HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Alexis Chappell, Director of Adult Health and Adult Social Care Ian Atkinson, Deputy Place Director (Sheffield)
Date:	27th June 2024
Subject:	Sheffield's Better Care Fund Q4 End of Year Report and Better Care Fund 2024/25 Refresh Update.
Author of Report:	Martin Smith – Assistant Director of Transformation and Delivery

Summary:

As Board members will be aware the Better Care Fund is a jointly led programme developed by the 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 Programme requires each Health and Wellbeing Board to ensure a joint plan meeting nationally set conditions is in place and assured. At the Health and Wellbeing Board meeting in September 2023 the Board were briefed on the requirement for Sheffield to have a two-year Better Care Fund Plan covering 2023/24 and 2024/25. The plan was developed jointly by Sheffield partners and the Board agreed to delegate the final approval of the plan to the co-Chairs of the Health & Wellbeing Board due to the demanding NHS England timescales. The Sheffield 2-year plan was reviewed by the national team and approved on 18 September 2023. This report covers a summary of the first year of the plan 2023 to 2024 and the agreed updates to the plan for second year of the plan covering April 2024 to March 2025.

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 2023/24 Better Care Fund Q4 update;
2. Note the submission of the 2024/25 refresh planning template; and
3. Delegate in year oversight to the Joint Strategic Executive Meeting and sign off of in year reporting to the Board Co-Chairs.

Background Papers:

1. BCF Q4 2023/24 Template Submission
2. Team Around the Person Case Study
3. Summary of the changes in 24/25 BCF
4. BCF Q1 2024/25 Template Submission
5. Reporting timeline for 2024/25

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 2023/24 SUMMARY

1.0 BCF END OF YEAR REPORT

Introduction

The end of year Better Care Fund reporting template was published on 24 April 2024 with a submission date of 23 May 2024. The template required confirmation that Sheffield is meeting all national conditions, update on Better Care Fund finance, key performance indicators and a summary of key achievements and challenges in 2023/24. The template was completed and jointly reviewed between Health and Care Leads. To meet the national deadline a briefing and sign off session took place with the co-Chairs of the Health and Wellbeing Board on 22 May 2024. The template was approved and sent to NHS England on 23 May 2024 (appendix 1).

Performance against BCF Targets

National Conditions

The Q4 report confirmed that Sheffield is meeting all the Better Care Fund National Conditions set nationally for the Better Care Fund.

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.	1014	1231* *Forecast as data set incomplete	Due to a delay in data during target setting we now know our 2023/24 plan was too ambitious. Sheffield has seen an increase in avoidable admission with the increases mostly seen in Chronic obstructive pulmonary disease (COPD), Heart Failure and Asthma related admissions when compared to the previous year, this trend can be seen in other South Yorkshire areas. Additional information on this metric is within the paper as requested at the Board meeting in March 2024. The key work areas on-going to support individuals to manage these conditions and provide urgent support should they require it are highlight below: Sheffield has a city-wide multi-agency approach that supports an individual's anticipatory care needs via holistic assessment of needs and care coordination, leading to creation of a jointly shared action

