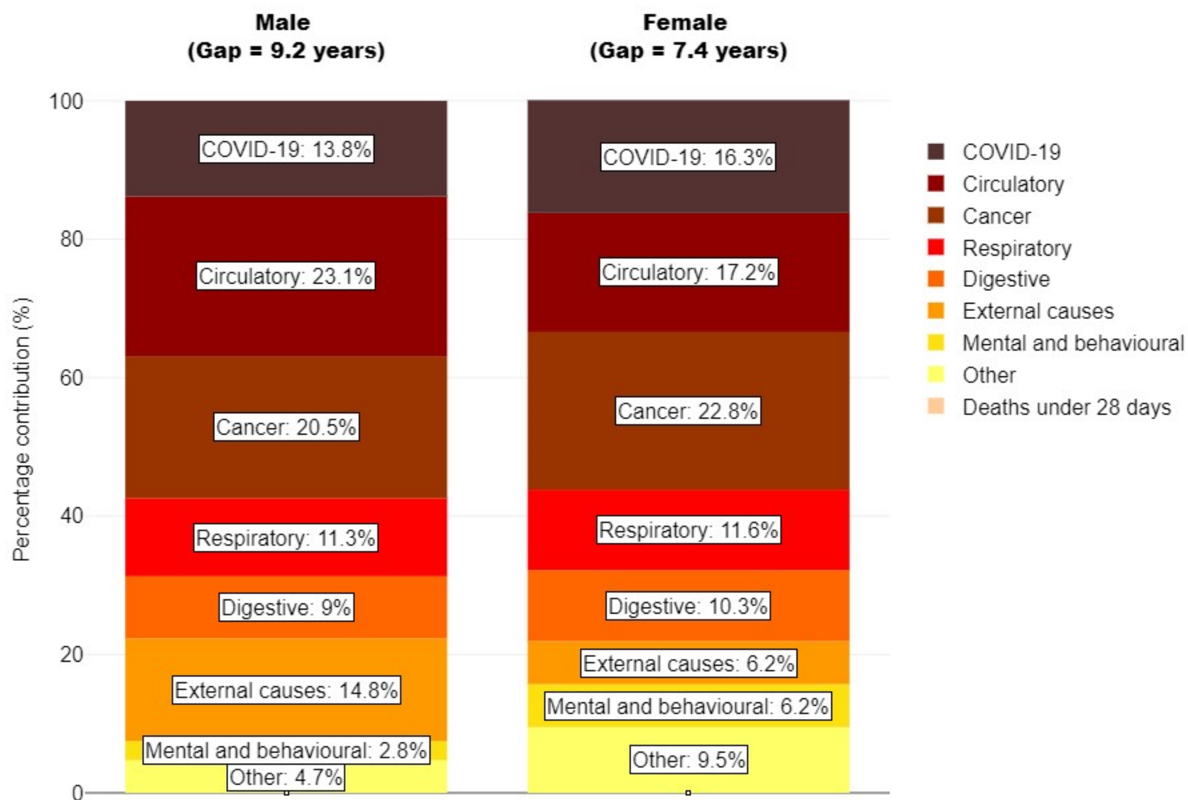


Figure 6 Breakdown of the life expectancy gap between the most and least deprived quintiles of Sheffield by cause of death, 2020 to 2021. Source: Office for Health Improvement and Disparities based on ONS death registration data and 2020 mid year population estimates, and Department for Levelling Up, Housing and Communities Index of Multiple Deprivation, 2019

The PH team published the **covid rapid health impact assessment** in 2021. The numbers will have shifted but the broad story has not.

Again and again, conversations on health come back to being about or framed in the National Health Service (NHS) or framed in NHS at the centre and then worked out from that focal point. It is the wrong starting point. The starting point should be the whole of government, and the structural determinants and environment, not individual behaviour and personal responsibility. This point probably cannot be underscored enough. The cycle of ever increasing spend on health care, (mostly the high technology variety where the incremental marginal benefit is low relative to cost), comes with the opportunity cost of less health, as investments with a much higher value in health terms get crowded out. The opportunity cost of more medicine is less health. Illich wrote about this at least five decades ago.

The data shown in the charts in Figure 4 further emphasises that ill health and its main drivers are amenable to prevention and intervention. There is a temptation to view this data and reduce the risk factors and the burden of ill health to a simplistic and false narrative, about poor individual choice and a lack of 'personal responsibility' for health. Commercial actors and media outlets sympathetic to this narrative encourage policy to be shaped around the individual and education to make 'informed decisions' about commodities

that are addictive, harmful, and heavily promoted. This detracts from investment in upstream interventions which have much greater benefit to population health (see Defining and conceptualising the commercial determinants of health - The Lancet 2023 for more detail).

Why does this matter in the context of a pandemic?

The overall story on health is of a stalled improvement based on historical trends. The underlying health of a population matters enormously to individuals and to society. However, it also mattered to the spread of Covid-19 and its impact on Sheffield particularly with reference to the inequitable nature of that impact.

The illness profile is largely made up of what is known as non-communicable disease (NCD), preventable illness. Not really a function of “lifestyle choices” but a function of social, commercial, and other determinants of our health.

Sheffield in 2020 had broadly well understood and stable causes of ill health in the population. There were concerning trends in LE and HLE which were indicative of worsening inequalities in some areas and were underpinned by the growing problem of multimorbidity. When Covid-19 arrived in Sheffield, its impacts were overlaid on top of those existing inequalities.

Multimorbidity is a defining feature and single biggest shift in epidemiology in the last three decades. It is caused by multiple, often preventable, or delayable illness and is not simply a function of an ageing population. Multimorbidity and frailty are not inevitable. The inequality in the prevalence of multimorbidity and frailty was a major contributor to the unequal impacts of the pandemic.

The underlying health status of a population, particularly the unequal nature of it, when combined with underpinning inequality in differences in social and economic factors (overcrowded housing, the financial inability to be able to afford isolation, the type and nature of some roles meaning they cannot be undertaken remotely) explain a large proportion of inequality in exposure to the virus, overall infection force and outcomes from the virus.

The pandemic was marked by a series of phases characterised by the dominant strain of Covid-19 circulating at the time, the non-pharmaceutical interventions deployed by the government to mitigate against it, and the numbers of cases, hospitalisations, and deaths.

In terms of pandemic recovery, which the city still finds itself in and will do so for years to come, the Marmot recommendations detailed in Build Back Fairer: The COVID-19 Marmot Review (December 2020) are all highly relevant to Sheffield. These are:

- Communities and places (providing more resources for more deprived areas and communities by redistributing existing assets and seeking greater investment from business and Central Government), housing.

- Transport and the environment (‘healthy living’ standards for housing, environment and employment. Addressing overcrowded housing, and damp, cold and mouldy homes which are a risk for respiratory health. Providing guaranteed training and support for young people).

- Early years, children and young people (prioritising future generations – with no young person without employment, education or training after they leave school. Providing additional support for mental health in schools and workplaces and more mental health service provision for young people).

- Income, poverty and debt (advocating nationally for a minimum income level to be the benchmark for wages and welfare payments).

- Work and unemployment (a stronger role for business in achieving social goals, including reducing health and social inequalities, by being good employers, having ‘equitable’ supply chains, investing in / contributing to communities, investments to be sustainable and healthy, and providing beneficial products and services).

In terms of the role of the healthcare system in recovery, there are other specific actions that it can take.

- Covid-19 has seen unprecedented growth of elective care waiting lists. The prioritisation of reducing these should be biased towards unmet need in underserved, more deprived communities. As part of this effort, there is a need to re-emphasise the “Make every contact count” effort on smoking, alcohol, exercise, debt management and others at every opportunity.

- The healthcare system needs to take concrete steps towards addressing multimorbidity and resourcing primary care and generalists with that goal in mind. Improving technical efficiency in single disease specialties will not address this fundamental demand pressure. Given the resource constraints, and the problems of allocative inefficiency which are making inequalities worse in some areas, the healthcare system needs to work with and if necessary, fund partners/allied sectors. Given the challenges of multimorbidity and increasing complexity, primary care needs to be able to fulfil the generalist role best suited to meeting these challenges – with funding commensurate to that task. This may require a rethink of current funding models.

