Report to Policy Committee

Author/Lead Officer of Report:
Alexis Chappell, Director Adult Health and Social Care

Report of:	Director of Adult Health & Social Care
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	16th November 2022
Subject:	*Director of Adult Social Services (DASS) Report to Committee*

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	X	No	
If YES, what EIA reference number has it been given?				
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*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*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 paper provides a Director's update regards the performance and governance of Adult Health and Social Care Services, including progress in meeting DASS accountabilities and delivering on our statutory requirements.

It also provides an update regards Adult Health and Social Care progress in relation to the Council's Delivery Plan and key strategic events and issues on the horizon.

Recommendations

It is recommended that Adult Health and Social Care Policy Committee:

- Notes the Director of Adult Health and Social Care report

Background Papers:

None

<table>
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<tr><td>Lead Officer Name:
Alexis Chappell</td><td>Job Title:
Director Adult Health and Social Care</td></tr>
<tr><td colspan="2">Date: 5th November 2022</td></tr>
</table>

1 PROPOSAL

1.1 This paper provides a Director's update regards Adult Health and Social Care Services, including progress in meeting DASS accountabilities and delivering on local and national reforms and our change programme.

2.0 BACKGROUND

2.1 This report starts with a thank you again to all of the social care sector, our teams and partners, who work consistently work well together to deliver the best outcomes for people of the City.

2.2 Following on from the last DASS report, the service has continued to make significant inroads in achieving and delivering upon our vision and our ambition to improve outcomes of people of Sheffield which is described in our strategy[1] and accompanying Delivery Plan[2] - Living the Life You Want to Live:

Everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are - and when they need it, they receive care and support that prioritises independence, choice, and recovery'.

2.3 These inroads, are being made at a time of significant change and reform across adult social care at a time where all adult social care services are continuing to respond to the pandemic, the cost of living and energy crisis as well as prepare for the introduction of the: -

- Social Care Charging Reforms
- Fair Cost of Care and Market Sustainability Planning
- Care Quality Commission (CQC) Adult Social Care Assurance Framework
- Liberty Protection Safeguards and further strengthening of our approaches preventing abuse and harm to individuals and protecting individual's human rights.
- Changes to the Mental Health Act along with significant increase in mental health contacts during the pandemic.
- Reporting on our Social Care Workforce Capacity
- Integration and the development of the new Integrated Care Systems, which also includes an assurance framework.

2.4 Over the past two months, we have particularly engaged with Department of Health and Social Care to support implementation of social care charging reforms and understand current position. In addition, worked with partners across Yorkshire and Humber and with providers to take forward the fair cost of care. It's planned to bring a further update on both to the February 23 Committee and further updates and briefings will be provided in December once the national position is known.

[1] Adult Social Care Strategy - Living the life you want to live Sheffield's adult social care vision 2021 to 2030
[2] Adult Social Care Delivery Plan - 11. Appendix 1 - Adult Social Care Delivery Plan.pdf (sheffield.gov.uk)

2.5 Key Service Updates

2.5.1 At Committee today, is an update regards key change activity for approval by Committee which continue to assist us to further our change programme and deliver upon our vision and strategy. These are:

- Our Future Design of Adult Social Care
- Our Quality Matters Practice Framework and Care Governance Update
- Our progress with delivering upon changing futures, technology enabled care, equipment and adaptations performance, better care fund.
- Our Budget Position 22/23 as well as our proposals for delivering a balanced budget in 23/24.

2.5.2 Alongside these developments, the service has also taken forward implementation of the decisions from June and September Committee namely:

- Publishing of the tender for care and wellbeing services, extra care, supported living and day services. These lay a significant foundation for our design of adult social care for the future.
- Implementation of the Safeguarding Delivery Plan and in particular progression with an Adult MASH Model with partners and progression of an external assurance self evaluation with the Safeguarding Partnership.
- Implementation of the Care Governance Framework and in particular embedding performance clinics and an annual cycle of assurance and business management improvement planning across the service.
- Implementation of an Achieving Change which redesigns Adult Social Care Services as a foundation for our future design of adult social care.

2.5.3 Key to the new model and changes we are taking forward is building trust and collaboration and partnerships, which enable individuals to live the life they want to live and feel listened to and heard by all parts of health and social care.

2.5.4 To that end, our first Summit took place on 8th November and was well attended by colleagues across the Sector. The first Summit focused on launching the strategy and our delivery plans and engaging colleagues in a discussion about how we improve outcomes for people.

2.5.5 Its planned as a key next step that we move now to regular online Summits to continue to engage and involve a range of colleagues to build relationships to deliver upon our vision and outcomes for people of the City. Reporting of the outcomes will be provided to Committee.

Key Performance Updates

2.6

2.6.1 The Local Account 2021 – 2022 has also been brought to Committee today and sets out our performance, strengths, areas of challenge and key priorities in going ahead. It highlights our response during COVID 19 and lays a foundation for future annual and quarterly performance reporting to the Committee.

2.6.2 Our priority over the past couple of months has been to reach a position where we could deliver a balanced budget and a new design which would improve our performance and impact on people. In addition, undertake further self-assessment activity to prepare for the advent of CQC Assurance in 2023.