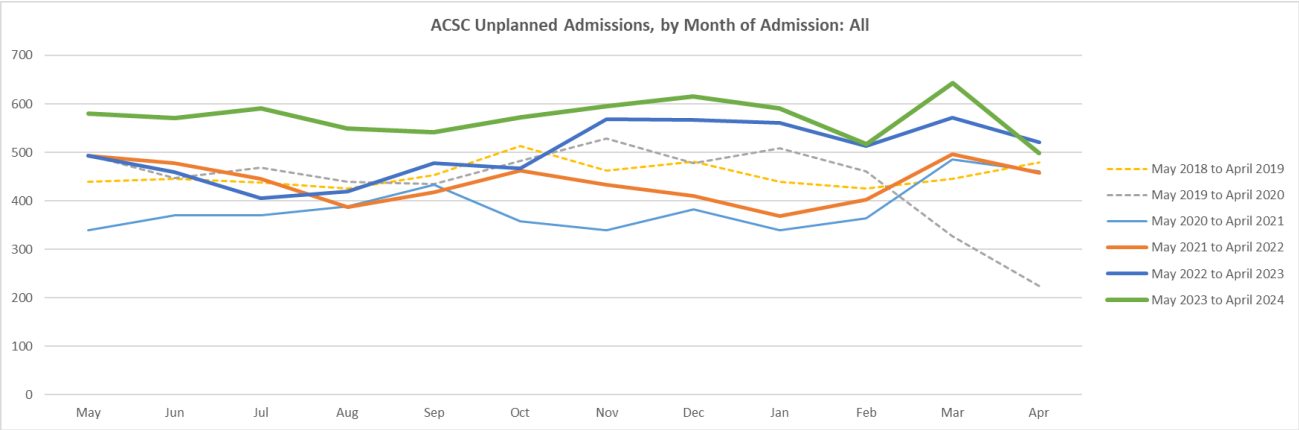
				plan with the patient wishes at the centre. We have embedded an urgent community response pathway to support people in crisis in the community - Creation of a service offer for UCR support in care homes - Established a 'Push' model from 999 to Urgent Community Response Teams - Sustainably delivering against target supporting Sheffield to achieve the lowest percentages of See Treat and Convey in South Yorkshire and second lowest in North East and Yorkshire. We have the highest percentage of those going to elsewhere other than Emergency Departments recognising the focus on integrated primary and community services offer in Sheffield.
Discharge to normal place of residence	% of people who return to their normal place following discharge from hospital	98%	98%	Sheffield achieved the target of 98% in 2023/24 and continues to prioritises ensuring people return home, or to their usual place of residence on discharge from hospital. An update on progress made our joint discharge model was provided to the Adult Committee on 19 June 2024 and more information can be found here.
Residential Admissions	Rate of permanent admission of older people per 100,000 population into care homes.	668	638	Sheffield was lower than target on this target reflecting the principles of home first embedded within teams and supporting people in communities to live at home for as long as possible. The Market Oversight Report and Plan was provided to Adult Health and Social Care Committee in March 2024 and highlighted good progress made in ensuring to a sustainable, diverse, and quality market to support the residents in Sheffield.

				- The Transforming Care Homes programme has supported the delivery of this indicator and is developing in a phased approach following approval of the Transforming Care Homes Programme at Adults Committee in February 2023 along with the Care Homes High Level Plan and Commissioning Strategy. This programme alongside the embedding of the new quality assurance framework will aim to ensure that people in Sheffield who need residential or nursing care, and their families, have positive experiences and outcomes, and we can reach a position collectively with the sector for delivery upon fair cost of care. A new framework using a Dynamic Purchasing System for standard rate care homes for Older People's (residential and nursing care) went live on Monday 5th February 2024 with 25 Providers (45 care homes) successfully joining the framework.
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%	Sheffield achieved this target with 85%. The Short-Term Intervention Team (STIT) have been working with individuals supporting them to return home after a period in hospital, to regain independence. The Service supports on average up to 270 people at any one time and accept referrals seven days a week. The team has been maximising its capacity by reducing duplication, streamlining existing processes and working to the Intermediate Care Framework. HomeLink has been commissioned to support individuals who return home on discharge pathway one as part of the transformation of the discharge to assess programme. They are working with up to 150 individuals at a time to expedite discharge from the hospitals and handover to the home care independent sector providers.

Falls	Emergency Hospital Admissions due to falls in people aged 65 and over directly age standardised rate per 100,000	2023	2022* *Forecast as data set incomplete	The work on falls in 2023/24 has included joint working with Yorkshire Ambulance Service and Pharmacy colleagues to prevent falls and medication errors. We are currently preventing around 10 ambulances a week, supporting uninjured fallers through our City-Wide Care Alarms Service. Our work on falls was presented at BCF Regional Event with the model shaping some of the national thinking in this area. A copy of the presentation was shared the Board in March 2024 - PowerPoint Presentation (sheffield.gov.uk). Other key areas of work this year have included: - Development of a Sheffield Falls screening tool embedded in "What Matters to Me" shared across services; voluntary, council and health. - Development of a self-assessment falls tool that can be used by clients and staff. - Training of staff in the voluntary sector on Falls risk awareness and self-assessment. - Training of staff across the pathway to enable delivery of falls strength and balance programmes. - Mapping of the current pathway for falls Rehabilitation in the city. - Engagement with staff and residents in council housing to describing the anticipatory care needs of over 60s to prevent falls - The Falls team have written a 'Team Sheffield' Falls plan - Interventions to reduce unnecessary hospital admissions – expansion of falls pick up – Joint initiative between SCC/ICB & YAS