- Population Health Management is still very much a concept rather than actual practice and there is a risk that if the focus of it is, as a result of where data is most complete and comprehensive, disease and clinical risk stratification it will lead many to conclude that resources should be moved towards precisely the wrong things. Diagnostic screening, increasing medicalisation of social ills, and a medical system that will design services and patient care based on data that is about the conditions people have and does not give equal importance to the conditions people live in. This will miss an opportunity to use this data to resource, empower and develop communities recovering in the wake of one of the most significant societal emergencies of our lifetimes.

Poverty

Poverty is intricately linked to public health outcomes, creating a web of challenges that affect individuals and communities. The impact of poverty on public health is pervasive, influencing factors such as access to healthcare, nutrition, education, and living conditions. Limited financial resources often lead to inadequate nutrition, increasing the prevalence of malnutrition and associated health issues. In impoverished communities, access to quality healthcare is often restricted, exacerbating the burden of preventable diseases.

Poverty also contributes to the perpetuation of morbidity, with crowded living conditions making infectious diseases more likely to spread while damp and mould can cause and worsen respiratory conditions like asthma. Moreover, individuals in poverty may face heightened stress and limited mental health resilience, further impacting overall well-being. Lack of education and employment opportunities can hinder the effectiveness of measures designed to improve of health and reduce risk.

Addressing poverty is essential for promoting public health equity. By implementing policies that alleviate economic disparities, communities can break the cycle of poor health outcomes. Initiatives aimed at improving education, housing, and income security contribute not only to poverty reduction but also to the enhancement of overall public health. Recognizing the interconnectedness of poverty and health is crucial for developing comprehensive strategies to create healthier, more equitable societies. However, austerity measures in the UK introduced after 2010 had profound implications on trends in poverty and health. Reductions in public spending, strained the NHS, leading to longer waiting times, staff shortages, and limited access to vital services. Mental health and Social Care services, both for adults and children, also faced cutbacks, exacerbating the burden on an already stretched system. Austerity widened social inequalities and exacerbated health disparities, with marginalized communities experiencing poorer health outcomes. Public health initiatives suffered, impacting disease prevention efforts. Critics argue that the austerity-driven health policies disproportionately affected the most vulnerable, widening health inequalities and leaving a lasting imprint on the overall well-being of the population. In the same way that Shefield found itself in a vulnerable position in terms of population health and well-being prior to the pandemic, the city was not best placed to absorb the enormous economic shock either.

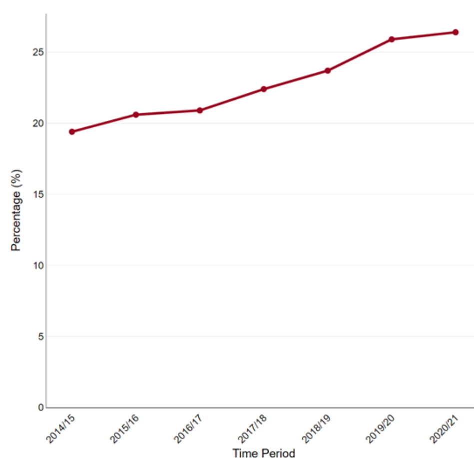


Figure 7 This indicator shows the percentage of children (<16) in Sheffield, living in relative low income families. A family is defined as a single adult; or a married or cohabitating couple; or a Civil Partnership; and any dependent children. Source: Public Health Outcomes Framework

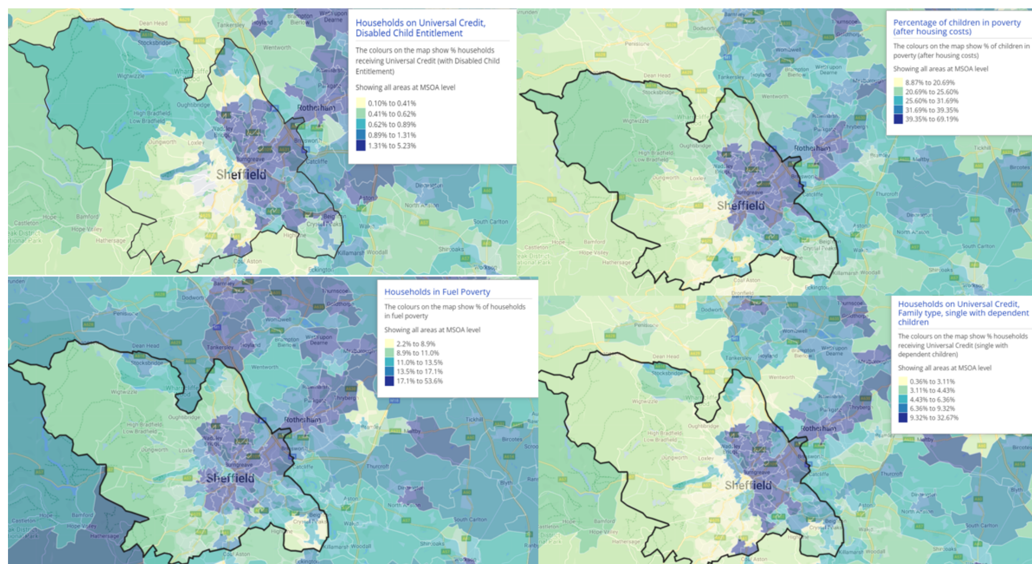


Figure 8 Clockwise from top left: Households on universal credit disabled child entitlement, Percentage of children in poverty after housing costs, Households in fuel poverty, and Households on universal credit with single parents with dependent children.

Poverty in Sheffield is highly correlated ($R^2 > 0.7$): with health outcomes including: Deaths from causes considered preventable, under 75 years; prevalence of obesity (including severe obesity) in Year 6; deaths from all causes, under 75 years; prevalence of overweight (including obesity) in Year 6; low birth weight of live babies; deaths from all cancer, under 75 years; life expectancy for both men and women and healthy life expectancy for both men and women.

Conclusions

We also know covid will cast a long shadow on the health of the population. We know that structural issues in society were more impactful in the spread of covid and infection rates and thus outcomes. We know there was more covid in some communities than others, and on account of underlying morbidity there were more serious consequences). We can expect there will be more long covid in those communities. There are lots of worrying indicators on the indirect impact of covid (frailer, more drinking, less activity, obesity in children, mental illness, all of which will be unequally spread. The social and economic impact will affect the health of the population for many years (maybe decades) to come. Impact of pandemic has accelerated (significantly) fundamental flaws in the local state funding position

The impact of long covid on population health is as yet uncertain. ONS have the best estimates with their ongoing tracking. As with all health need this will not only be an NHS and care demand issue, it will also become an issue of poverty (inability to work thus earn), benefit demand, economic productivity and social justice issue. This is yet to be well quantified.

The gap in healthy life expectancy matters beyond just NHS and care. It matters to the NHS & social care (demand largely from preventable NCDs with earlier onset in some populations) and the economy (lost productivity on account of poor health at earlier ages). It is obviously also a social justice issue.

The factors that contribute to HLE are well beyond only more or better health and social care, though that does matter enormously… but that whole life span, whole of society perspective for interventions, across every dept in govt, local and national, and well beyond govt.

The ability to impact at the margin is greater in those with lower starting point vs those at the top, those at the bottom have more to gain and those at the top less (diminishing marginal returns). This has **obvious implications in terms of NHS and social care demand, is also has huge implications in terms of overall economic productivity (health is a constraint to economic growth) and obviously social justice.**

The main risks for non communicable diseases (NCD) are largely preventable (tobacco, obesity, alcohol, diet, lack of activity, these things then lead to NCD. This then often accumulates into what we know as multi morbidity). When "health" is considered more broadly, the core deterimnants of health are well established, and our Health and Well Being Strategy is based on those determinants – factors upstream of lifestyle risks.