2.6.3 This has meant that the update regards our progress in delivering upon the milestones contained within the Councils Delivery Plan, the One Year Plan and our progress in responding to areas of challenge and risk will now be brought to December Committee, with briefings and discussion with Members regards performance and an update regards CQC Assurance.

2.6.4 Although it is a busy time for Adult Social Care, Sheffield remains a great place for Adult Social Care to thrive and develop as we lay the foundations for delivering excellent support which enables people to life the life we want to life.

3 HOW DOES THIS DECSION CONTRIBUTE

3.1 Organisational Strategy

3.1.1 Our long-term strategy for Adult Health and Social Care, sets out the outcomes we are driving for as a service, and the commitments we will follow to deliver those outcomes:

- Support people to live a fulfilling life at home, connected to the community and resources around them, and provide care and support where needed.
- Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis.
- Provide care and support with accommodation were this is needed in a safe and supportive environment that can be called home.
- Make sure support is led by ‘what matters to you,’ with helpful information and easier to understand steps.
- Recognise and value unpaid carers and the social care workforce and the contribution they make to our city.
- Make sure there is a good choice of affordable care and support available, with a focus on people’s experiences and improving quality.

4 HAS THERE BEEN ANY CONSULTATION?

4.1 The purpose of this report is provide and update in relation to Adult Health and Social Care Services.

4.2 Consultation is undertaken during the development of proposals for the budget and implementation of proposals for the budget as appropriate.

4.3 An overall approach to coproduction and involvement is also a key element of the delivery plan, ensuring that the voice of citizens is integrated into all major developments ahead. This includes signing up to Think Local Act Personal Making It Real. A dedicated item on this is proposed as part of the Committee's forward plan

5 RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

5.1 Equality Implications

5.1.1 This update is based on a strategic approach, which was supported by a comprehensive equality impact assessment, which can be found on the Council website Our adult social care vision and strategy (sheffield.gov.uk).

5.1.2 Any individual parts of our change and activity will require their own detailed equality impact assessment, which will be completed to inform plans and decision making.

5.2 Financial and Commercial Implications

5.2.1 The strategy was supported by a financial strategy, which can be found on the Council website Our adult social care vision and strategy (sheffield.gov.uk), and is closely aligned with the budget strategy.

5.2.2 The additional update does not alter this strategy, although does add a layer of detail.

5.2.3 All individual components of Adult Social Care activity will be assessed for their financial contribution to this finance strategy and the Council's budget. This will be used to inform both plans and decision-making.

5.3 Legal Implications

5.3.1 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.

5.3.2 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.

5.3.3 The Living the life you want to live – Adult Social Care Strategy which was approved in March 2022 set out the high-level strategy to ensure these obligations are met. This report builds upon that by setting out how the aims of the strategy will be delivered and provides for the monitoring and review encouraged by the statutory guidance.

5.4 Climate Implications

5.4.1 The Adult Social Care Strategy makes specific reference to ensuring a focus on Climate Change – both in terms of an ambition to contribute to net zero as well as adapt to climate change.

5.4.2 It is planned within the forward plan of the Committee to bring a specific Climate Action Plan in February 2023.

5.5 Other Implications

5.5.1 There are no specific other implications for this report. Any recommendations or activity from the detailed workplans of the strategy will consider potential implications as part of the usual organisational processes as required.

6 ALTERNATIVE OPTIONS CONSIDERED

6.1 Not applicable – no decision or change is being proposed.

7 REASONS FOR RECOMMENDATIONS

7.1 Reasons for Recommendations

This report provides an update regards Adult Social Care activities for Members.

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Report to Policy Committee

Author/Lead Officer of Report:
Jonathan McKenna-Moore,
Service Manager

Report of:	Director of Adult Health & Social Care
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	16th November 2022
Subject:	Adult Health and Social Care: Approve Adult Social Care & DASS Local Account 2021 - 2022

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	x	No	
If YES, what EIA reference number has it been given? 1314				
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

Purpose of Report:

The purpose of this report is to approve the publication of the Sheffield Local Account for 2021/22.

A Local Account is a public document reporting on the performance of Adult Social Care for the Local Authority area. The *Sheffield Local Account 2021-22* will be published online on the Sheffield City Council website, with accessible print and audio versions.

Recommendations:

It is recommended that the Adult Health and Social Care Committee:

1) Approve the document *Sheffield Local Account 2021-22* for publication online.

Background Papers:

None

Appendices

1) Appendix 1 – Sheffield Local Account 2021-22
2) Appendix 2 – Sheffield Local Account Performance Data 2021 - 2022
3) Appendix 3 – Equalities Impact Assessment

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<tr><td colspan="2">Lead Officer Name:
Jonathan McKenna-Moore

0114 2734914</td><td>Job Title:
Acting Service Manager, Planning Performance and Risk</td></tr>
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1 PROPOSAL

1.1 Our vision is that everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are and, when they need it, they receive care and support that prioritises independence, choice, and recovery.