Long Terms Conditions Unplanned Admissions Review

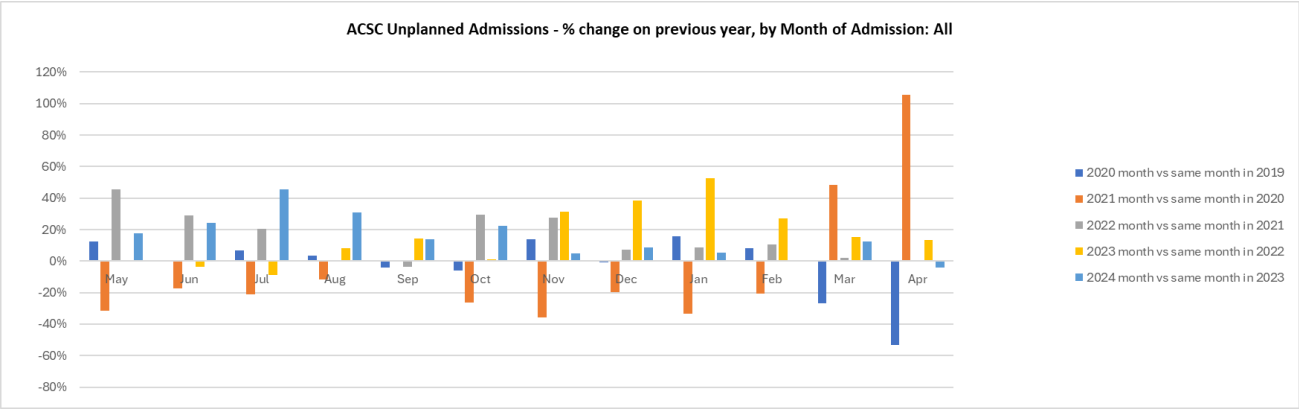
The ambulatory care target was not achieved in 2023/24 with the overall number increased by 14% against the previous year. The graph below shows the changing trend in total number from 2018/19 to 2023/24.



The data in the table suggests that whilst activity does look to have been increasing overall for the past few years, it should be noted that:

- we would expect c.1% population growth per year, so some increase in activity is usually apparent
- activity has, as expected, been rising to pre-Covid levels around January 2021 and looks to have plateaued around November 2022 - i.e., no significant spikes since then and this is also the case with South Yorkshire.

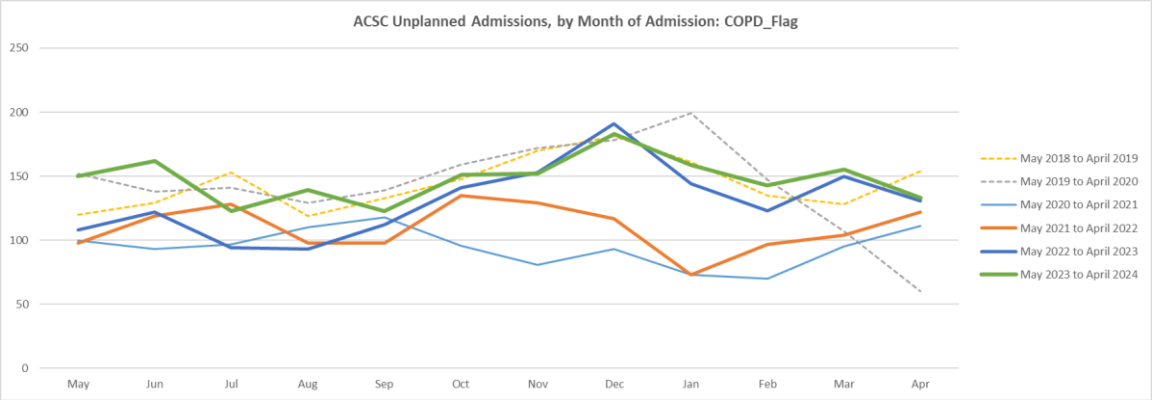
The graph below the shows the unplanned admission on previous year by month that shows although there has been an increase the slowdown in the rate of increase is consistent with reaching the pre-pandemic level and plateauing.