A lot of demand is preventable. Someone needs to prevent it. It doesn't happen by itself. Long term decline in smoking (and CVD and lung cancer hasn't happened by magic). It isn't a project, it is about orientation, purpose and mission.

A test for all discussions will be the extent to which in any area we are seeking to enable a shift to a more preventive model.

The ageing population is usually held as the core issue determining ever increasing NHS and social care demand. This is a fallacy and the reality is considerably more complex, as has been set out in this comprehensive Health Foundation analysis amongst others. All the available analysis points towards preventable illness, and wider living standards not ageing per se. The absolute number of people aged >65 is increasing, but the overall age structure is not changing that quickly. Thus there are more "person years" in the population. Multi morbidity and the stalling life expectancy and HLE improvement are the main drivers of the unsustainable yet largely preventable growth in demand for health and social care services. This basically leads to more "unhealthy person years" in a fixed capacity system.

Multi morbidity or frailty is not "inevitable". The things that make up are all largely preventable. For many of the core issues within the existing burden of disease we haven't achieved any level of meaningful disease prevention. From the Lancet Commission paper on health need: "Meeting the challenges of the future will require an increased focus on health promo & disease prevention, involving a more concerted effort to tackle the multiple social, environmental, and economic factors that lie at the heart of health inequalities."

No single person or body is accountable for health. Often our machinery asks for financial balance and service delivery metric improvement, not outcomes. Given the wide ranging nature of what contributes to good health outcomes, no single body is accountable for it all. Nobody is held accountable for the gap in healthy life expectancy between most and least affluent or those with a learning disability and those without. Maybe something about setting up a 2 way conversation on accountability for outcomes. A once a year exercise? Open and transparent.

All risk factors / demand and outcomes are unequally spread. There are many very helpful sets of policy recommendations on health inequalities (notably the 2021 Marmot recommendations for Greater Manchester). These provide and excellent basis on which to regresh out Health and Well Being Strategy. Addressing this needs a shift in purpose, not a "project". There are some core fundamentals (the basic Marmot principles – proportionate universalism, shift to preventive model, early years focus, focus on community level capacity and capability). There may be many opportunities to push this through both levelling up and the DHSC approach to health disparities.

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6 QUESTIONS FOR THE BOARD

The board is asked

1. **To approve the process for updating the JSNA and PNA, both to be completed by Oct 2022 alongside the DPH report.**
2. **To consider, as we come out of covid and thus have more capacity, what broad or specific intelligence questions members would wish to focus analytic attention to.**
3. **To note the high level points set out summarising the high level picture on health need.**

Sheffield Clinical Commissioning Group

NHS England healthwatch Sheffield

Sheffield City Council

HEALTH AND WELLBEING BOARD PAPER

Report of: Chris Gibbons and Jackie Mills

Date: Dec 2023

Subject: Spend and Outcomes analysis for Sheffield

Author of Report: christopher.gibbons@sheffield.gov.uk & jackiemills@nhs.net

Summary:

The slides presented to the board cover a broad description of key outcome measures of interest for the Health and Wellbeing Board that will likely feed into the Strategy to be published in 2024. The difficulties of outcomes measurement are discussed, with some suggested areas where outcomes are not currently captured where it may be beneficial to do so. Key outcome measures are presented from the OHID Fingertips Toolkit. Fingertips profiles are a rich source of indicators across a range of health and wellbeing themes. They are designed to support Joint Strategic Needs Assessment (JSNA) and commissioning to improve health and wellbeing and reduce inequalities. The Local Authority Spend and Outcomes Tool (SPOT) data for Sheffield is presented. Using the SPOT, public health teams and commissioners can compare spend and outcome measures against other local authorities including Chartered Institute of Public Finance and Accountancy (CIPFA) statistical neighbours; look at spend and outcome measures across a range of public health areas, as well as other local authority spending areas; identify programmes with outcomes significantly different to similar local authorities that may need more analysis and use the tool alongside economic evaluations and evidence of return on investment. An alternative outcomes measure, the Thriving Places Index (TPI), is also discussed. The trends from Fingertips, SPOT and TPI are discussed in relation to the return on investment (ROI) of work programs which deliver the outcomes they measure, and in the context of budgets and pressures over the last decade.

From the high-level picture of spend and outcomes detailed above, a local analysis focussing on two examples where moving funding may deliver improved outcomes:

- Discharge home first and flow –what could this look like if we did more anticipatory care/admissions avoidance/improved discharges

- Non-elective Respiratory care & Developing model neighbourhood

Questions for the Board

1. How do we create consistent methodologies for evaluating VFM, both for existing spend and future investment?
2. What outcome measures (for example, Wellbeing measures) do we not currently measure that we should? How can this be operationalised?

3. Who or what should be responsible for reviewing progress towards improving outcomes? How would this work?
   How should this be reflected in the Health and Wellbeing Board Strategy?

HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Emma Latimer, Executive Place Director of Sheffield (ICB)
Date:	7 December
Subject:	NHS Sheffield North East Neighbourhood Work
Author of Report:	Lucy Ettridge, Deputy Director of Community Development and Inclusion (ICB)

Summary:

This paper sets a programme of work to help tackle health inequalities using a ringfenced budget for health inequalities with the priority for the funding being neighbourhood work in the north east of the city. It sets out a new way of working for the NHS, with investment into communities rather than services to effect long-term change in people's lives.

There's strong evidence that the answers to better health lie outside the health care system, with the VCS playing a pivotal role in our communities both delivering services directly but also critically important in developing long term social capital.

We will be ambitious in our approach to support these communities, by embedding a model of community development, which empowers local communities. We know those who are disconnected and disempowered have worse health; conversely, those who are connected and empowered have better health outcomes. This approach is about tackling the wider determinants of health, creating health and wellbeing rather than providing health care.

This plan complements and connects to lots of great work in the city on neighbourhood working and health inequalities. The funding and plan aren't a silver bullet for entrenched inequalities but via thorough evaluation, we hope to present a case for the approach for ongoing investment to scale up the work and deliver in communities citywide.

This isn't a one year programme; it'll be a multi-layered complex piece of work to create health and help improve people's lives -we hope to embed this approach for the long term due to the scale of the challenge. Impacts will only be fully realised over years, if not decades. We want to change Sheffield, one neighbourhood at a time.

Questions for the Health and Wellbeing Board:

- What oversight of the programme would the board like to have?
- What work in the city this programme need to link to?

Recommendations for the Health and Wellbeing Board:

- The board is asked to note the paper and the progress of the work.

Background Papers:

n/a

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

Who has contributed to this paper?

Members of community development and inclusion group, ICB clinical lead Leigh Sorsbie.

North East Neighbourhood Plan 2023-2028

1. Introduction and background

Sheffield Health and Care Partnership (the HCP) has highlighted the key priority of reducing health inequalities and improving population health, aligning our work with the development of the South Yorkshire Integrated Care Strategy and the Sheffield Joint Health and Wellbeing Strategy. Health Inequalities are differences experienced across the population and between different groups within society. They are a combination of factors that contribute to an individual's experience including where we are born, grow, live, work and age. Targeting interventions based on need is fundamental to tackling health inequalities.

This paper sets a programme of work to help tackle health inequalities using a ringfenced budget for health inequalities with the priority being neighbourhood work in the north east of the city. There's lots of other work going on in the city and HCP on tackling health inequalities and neighbourhood working including a system approach to neighbourhood working, refresh of health and wellbeing strategy, collaborating for Health work, and reforming of public services. This programme complements and connects to the other work.

This isn't a one year programme; it'll be a multi-layered complex piece of work to create health and help improve people's lives -we hope to embed this approach for the long term due to the scale of the challenge. Impacts will only be fully realised over years, if not decades. We want to change Sheffield, one neighbourhood at a time.

The HCP Board approved the plan in October 2023.

2. Aims and objectives

Our ambition is to empower communities in north east of Sheffield to live happier and healthier lives.

We have three key aims:

- To connect people to each other in their communities
- To build community capacity of individuals and neighbourhoods to help them address issues that are important to them
- To devolve power to communities.

We'll meet the aims by delivering these objectives:

- Communities will produce their own plans
- Make long term, sustainable investments in communities via the VCS
- Improve opportunities for people to connect and contribute to their local area
- Coordinate work of partners in NE to maximise impact
- People can influence decisions that affect their neighbourhood via participatory budgeting
- Ensure we make the best use of local infrastructure to improve connection to people in the community
- Enhance the skills, knowledge and resources of local people to improve their communities and own lives
- Pilot a new relational model for a small number of families experiencing disadvantage.

3. Case for change

Sheffield has high levels of inequality and deprivation in the city, with disempowered and disconnected communities. The north east of the city has very high levels of deprivation, this is impacting on life expectancy, healthy life expectancy, skill-level and the overall health and wellbeing of our communities. This area also has many people who live in multi-occupation households, are digitally excluded, experience fuel poverty and food insecurity. The north east also has poor education attainment, high unemployment and high crime rates.

Communities in the north east are big users of public services, many with complex needs and lives, they are outliers for hospital admissions, yet have little say, if any, or control over decisions that affect them. Public sector services are designed around the needs of the system, not communities. Very few people would argue this paternalism is working.

The voluntary and community sector is on its knees, suffering huge demands and managing more complex caseloads than before, yet their funding is short-term funding and unsustainable. The health and care system is also overwhelmed and understaffed.

The answers to better health lie outside the health care system with the VCS playing a pivotal role in our communities both delivering services directly but also critically important in developing long term social capital.

While the driver for this work is to improve people's lives, rather than health in the most traditional sense we know that having connected and empowered communities, will over time create health and help the health and care system to cope.

Disconnection and loneliness negatively impact on health:

- Loneliness and social isolation have been linked to a 30% increase in the risk of having a stroke or coronary artery disease (British Medical Journal – Heart)
- Loneliness is associated with a 40% increased risk of dementia (Loneliness and the Risk of Dementia Pub: OUP)
- Loneliness, social isolation, and living alone have all been associated with an increased risk of premature death.

The Race Equality Commission on racism and racial inequalities in Sheffield published a report in July 2021. To help become an anti-racist city, one of the many recommendations is for the NHS to "reconsider the balance of health funding for prevention and treatment services, disproportionate investment including in community capacity and infrastructure building". This plan aims to address some of the longstanding, historic imbalances in funding where ethnic minority groups have missed out.

Despite the challenges, the north east communities are committed and proud of the area. We have a great, vibrant voluntary and community sector, and innovative PCN. We have hundreds of assets to build on, enabling us to approach an asset based approach to our work.

4. Building a model neighbourhood across north east Sheffield

One of HCP's big five priorities for Sheffield in 2023/24 is to build a model neighbourhood across north east Sheffield, the area with the greatest needs and deprivation. This is our way of focusing on the 'Core20' part of Core20Plus5. Our 'plus' areas will be inclusion

health (refugees/asylum seekers, those experiencing homelessness), and people from ethnic minority communities.

We will be ambitious in our approach to support these communities, by embedding a model of community development, which empowers local communities. We know those who are disconnected and disempowered have worse health; conversely, those who are connected and empowered have better health outcomes. This approach is about tackling the wider determinants of health, creating health and wellbeing rather than providing health care.

We won't be setting the priorities or identifying the solutions, we'll be investing in communities and using asset-based community development approaches so local residents can come up with the solutions to their problems. All evidence points to successful sustainable change happening at a grassroots level and we will facilitate that to happen.

The New Local report, Community Power: The Evidence (2002), sets out three main benefits of our proposed approach to empower communities:

- Enables public services, their workforces and users to operate in a more preventative and less acute response-driven way
- Improves personal health and well-being making ill-health less likely to emerge
- Improves the resilience and collective well-being of local communities directly improving the social determinants of health.

Our focus is to work with the VCS and for them to lead the change alongside their communities and give appropriate funding so they can scale up what they do around health creation and early intervention. We'll help better connect the statutory sector to each other, the statutory sector to VCS, VCS to communities, and people within communities to each other.

5. Where in the north east?

The north east is a big area, so we are taking a funnelling approach. Starting with the Northeast we have selected Foundry Primary Care Network (PCN) the network with the largest number of people living in the top 20% of most deprived communities and the largest number of people from an ethnic minority background. Within the PCN, four of the middle super output areas are in the 10% most deprived areas nationally for deprivation and communities experience a range of poor health outcomes.

These are:

Area	Pop size	No. ethnic minority pop
Burngreave and Grimesthorpe (includes Pitsmoor)	12,363	10,187
Firth Park	8,166	4,516
Crabtree and Fir Vale (includes Page Hall)	9,253	7,430
Southey Green East	7,910	1,835
Total	37,692	23,968

All but Southey Green East has the majority of people from an ethnic minority background, it is traditionally a white working-class area. The first three areas have a diverse, younger population with many different ethnicities. Crabtree and Fir Vale and Firth Park have large Roma populations who experience very poor health outcomes and life expectancy, live in

very poor standard accommodation which is often multiple occupancy with reports of 20-30 people living a two-up two-down terrace houses and children sharing beds.

They have many refugees and asylum seekers, with many new communities migrating to Sheffield, so there aren't settled groups they can connect to.

Southey Green East has several large council housing estates, with an older population than the other areas. The area has fewer assets and poorer community infrastructure than the other areas.

6. Our principles

Sheffield's principles which will be the framework for our work are:

- Shift power to communities
- Place the public at the heart of the work
- Target resources to where needs are greatest
- Focus on what's strong and local, not what's wrong and external
- Readdress the imbalance in funding for black, minority ethnic communities
- Work alongside communities on identifying needs and solutions
- Plans will be community led and community focused, not system led
- Investment into the VCS promotes partnership working, and is long-term, sustainable, flexible, and accessible
- Non-medical model based on relationships and connections, not services
- Be inclusive and recognise communities of interest alongside neighbourhoods
- All partners will work together to maximise opportunities for extra investment
- Improve coordination of work between local organisations and different parts of the same organisation
- Work will be evidence based
- Share good practice locally and wider
- Monitor long-term impact on the system and communities via stories, not inputs or outputs.

7. What do we mean by empowered communities?

The WHO says, "community empowerment necessarily addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions".

Imagine in five years, that we have happier and healthier populations, who are better connected, feel a sense of belonging, and work together to bring about change. Local people have stronger relationships and a network of people who support and look out for each other. We have a robust community infrastructure that will help attract investment into the north east and Sheffield. People employed in meaningful work or volunteering. We have a well-funded VCS that thrives, is self-sufficient and less reliant on public funding. We have the public less reliant on public institutions and services, who actively have a right and say on what matters to them and their community.

The pandemic highlighted the importance of communities. People united to support one another with mutual aid – helping with food and prescriptions. Some people called on elderly neighbours to see if they were ok and others hosted quiz nights on Zoom. This helped people's mental health and their physical health and protected the NHS. We want to

build on this, make communities more resilient and form a sense of belonging and solidarity in ordinary times.

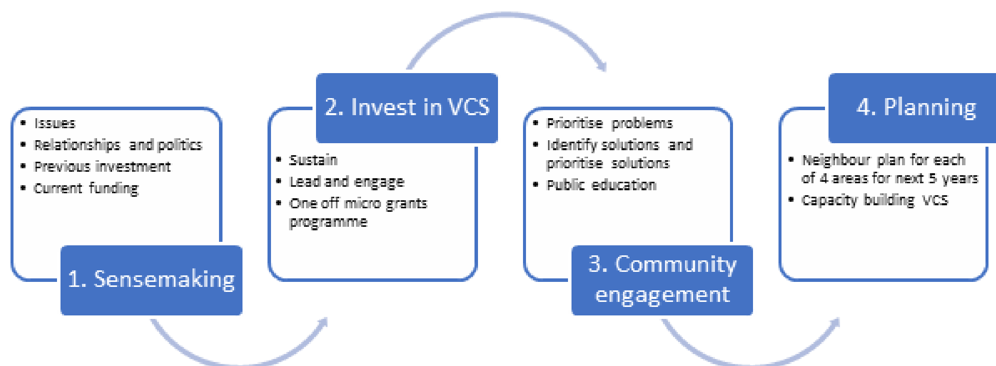
8. Phased plan

In the following section, the different phases of the plan over five years are detailed. Some of the phases will overlap and be continual.