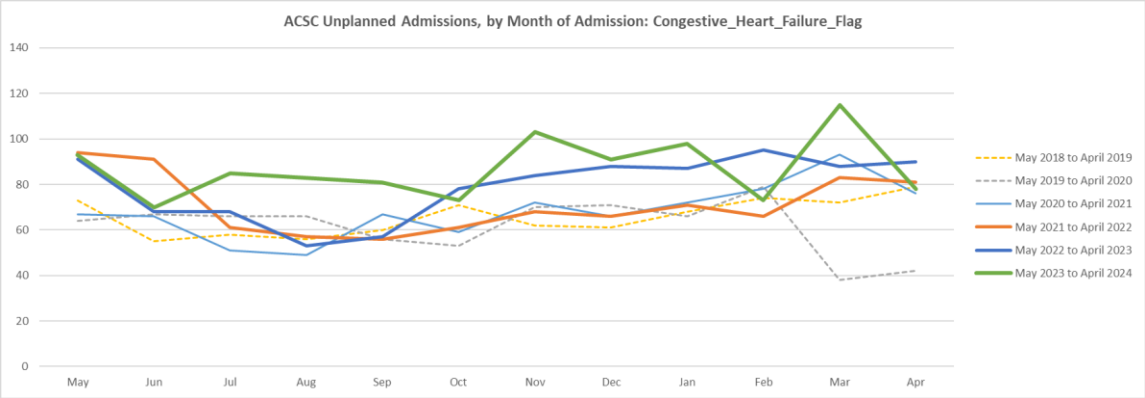
The unplanned admissions indicator is made up from a number of long-term conditions and within individual conditions there is more fluctuation, but this is in part due to smaller numbers. Dementia admissions look to be falling, but this may be related to slower diagnosis in practices. The largest proportion of admissions are for COPD, Congestive Heart Failure and Asthma making up around 51% of total admissions.

Although the number of admissions is high the change from previous year for some of these is not significant. The Graph below shows those highlighted above and the change over time.

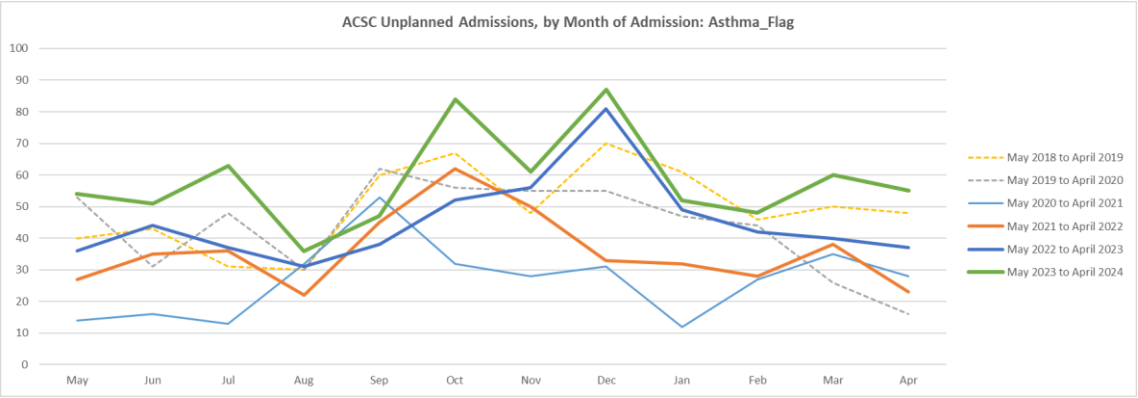
COPD



Congestive Heart Failure



Asthma



Work is underway to validate the primary and secondary care data. The first cut of data shows a variation of rates by GP practices, but this tends to be for those with smaller numbers, which means the rates fluctuate more widely. More data quality work is required to understand the impact at GP level and work is on-going with primary care to understand this variation.

The data is caveated as the condition type is based on primary diagnosis of each admission. Anyone admitted with a respiratory condition due to Covid would probably have this as their Primary diagnosis and other e.g., Asthma/COPD as secondary and therefore, when Covid was at its highest, these 2 flags will likely show a fall due to priority of coding used - it therefore doesn't necessarily mean that admissions with Asthma or COPD fell during this period.