The investment will be to change people's lives in several areas, including:

- Wellbeing
- Voice and participation
- Employment and volunteering
- Environment
- Collaboration
- Community cohesion
- Self-determination

Year one



1. Phase one - Sense making (September to December)

We'll carry out sensemaking in each of the four areas. The challenges facing the areas are complex and before we can make detailed plans on what each area needs, or level of investment, we need a full understanding of the history of the neighbourhoods and their communities, understand key organisations, relationships, demographic changes, current funding and past funding, and learning from past investments and schemes.

This work has already started with interviews, research and asset mapping but as it's a large piece of work, we will commission a third party to support VCS leaders and to facilitate discussions and produce a report.

The sensemaking also includes working with Citizen Network to develop a network map for the whole of Sheffield, identify key people and assets. There are 142 neighbourhoods in the city. We will start with the neighbourhoods in the north east.

2. Phase two - Invest in VCS (October to March)

The north east has a diverse, strong VCS. The sector has expertise and involvement with all communities and are vital system partners in this work. This phase will have the greatest investment.

However, the VCS has been poorly funded or funded unsustainably for over a decade now. This lack of funding is undermining the capacity of VCS organisations to improve the social determinants of health, and the cost of living crisis, exacerbates this. Before the transformation can happen, we need to help build the foundations by helping to sustain key VCS organisations in the north east. We will do this via direct awards and small grants. The funding will be for one year, with a commitment to long-term funding in years 2-5 following the sensemaking and production of area plans.

As well as helping to sustain organisations, we plan to fund at least four place based VCS organisations to lead and steer the model neighbourhood work in their communities, including sensemaking, time for their staff to commit and collaborate, capacity building, and funding the engagement. We will fund other VCS representing communities of interest to engage communities and deliver work on the ground. We will also award dozens of small grants to organisations that can start connecting people such as money for dance classes or gardening tools.

We will co-produce plans with multi-agency partners, examples of how the money will be invested:

- Core funding grants of £30-50k
- Funding for community workers at £27k per worker (includes oncosts)
- Small grants of less than £10k
- Microgrants of less than £1k.

Albeit small, the grants may have a big impact on people's lives. Take, for example, Hani, a Somali woman who lives alone in Burngreave. She's socially isolated which is affecting her mental health. She loves to sew but doesn't have the money for a sewing machine or material. Hani would like to form a sewing group of like minded women, to form friendships and make culturally appropriate clothes for women in Burngreave. Not only could it help improve her loneliness and mental health, but it may also reduce her chances of getting CVD, dementia and early death. The mutual aid may help women who can't afford to buy dresses. Perhaps, with the right support it might build into an enterprise taking Hani and other women out of poverty.

3. Phase three - Community engagement (January to March)

This plan isn't about improving NHS targets or prioritising what's important to the system, it's about improving people's lives - the people know what's important to them, and with the right support and environment, know how to solve their own problems.

The approach will be multifaceted and tailored to audiences to reach as many people as possible in the four areas. The methods will include deliberative workshops and focus groups, interviews, and surveys. All the engagement will be culturally appropriate and help remove barriers to participation.

As mentioned above, we will fund the VCS in the northeast to come together, plan and deliver community engagement covering these themes:

i. Information sharing on problems we're trying to solve – summarising insights i.e., City Goals, public health data, sensemaking.
ii. Discussion and debate on prioritising the problems and issues to solve

iii. Discussion and debate on how best to solve problems helping both individuals and neighbourhoods
iv. Baseline surveys to measure health, happiness, connection, support, etc.

4. Phase 4 - Planning (March)
Following the engagement where we will have a clear idea of the issues people want to solve and possible solutions, the VCS will bring back together the community to turn the insights into four year plans for each neighbourhood.

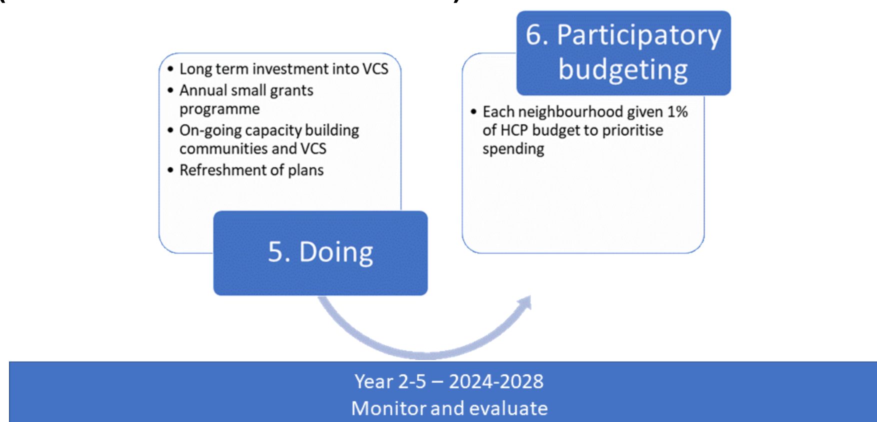
We will also invest in the capacity building of the VCS. Relationship and trust building within communities is essential but takes time and needs to be an ongoing process throughout this work.

These relationships include those between
- VCS staff and residents/community members
- Statutory staff and VCS staff
- VCS organisations with each other

We plan to develop an ongoing series of activities that will help facilitate and nurture the above. This will include:
- Listening lunches – held in community venues. Food is provided and local VCS invited to come along and whilst eating, share their thoughts on how things are progressing, the "solutions/ideas" to what is needed, and a chance to take their issues and reframe within what is possible with this fund.
- Grass roots network meetings – for those working at a grass roots level across their patch to meet and share their work, developments, challenges and so on.

Years two – five

5. Doing (Quarter one 2024/25 onwards)



We will give long-term investment to VCS to collaborate, self-govern and deliver the plans in each neighbourhood, and carry out frequent engagement.

We will also continue an annual small grants programme to help fund smaller grassroots organisations or groups of people to connect.

As well as continuing the capacity building started in year one, we will build on this. We will focus on VCS and the community.
We plan to offer an ongoing suite of training and mentoring, and support the VCS involved in this work. This will include:

- Multi-level Community Development and Health (CDH) training for VCS, statutory sector and local citizens to be held in the patch. This would also help address the issues around shifting power and the organisational culture of the statutory organisations.
- Behavioural science and insight to support work around reducing health inequalities. Behavioural science techniques can be used alongside development activities, to better understand how and why individuals and organisations act in certain ways, rather than relying on assumptions of how they should act.
- We'll hold back a percentage of funding "under the radar groups" that are doing good work but are overlooked when it comes to funding and that attached to this is an offer of support in terms of applying for the fund and administering and monitoring the work.
- Mentoring and coaching. Giving VCS the space and think to think and reflect on how to solve their own problems and questions and set goals for their own organisations.
- Mental health support. VCS staff see, hear and experience trauma in their day to day working lives, taking a toll on their own mental health and wellbeing. Look at bringing in peer to peer support to help manage.
- Access to statutory sector training and development such as mentoring and coaching, mental aid training, Thinking Differently.
- Upskill communities. To help people gain employment we will support communities in work. For example, young people in Burngreave could run the social media channels for the community highlighting events, while also being supported with comms and marketing apprenticeships, with opportunities for work experience in partners' comms team.

6. Phase six - participatory budgeting

To shift power to communities, the system needs to give up power. Participatory budgeting (PB) is a democratic process in which community members decide how to spend part of a public budget. It gives people real power over real money.
This will be a huge cultural shift for the HCP and respective partners, so we will start small, and establish processes and best practice. It'll build on the processes and relationships established in year one and moves the co-produced plans to the next level. Here, the HCP will apportion a percentage of its budget to the neighbourhood each year to develop proposals and deliberate the final plans. We aim to include the commissioning and decommissioning of health and care services.

Below is an example of a PB process. VCS leaders will drive this working alongside health and care managers.

PB is a well tried and tested method of devolving power, to great success. It's commonly used in Scotland and is embedded in legislation (whereby the national government and local government committed 1% of their budgets to PB by 2021). It can be used for small budgets or millions of pounds.

It's being proposed that 1% of HCP (estimated to be £10 million) will be part of city wide PB by 2028, with the method being tested in the north east from year two, with year on year increase in the money devolved to communities.

7. Evaluation

A key part of the work will be evaluating the impact of the investment into communities. We will work with a credible, independent organisation, to set a framework for how we monitor the work and establish impact and outcomes. This work will span the lifetime of the work, with annual reports being published.

The evaluation will help us to understand what works and what doesn't, adapt the work, and look at the wider impact of the work for example social return on investment. We will share the findings locally, regionally and nationally to showcase and leverage money to the north east and the city.

We will be working with New Local, an independent think tank and network of councils, with a mission to transform public services and unlock community power, on the evaluation. They will develop a framework, looking at research questions to be answered, and monitoring and data collection protocols.

A draft list of outcomes that we will monitor and measure are included in the next section. These are illustrative and finalisation will be led by New Local.

9. Outcomes and metrics

The investment isn't a silver bullet for deeply entrenched inequalities in these areas, but it will improve outcomes in several ways. These are shown in the table below.

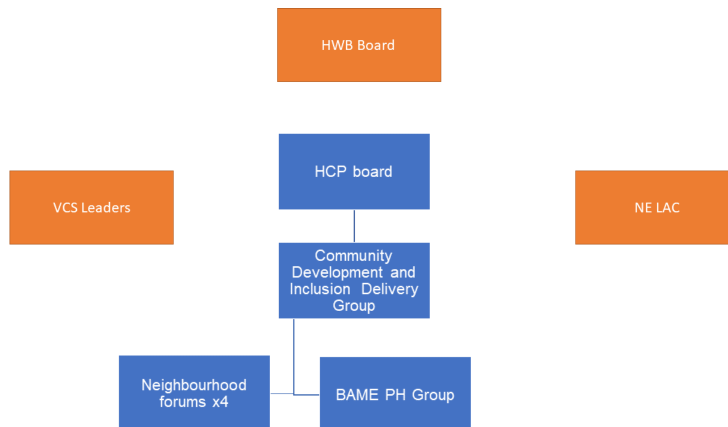
Aim	Objective	ST Outcomes (First 12 months)	MT Outcomes (1 to 5 years)	LT Outcomes (5 years plus)
1. To connect people to each other in their communities	Ensure we make the best use of local infrastructure to improve connection to people in the community	People feel happier and better about themselves People feel more supported by other people More people volunteering	More people have strong and supportive friendships and contacts to draw upon People have improved wellbeing and resilience Reduced inappropriate hospital admissions	Tackled significant inequalities Live, longer, happier lives
	Improve opportunities for people to connect and contribute to their local area			
	Make long term sustainable investments into VCS			
	To coordinate the work of partners in NE	Better partnership		

Aim	Objective	ST Outcomes (First 12 months)	MT Outcomes (1 to 5 years)	LT Outcomes (5 years plus)
		working across sectors		
2. To build community capacity of individuals and neighbourhoods to help them address issues that are important to them	Enhance the skills, knowledge and resources of local people to improve their communities and own lives	People feel happier and better about themselves People feel more supported by other people More people volunteering	People and communities are better able to identify and deliver solutions that meet their needs People are better able to gain the skills, capacity and confidence to play an active role in their communities People and communities are better able to participate in the social, economic and cultural life in Sheffield More people are at work Reduced inappropriate hospital admissions	Tackled significant inequalities Live, longer, happier lives
	Pilot a new relational model for a small number of families experiencing disadvantage	People feel more supported by other people More people volunteering People feel they have more influence over their life circumstances		
3. To devolve power to communities	People can influence decisions that affect their neighbourhood via participatory budgeting	People feel they have more influence over their life circumstances	People and communities are better able to influence and participate in decision making and service development People and communities are better able to identify and deliver solutions that meet their needs Reduced emergency hosp admissions	Tackled significant inequalities Live, longer, happier lives
	Communities will produce their neighbourhood plans			

10. Governance

We have set up a community development and inclusion group who are agents of change – a diverse and multi-sector membership from the community, VCS, VAS, health, police, DWP, PCN, education, and the council – to plan and deliver the work.

Due to the nature of work and the aim to coordinate work in the city, it's anticipated that governance will evolve. A draft governance structure is overleaf. Note the neighbourhood forums haven't been set up and will need local governance to oversee the work in year two.



11. Questions for the board

- What oversight of the programme would the board like to have?
- What work in the city does this programme need to link to?

12. Recommendations

- The board is asked to note the paper and the progress of the work.

Lucy Ettridge
Deputy Director of Community Development and Inclusion
NHS South Yorkshire

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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	November 2023
Subject:	Follow up from Mental Health & CYP Workshops
Author of Report:	Greg Fell

Summary:

This paper attempts to summarise the main points of learning from two focussed and lengthy discussions at the health and well being board. The board is invited to comment on these reflections from the two sessions set out in section 2. The board may wish to comment more specifically on what members expect to see from the perspective of both content and ways of working from these two workshops going into the next health and well being strategy.

Questions for the Health and Wellbeing Board:

This short paper attempts to summarise the main points of learning from two focussed and lengthy discussions at the health and wellbeing board. The board is invited to comment on these reflections from the two sessions set out in section 2, both on content and process / style of the workshop sessions. Members may have additional perspectives not captured. The board may wish to comment more specifically on what members expect to see from the perspective of both content and ways of working from these two workshops going into the next health and well being strategy.

Who has contributed to this paper?

Bethan Plant, Dr Anthony Gore, Dr Steve Thomas

Follow up from Mental Health & CYP Workshops

1.0 SUMMARY

1.1 This paper attempts to summarise the main points of learning from two focussed and lengthy discussions at the health and well being board. The board is invited to comment on these reflections from the two sessions set out in section 2, both on content and process / style of the workshop sessions. Members may have additional perspectives not captured. The board may wish to comment more specifically on what members expect to see from the perspective of both content and ways of working from these two workshops going into the next health and well being strategy.

Brief reflections on process and content

2.0 The paper reflects one view, not the only view, other views are appreciated. It summarises main points of reflection on content and on the process of organising what might be termed as a deep dive on two very broad topics – the June board meeting focused on mental health, the September meeting focused on Children and Young People's health and wellbeing.

Design, process, structure & set up of the sessions

2.1 For both sessions a significant amount of effort went into the design, planning, format/structure and organisation of the meeting, to an extent this was an experiment on the merit of this style of focused discussion.

2.2 Attendance at both sessions from board members wasn't optimal.

2.3 Both sessions were hugely informative and the content can and will be used in other spaces, it will stand for some time. There are mixed views from those involved in the planning and delivery of the sessions and also board members of the merit of the effort in organising and running the session versus the benefit to those board members that attended.

2.4 The purpose and intention of the sessions was to provide board members with up to date information relating to the theme and to consider/debate some of the current significant relevant challenges. Those involved aimed to consider what the Health & Wellbeing Board could do to support and address issues raised.

2.5 Arguably there was too much time in the presentation content and insufficient time for board members to discuss and debate what they had heard. This was a difficult balance with so much content to deliver focusing on each themed area.

2.6 The requirement for presentation content was necessary due to the limitations of delivering the sessions within the Council chamber and in planning what was expected to be a session delivered to 20+ board members. Whilst efforts were made in monitoring expected attendance in retrospect given the numbers present a more

informal workshop style session may have been more suitable. This was not possible due to the constraints of the space available and the planning required.