There is significant work ongoing in Sheffield to support people to manage their long terms conditions and get the same day urgent support they require. One the key evidence-based activities is Pulmonary Rehabilitation (PR). PR is a treatment programme of exercise classes designed for people with long-term lung conditions. A project is currently in progress to identify barriers patients face in accessing PR is underway. The groups include patients who are currently requesting a home programme, patients who are declining starting a PR pathway, and patients who start but do not complete a PR programme. The project aims to address any inequality of access. Healthwatch is undertaking this on behalf of Sheffield Teaching Hospital NHSFT.

Additional local data collection now includes CORE20PLUS5 data which will inform the service of population groups who are not accessing PR and assist planning to find solutions for the future.

Further analysis work will be conducted on this indicator and provided back at the Next Health and Wellbeing Meeting as part of the Better Care Fund update on metrics for Q1 2024/25.

2.0 BCF FINANCE AND PLANNING UPDATES

The Better Care Fund budgets are a subset of the total budgets within each commissioning organisation, which align to the principles and guidance of adult joint commissioning. As a result, the Better Care Fund reported position does not represent the full financial position of each organisation.

The HWBB delegates in year oversight to the Joint Executive Meeting, comprised of Directors at SCC and SYICB Sheffield Place. This meeting receives regular updates around the financial delivery of programmes and monitors in year variances. Any changes to budgets after initial sign off when the plan is submitted for national approval follow the internal process of the individual organisations and receive secondary approval to confirm they are made with joint oversight and to meet the changing needs of the Better Care Fund programmes by the Joint Executive Meeting on behalf of the HWWB.

The current agreed risk share arrangements with the Section 75 agreement state that each organisation is responsible for any financial variances on their individual budget areas. The final year end position within the Better Care Fund schemes for 2023/24 was a £0.106m overspend (NHS SYICB – Sheffield Place £1.329m overspent, SCC £1.223m underspent).

Across the seven Better Care Fund Themes the spend has been in line with plan with the exception of On-Going Care and Mental Health, where the change in spend relates to packages of care and a movement in the case mix between Mental and Physical Health based upon actual activity during the year.

A summary of the spend can be found in the table below:

NHS SYICB SPLC and Sheffield City Council Financial Position for Period Ending 31st March 2024 Memorandum: Section 75 - Better Care Fund				
Theme	Year to Date: March			
	Budget	Expenditure	Variance	
			Over (+)/ Under(-)	
	£'000s	£'000s	£'000s	%
Citywide Position				
People Keeping Well in their local community	7,357	7,497	140	1.9%
Active Support & Recovery	60,750	61,022	272	0.4%
Independent Living Solutions	6,408	7,015	606	9.5%
Ongoing Care	175,418	178,013	2,595	1.5%
Emergency Medical Admissions - STH	76,907	76,907	(0)	(0.0%)
Mental Health	148,667	145,576	(3,091)	(2.1%)
Capital Grants	6,200	5,783	(417)	(6.7%)
Additional Discharge Funded Schemes outside of Themes	7,172	7,172	0	0.0%
TOTAL EXPENDITURE	**488,879**	**488,985**	**106**	**0.0%**

The plans for 2024/25 have recently been approved and submitted for approval. The table below gives a summary of the funding allocated to programmes by funding source:

Sheffield HWBB Better Care Fund Memorandum: Section 75 - Better Care Fund Budgets 2024/25							
Theme	Full Year Budget 2024/25	Funding Source					
		Minimum Contribution by NHS	IBCF	DFG	Additional LA Contribution	Additional NHS Contribution	Discharge Funding
	£'000s		£'000s	£'000s	£'000s	£'000s	£'000s
Citywide Position							
People Keeping Well in their local community	7,334	1,379	923	0	5,032	0	0
Active Support & Recovery	62,912	22,662	8,742	0	0	31,507	0
Independent Living Solutions	7,335	3,091	0	0	4,244	0	0
Ongoing Care	207,563	25,947	19,625	0	109,125	52,865	0
Emergency Medical Admissions - STH	78,244	0	0	0	0	78,244	0
Mental Health	151,069	0	0	0	9,561	141,508	0
Capital Grants	6,187	0	0	5,572	615	0	0
Discharge Funding	11,814	0	0	0	0	0	11,814
TOTAL EXPENDITURE	**532,458**	**53,080**	**29,290**	**5,572**	**128,577**	**304,125**	**11,814**
NHS SYICB Sheffield Place							
People Keeping Well in their local community	1,379	1,379	0	0	0	0	0
Active Support & Recovery	54,170	22,662	0	0	0	31,507	0
Independent Living Solutions	3,091	3,091	0	0	0	0	0
Ongoing Care	78,813	25,947	0	0	0	52,865	0
Emergency Medical Admissions - STH	78,244	0	0	0	0	78,244	0
Mental Health	141,508	0	0	0	0	141,508	0
Capital Grants	0	0	0	0	0	0	0
Discharge Funding	4,970	0	0	0	0	0	4,970
NHS Total	**362,175**	**53,080**	**0**	**0**	**0**	**304,125**	**4,970**
Sheffield City Council (SCC)							
People Keeping Well in their local community	5,955	0	923	0	5,032	0	0
Active Support & Recovery	8,742	0	8,742	0	0	0	0
Independent Living Solutions	4,244	0		0	4,244	0	0
Ongoing Care	128,750	0	19,625	0	109,125	0	0
Emergency Medical Admissions - STH incl. Aligned Budget	0	0	0	0	0	0	0
Mental Health	9,561	0	0	0	9,561	0	0
Capital Grants	6,187	0	0	5,572	615	0	0
Discharge Funding	6,844	0	0	0	0	0	6,844
SCC Total	**170,283**	**0**	**29,290**	**5,572**	**128,577**	**0**	**6,844**

Notes:

Key elements of each theme are summarised below:	
People Keeping Well in their local community	Includes Care Planning, Health trainers/ Community Support Workers, Community Grants and Support to VCF sector, Public
Active Support & Recovery	Includes community nursing, Intermediate Care Beds, CICs, Transfer of Care Teams, STIT,and Intermediate Care Assessment
Independent Living Solutions	Includes community equipment and adaptations
Ongoing Care	Includes CHC, FNC, Learning Disabilities, and Adult Social Care.
Emergency Medical Admissions - STH	Includes Adult Inpatient Medical Emergency Admissions (excluding gastroenterology)
Mental Health	Includes all adult mental health services as commissioned by the CCG.
Capital Grants	Includes equipment and adaptations which meet the criteria for capital spend.

3.0 BETTER CARE FUND 2023/24 PROGRESS

The Better Care Fund plan aligns to all six of the commitments in the Adult Social Care strategy with two primary objectives:

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

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

During 2023/24 significant progress took place supporting the primary objectives. In the Q4 BCF return the progress on supporting unpaid carers was highlighted as well as the work to integrate the workforce delivering the services to people in Sheffield. Some of the key improvement and progress areas that support the BCF primary objectives are highlighted below:

CARERS ROAD SHOW AND UNPAID CARERS SUPPORT

Sheffield saw its first Carers Roadshow held on 5 October 2023 at the Winter Garden and St Paul's Hotel with over 30 local organisations that support unpaid carers in Sheffield coming together for the day. Carers are a key part of the Better Care Fund and the roadshow was organised by Sheffield City Council, Sheffield Carers Centre, Sheffield Young Carers, and NHS South Yorkshire and supported by NHS England, Sheffield Teaching Hospitals NHSFT and Sheffield Health and Social Care NHSFT, as well as two national Carers charities Carers UK and Carers Trust. It was formally opened by local dignitaries representing the partnership as well as the Lord Mayor and John Burkill know in Sheffield as 'the man with the pram'.

There are over 60,000 unpaid carers in Sheffield with only approximately 10,000 having contact with the Sheffield Carers Centre, Sheffield Young Carers and Sheffield Parent Carer Forum so awareness needs to be raised and carers encouraged to reach out. At the Roadshow carers were able to access a wide range of information and to consider what matters to them and those they care for. They were also encouraged to help plan future services. The support agencies attending also looked at how they could work together, strengthening essential networks and looking at improvements for the future. More information about the event as well as support for carers can be found on the Sheffield Carers Centre website (www.sheffieldcarers.org.uk).