Content of both sessions

2.7 This paper will not replay the content of the presentations or the discussion that followed.

2.8 Both sessions told a strong story on good practice across a wide spectrum of activity, over a long period. Arguably both sessions focused on the positive story and didn't dwell enough on the difficulties and the context. It is widely acknowledged that over the last decade delivery has been difficult and population need has risen, outcomes are static (and beginning to deteriorate in some places). We obviously shouldn't skirt over this. There still are many problems to address. There are also many examples of good practice, both sides of a story need equal airtime.

2.9 It was clear we have a strong culture of partnership across both areas discussed. Obviously something to cherish and nurture. For both areas, there is clearly a strong and coherent approach to programme delivery. How we do what we do matters, that we approach it that way also matters and it is clear we don't always get it right, where we don't we own that and work to put it right as best we can.

2.10 We have the right overall strategy focused on mental health and CYP. Whilst all agree that mental health is everyone's business, arguably the scope of the strategy is too big for a single controlling mind or programme management infrastructure. We know we have a fragmented landscape across many areas of policy and service delivery across multiple sectors.

2.11 In the conversation on mental health we had at the board we spent most time talking about one element of the strategy. The conversation was framed skewed towards the NHS, but strategy is well beyond. We spent our time talking about care for those who needed NHS care – children or adult.

2.12 The determinants of mental health didn't features strongly in the conversation we had, though we know we have plenty of delivery of interventions on the determinants of mental health. We equally know we have cut lots from this resourcing wise – and that has consequence on mental heath outcomes. Often this is not done explicitly in the name of "mental health". It is hard to get this properly documented and programme managed in a way framed and oriented around mental health. For example we didn't talk about child poverty, nor the welfare system and the enormous impact that has on mental health.

2.13 Particularly for mental health in children and young people this is usually not an organic intrinsic disease, but it is a product of the environment. Their physical environment in terms of housing and area they live, their trauma, not just ACE's trauma but living everyday with little food, with cold, with poor clothing, life experience and life expectations AND living with SEND and communication/neurodevelopmental issues - all of that is what drives mental health issues in children, and what drives

attendance/inclusion issues as well. It must therefore be considered preventable, and our city approaches should be preventative.

2.14 There is plenty of good practice from both policy through to service delivery. Getting the balance of accentuating positives whilst not shying away from difficult issues is hard.

2.15 We probably also focused too much on what is working well and avoided attention being given to some aspects of mental health (care or public mental health) that are fundamentally broken. For example CAHMS under resourcing, welfare policy that many say creates poverty.

2.16 It is easy to be focused on individual provider perspectives rather than whole population perspectives. Obviously, the challenge is to make the conversation about people and communities, not providers, (nor what individual agencies are "commissioned" to do). Some suggested there was some disconnect from user experience then what service providers said. There was an observed apparent lack of join up across system – each organisation saying what they were doing. In the conversation that followed it wasn't obvious at some points how as a system we are coming together – who acted as integrator.

2.17 Everyone accepts it is hard to shift focus of investment to prevention and tackling causes, also avoiding the danger of medicalising social ills. We say shift from medical to social model, and the concept of parity of esteem. On all these we don't make the progress we hope to. We broadly know the reasons, not the least of which is significant under funding of some pretty primary level services.

2.18 The C&YP's session attempted to follow the 0-25 years life course approach. It was unrealistic to attempt to cover such a wide age range in the session. The presentation referenced the many different strategies in existence that attempt to address C&YP's health and wellbeing, as well as describe some of the governance structures that attempt to co-ordinate and oversee their delivery.

2.19 The key priority of Start for Life was shared and board members shared their views of how the best start in life is essential to ensure the best outcomes. Development of a city wide, approach to early identification of need and early help. Ensuring how we link maternity to Best Start in Life, early identification of need and our early help system and services. A focus on children and young people 'belonging'. Views from board members reflected on how our early help system of services and support needs to fully integrate so all our families with needs are identified and receive joined up help and support. All aligned with the priority of identifying those most vulnerable and prioritising areas of the city with greatest need. The themed session used 'real life' annoymised case studies to describe children, young people's and families experiences. Real life examples of navigating services, health needs and the challenges of the system. The case studies were an example of describing lived experience and provided by the VCF sector demonstrating their involvement in the planning and delivery of the session.

2.20 A consistent theme across C&YP session was the correct identification of communication issues whatever the diagnosis and the impact this has on a child/young persons ability to learn and thrive, school behaviour and the wider attainment of the child. There are complexities like the correct diagnosis of DLD, parent/carer expectations of diagnosis, potential over medicalisation of some issues, huge pressure regarding assessment for neuro diversity across the system and the impact on education sufficiency and schools.

2.21 Ultimately unlike perhaps treating an infection or a fracture or a cancer, the NHS' role in most CYP's lives is supportive. It's facilitative of their development, of their education, of their growth (in every sense) - some of our interventions will be from health services but our significant outcomes are actually in the main education outcomes. If we reduce health waiting lists but no more children are in education and learning and getting qualifications then that isn't success. The session emphasised the challenges for the education sector, of regular school attendance and presented the board with some key questions to consider.

3.0 The next health and well being strategy.

Both themed sessions should help shape the development of the next Health and Wellbeing Strategy. As the design and development of this is considered:

3.1 It is expected that quick wins are going to be difficult.

3.2 The broad themes from these two sessions and the board discussion that was prompted from the themes will therefore become integral to the strategies development.

3.3 The strategy should set an expectation of leftward shift of resource (both focus of intervention and age wise), and making progress on parity of esteem.

3.4 It is expected the board may wish to see a strong push on equity of funding for all resource areas that contribute to health and well being (the concept of proportionate universalism)

4.0 QUESTIONS FOR THE BOARD AND RECOMMENDATIONS

4.1 The board is invited to comment on these reflections from the two sessions set out in section 2, both on content and process / style of the workshop sessions. Members may have additional perspectives not captured.

4.2 The board may wish to comment more specifically on what members expect to see from the perspective of both content and ways of working from these two workshops going into the next health and well being strategy.

4.3 Reflection from those facilitating and planning the sessions confirmed it was useful to have 'time' to discuss and present to board members. Overall the constraints of the

Council chamber and limitations this posed were key learning points. For future workshop sessions a different venue and workshop style model may be preferable.

4.4 What other themes should be considered for workshop sessions in the future? Feedback from the C&YP session suggested further discussion on key challenges such as attendance, C&YP MH, neurodiversity, 0-19 Healthy Child Programme Services as individual themes which the board could consider in future.

4.5 The most obvious and final consideration is how we incorporate the main points into the the development of the HWB strategy going forward. Whilst all are agreed the HWBB must reflect on the “right thing to do” at a strategy level (as has been discussed and articulated many times), a wide set of constraints – financial, externally imposed “must do” issues - may make this difficult. Thus board members may reflect on how insistent we are on holding to a strategy and approach that will most reduce the gap in health over a long period and openly discuss trade offs. A key role for the board and the strategy of the board is to set an environment where the “right” things health inequalities wise are more likely to be executed.

Agenda Item 10

HWBB Forward Plan - Public Meetings

Month	Type	Topics	Topic Leads	Ambition	Time	Additional invitees and notes	Chair
14th December 2023	Public	Healthwatch Update	Judy Robinson		00:10		Dr McMurray
		BCF Update	Martin Smith		00:20		
		Joint Strategic Needs Assessment	Chris Gibbons		00:25		
		NHS Sheffield Neighbourhoods Work	Eleanor Rutter/Lucy Ettridge		00:20	Bump this? - email Lucy/Eleanor	
		Follow up from Mental Health and CYP Workshops	Greg Fell		00:10		
		Assessing spending decisions against our Strategy	Chris Gibbons/Jackie Mills		01:00		
		Forward Plan	Greg Fell		00:05		
					02:30		
28th March 2024	Public	Healthwatch Update	Judy Robinson		00:10	Meeting inside PERP - guidance needed	Cllr Argenzio
		BCF Update	Martin Smith		00:10		
		Employment and Health	Ruth Granger/Laura Hayfield		00:45	30-45 mins requested	
		Collaborating for Health - update	Eleanor Rutter				
		Unpaid Carers	Alexis Chappell/Janet Kerr				
		Joint Health & Wellbeing Strategy update	Susan Hird				
		Health Protection	Ruth Granger				
		Annual Report	Greg Fell				
		Forward Plan	Greg Fell		00:05		
					01:10		
27th June 2024	Public	Healthwatch Update	Judy Robinson		00:10		Cllr Argenzio
		BCF Update	Martin Smith		00:10		
		Joint Health & Wellbeing Strategy Sign Off	Susan Hird				
		Delivering change through the Strategy - making progress	TBC				
		ICB Update	TBC			CEX and Chair of ICB to be invited	
		Collaborating for Health - update	Eleanor Rutter				
		Forward Plan	Greg Fell		00:05		
					00:25		
26th September 2024	Public	Healthwatch Update	Judy Robinson		00:10		Dr McMurray
		BCF Update	Martin Smith		00:10		
		Health Protection Update	Ruth Granger				
		Forward Plan	Greg Fell		00:05		
					00:25		

Strategy Key			
1	Every child achieves a level of development in their early years for the best start in life	6	Everyone can safely walk or cycle in their local area regardless of age or ability
2	Every child is included in their education and can access their local school	7	Everyone has equitable access to care and support shaped around them
3	Every child and young person has a successful transition to adulthood	8	Everyone has the level of meaningful social contact that they want
4	Everyone has access to a home that supports their health	9	Everyone lives the end of their life with dignity in the place of their choice
5	Everyone has a fulfilling occupation and the resources to support their needs	HI	Overall Health Inequalities Goal

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 28 September 2023

PRESENT: Councillor Angela Argenzio (Co-Chair), Alexis Chappell, Councillor Dawn Dale, Greg Fell, Councillor Douglas Johnson, Yvonne Millard, Judy Robinson, Rachel Siviter, Dr Leigh Sorsbie, Helen Steers (Substitute Member) and Meredith Dixon-Teasdale

1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Dr David Black, Sandie Buchan, James Henderson, Kate Josephs, Benn Kemp, Megan Ohri, Kate Martin, Dr Zak McMurray, Joe Rennie, Dr Toni Schwarz, Helen Sims, and Rob Sykes.

1.2 Helen Steers attended as a substitute for Helen Sims.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

3. PUBLIC QUESTIONS

3.1 No questions had been submitted by members of the public.

4. BETTER CARE FUND UPDATE

4.1 The report which updated the Board on the 2023/25 Better Care Fund Plan, was introduced by Martin Smith Deputy Director of Planning and Joint Commissioning.

4.2 Board Members felt that the following issues arising from the report were important:

- “Team around the person” offered important lessons.
- It would be important to summarise what impact there would be on Housing and what would be done differently as a result of the plan.
- Services such as Homelessness, and Disabled Facilities Grants are part of the Better Care Fund. This work should be described better and added into the work programme where appropriate.
- It should be considered whether the aim of shifting funding upstream had been achieved.
- Whilst the efficiencies described in the report were welcomed it was felt to be important to consider investment too, particularly in housing.
- Resilience should be a focus, going forward, to enable people to live more independently. It would be useful to have a dedicated session of the Health and Well Being Board focussing on promoting independent living.

4.3 The Sheffield Health and Wellbeing Board

(a) notes the 23/25 Better Care Fund Plan update and
(b) delegates sign off to the Chair and Better Care Fund organisational leads.

5. HEALTH PROTECTION

5.1 The report which gave one of the twice-yearly updates on the health protection system, was delivered by Ruth Granger, Consultant in Public Health. The report included a review of the Public Health Outcomes Framework measures of health protection for Sheffield, an update on increase in Sexually Transmitted Infections, reporting progress on reviewing the Sheffield Mass Treatment and Vaccination Plan and work to increase capacity for Infection Prevention and Control in the city.

5.2 A discussion took place regarding whether the community channels which had been set up during the Covid pandemic were still being used. Ruth Granger advised that this was being encouraged but there were funding constraints. Greg Fell stated that NHS England was about to publish its vaccine delivery strategy and this was likely to encourage community facilities to assist with vaccine take up.

5.3 A question was raised regarding latent TB screening through primary care. Ruth Granger advised that she could come back to a subsequent meeting of the Board with further information on this, but progress was good against NHS targets. Screening was currently being focussed on new university students.

5.4 The Chair (Councillor Angela Argenzio) stated that she should declare an interest as she worked for City of Sanctuary, however she wanted to raise that regarding accommodation for asylum seekers, the government were pushing for two people per hotel room. She asked whether there was funding in place for the resulting spread of infectious diseases.

Ruth Granger advised that this was a known risk and accommodation providers had to have Outbreak Plans. They were also given advice by the UJ Health Security Agency regarding supporting and managing any cases. Funding had been extended to housing settings where vulnerable people lived, and this included asylum seekers.

5.5 Sheffield Health and Wellbeing Board:

(a) Agrees to consider what role partners on the Health and Wellbeing Board can play in addressing issues highlighted in the Public Health Outcome Framework indicators;

(b) Agrees to consider the link to its representative on the Sheffield Mass Vaccination and Treatment Plan to ensure that there is a good fit between Council organisational plans and the city-wide MTV Plan as its updated;

(c) Notes the increase in levels of Gonorrhoea and Syphilis and where appropriate will take action to increase testing; and

(d) Endorses work to increase capacity around Infection Prevention and Control in the city.

6. COLLABORATING FOR HEALTH- CONFERENCE UPDATE

6.1 The report, which provided a short summary of the outputs from the “Collaborating for Health”, conference, which had been supported by the Board, was presented by Helen Steers of Voluntary Action Sheffield.

6.2 The conference had brought together a number of organisations to promote collaborative working with people at its centre. Greg Fell advised that this was likely to form a core feature of the next Health and Wellbeing Strategy. Also he felt there should be greater communication promoting existing physical assets.

Judy Robinson of Healthwatch stated that conference speakers had emphasised that it was political commitment which enabled change to happen.

Alexis Chappell advised of the importance of tying this work in with the new Physical Health Strategy.

The Chair (Councillor Angela Argenzio) added that it was important that the Council be an enabler rather than gatekeepers, in particularly regarding financial resources, in order to tackle health inequalities in the city.

6.3 Sheffield Health and Wellbeing Board

(a) Notes the update on the conference event; and
(b) Agrees to receive a fully developed proposition at a future meeting.

7. CO-OPTING A NEW BOARD MEMBER

7.1 The report which proposed to co-opt the Chief Executive of Sheffield Health and Social Care Trust as a member, was presented by Greg Fell, Director of Public Health.

7.2 Sheffield Health and Wellbeing Board agrees to co-opt the Chief Executive of Sheffield Health & Social Care Trust as a Board member, pending a full review of the Board’s Terms of Reference as part of broader review of strategic partnerships.

8. FORWARD PLAN

8.1 The Forward Plan was presented by Greg Fell, Director of Public Health.

8.2 Greg Fell asked for suggestions as to what work should be added to the forward plan and it was suggested that an expanded discussion about housing could take place in March, including the Better Care Fund.

9. MINUTES OF THE PREVIOUS MEETING

9.1 The minutes of the previous meeting of the Board held on the 29th June 2023 were approved as a correct record subject to the following corrections:

- Dr Andrew McGinty had been in attendance deputising for Dr Zak McMurray, Tim Gollins had deputised for Alexis Chappell and Sarah Batty had deputised for Rachel Siviter.

10. DATE AND TIME OF NEXT MEETING

10.1 The Board noted that its next meeting was scheduled to take place on 7th December 2023 at 10.00am.

11. THE HEALTH AND WELLBEING OF YOUNG PEOPLE IN SHEFFIELD

11.1 The webcast ceased at 14.54 and was followed by a Board workshop.