In relation to carers performance, we are referring 65% more Carers to the Carers Centre: 2023 (to end of October) – 612 (61 carers per month) set against in 2022 – 443 (37 carers per month). 100% asked said they were satisfied or very satisfied with the service they received.

TEAM AROUND THE PERSON (TAP) MODEL IN SHEFFIELD

The TAP model in the Better Care Fund was developed with the aim to offer exceptional care to individuals with complex needs and is a joint initiative developed between Sheffield City Council, Sheffield's Integrated Care Board (ICB), Sheffield Teaching Hospitals, and other partners. The model has been recognised nationally as best practice and has been shortlisted for prestigious awards like the MJ Awards and the Prince of Wales Nursing Times Award.

Through 2023/24 the TAP model has supported individuals with complex needs, involving coordination where service overlap and escalating needs are prevalent. This approach includes collaborative meetings involving practitioners, the individuals concerned, their families, and caregivers to devise personalised, solution-focused action plans.

The team received on average 80 referrals a month and 50% require full TAP support with the others being solved via Information and Guidance or our new Early Intervention panels. The service has at any one time around 240 live cases open which translates to around 40 open cases per TAP Coordinator with a 7-month average open case time. The benefits of TAP include minimised risk of case escalation, reduced service duplication, enhanced outcomes for individuals and families, improved integrated operations, and better access to appropriate care in a timely manner. A case study of one of individuals supported this year is included in appendix 2.

DISCHARGE PROGRESS

Partners across the city are committed to the principle of home first, optimising on-going care and support through timely out of hospital assessment. We are moving towards the national pathway definitions to describe our work, with 98% of people, supported to return home upon discharge. During 2023/24 we have established clear city-wide collaborative and governance arrangements, set out in our Sheffield Discharge Model. This will enable us to implement a new way of working where people are discharged within 24 hours of being identified as having No Criteria to Reside, by November 2024. Key to this is delivering a person-centred approach which puts the individual's views and wishes at the heart of discharge, shifting our focus towards prevention of admission.

Prevention is our preferred approach in Sheffield and discharge and home first are a key priority as part of Sheffield Integrated Health and Social Care Board Priorities within the **place plan.** The Sheffield Health and Care Board received the Approach-to-Discharge-Pathways-Redesign.pdf (sheffieldhcp.org.uk) in April 2023 that provided an overview and described our unique Place challenges, work proposed and underway. The Hospital Discharge Model to support this was agreed at Adults Committee in June 2023 and an update report Hospital Discharge and Urgent Care Delivery Plan Update was provided in January 2024. The June 19th report provides a current progress report on the implementation of this work.

To drive this work forward a system discharge lead has been appointed as a single coordinator working across the Council, ICB and Sheffield Teaching Hospitals NHS Trust (STH) to provide strategic oversight and delivery of hospital discharge.

During 2023/24 the Discharge Funding Allocation, governed under the terms of the Better Care Fund, was fully utilised to support the transformation plans across both physical and mental health and spanning all discharge pathways.

4.0 BCF PLAN REFRESH 2024/25

At the Health and Wellbeing Board meeting in March 2024 the Board were advised that the BCF National Team have indicated that the Addendum to the BCF Policy Framework and Planning Requirements for 2023/25 to be published along with the NHS Planning Guidance.

The BCF 2024/25 refresh requirements were published in April and a summary of the changes is attached as appendix 3 and were required back with NHS by 10 June 2024. To meet the deadline the refresh was agreed via delegated sign off by the Co-Chairs of the Health and Wellbeing Board due to the time frame set by the national BCF Team and DHSC. The refreshed targets and template for 2024/25 are included in appendix 4.

The BCF National Team has released the reporting timeline for 2024/25 which has been included in appendix 5. Due to the timings of the returns there is an ask to continue the delegation of in year oversight in 2024/25 to the joint executives and sign off to the Co-Chairs to meet the deadlines. Progress will be shared each quarter to this Board with data from the submissions to inform more detailed reviews and updates as required throughout the year.

5.0 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.

6.0 Questions for the Health and Wellbeing Board:

1. N/A

7.0 Recommendations for the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

1. Note the 2023/24 Better Care Fund Q4 update
2. Note the submission of the 2024/25 refresh planning template
3. Delegate in year oversight to the Joint Executive Meeting and sign off of in year reporting to the HWBB Co-Chairs

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