1.2 The purpose of this report is to improve our accountability for performance against key indicators for our strategy and align our performance reporting with people's personal experience of the services we provide.

1.3 The format of this year's Local Account represents a change in approach from previous years, moving away from a focus on statistical data and putting our strategy, actions, and people's experiences to the fore.

1.4 Performance data will continue to be reported and available for scrutiny, but the primary interest for this and future years will be improving engagement and providing the information that people tell us matters to them.

2.0 BACKGROUND AND CONTEXT TO THE LOCAL ACCOUNT

2.1 The Local Account is intended to be an annual report to the public undertaken by each local authority to update local citizens on Adult Social Care performance and strategic aims for the year ahead.

2.2 The most recent published Local Account for Sheffield is currently from 2018, reporting on performance in 2017/18.

2.3 Subsequent disruptions due to Covid meant that Local Accounts in the intervening period were not published. Therefore, this report looks back over the period January 2021 to 31st March 2022 to include the extraordinary challenges and services provided during the pandemic.

2.4 The Local Account highlights our strengths, areas of challenge and priorities for 2022 to 2023. It emphasises our journey towards enabling people to live the life they want to live and in particular enabling people to live independently at home. In particular, the Local Account thanks all social workforce for their dedication and commitment during the pandemic and sets out a path to enable people to be at the heart of all we do.

2.5 To develop the Local Account, views were sought from a citizens representative group, a review of our performance was carried out and consider of our progress in relation to the outcomes set out in our strategy.

2.6 Benchmarking was also undertaken through a regional ADASS group for Yorkshire and Humber. The group was formed to promote a consistent approach to Local Accounts across the region.

2.7 Key elements drawn out through regional workshops have been the emergence of the CQC Assurance Framework and with that the development of Quality statements, the importance of co-production and use of common terminology and datasets. This benchmarking supported development of our Local Account.

2.8 In addition to this, he ongoing implications and commitments under the One Year Plan, the Council's Delivery Plan, and the deliberately personal definitions of quality under the CQC Assessment Framework and our Adult Social Care Strategy, our historic approach to the Local Account with reference to national data sets, average time scales and volumes delivered are no longer sufficient.

2.9 Due to this, future iterations of the Local Account will aim to demonstrate to the public of our progress against our commitments and outcomes agreed through our Adult Social Care Strategy, key service improvements we have identified through our self-assessment of our performance aligned to the CQC framework and priorities identified in the Council Delivery Plan.

2.10 It's planned that this approach will ensure transparency in our setting out our strengths, our impact on people and our areas of continued improvement. In doing so it will evidence our trajectory towards delivering on our vision and outcomes.

2.11 The Local Account is included at Appendix 1 for approval by the Committee. The associated performance data is included at Appendix 2.

2.12 To make the Local Account accessible to members of the public the Local Account, if approved, will be published online with information about how to access in different language and formats. In addition, an audio version will also be developed further enable accessibility of the Local Account.

3.0 HOW DOES THIS DECISION CONTRIBUTE?

3.1 Our long term strategy for Adult Health and Social Care, sets out the outcomes we are driving for as a service, and the commitments we will follow to deliver those outcomes.

3.2 One of the commitments under the strategy is to "Make sure support is led by 'what matters to you', with helpful information and easier to understand steps."

3.3 The Local Account provides one of the cornerstones of our engagement with the citizens of Sheffield, including the people who use our services but also the wider population who fund those services and may come to require them in the future.

3.4 Engagement and accountability on performance will inform our service priorities and direct the format and content of future iterations of the Local Account in order to ensure that it is relevant to its intended audience.

4.0 HAS THERE BEEN ANY CONSULTATION?

4.1 The purpose of this report is to provide information of interest to the public. To provide a guide to the key points of interest we canvassed opinions from established co-production groups and our workforce.

4.2 Feedback from 20 respondents indicated that the key information people wanted from a Local Account were:

1. What services are available
2. Our strategy for Adult Social Care
3. People's experiences of the services they use
4. How people access services
5. The changes and improvements we plan to make in the year ahead

4.3 The Local Account 21-22 includes an invitation to the public to feedback on what they want to see in future reports and it is hoped that a wider and more representative response will inform improvements to the content and format.

5.0 RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

5.1 <u>Equality of Opportunity Implications</u>

5.1.1 The Local Account is intended to:

i. Inform people about what Adult Health and Social Care does
ii. Monitor our progress in delivery of the AHSC strategy
iii. Establish areas of focus for improvement
iv. Invite feedback/challenge
v. Let people know how they can contribute to a healthier city

5.1.2 From an equality perspective (including our general duties under the Equality Act 2010), we have aimed to ensure the 2021-22 Local Account is:

Accessible

- This principally means its accessibility to people using AHSC, carers and other stakeholders. In Equality Act terms, this includes people sharing protected characteristics of Age (e.g. older people), Disability (e.g. sensory impairment or learning disability) and Race (e.g. people who experience language or cultural barriers).
- It includes the Local Account's language and format, which we have strived to keep as accessible as possible without affecting necessary detail
- We have made an open offer to provide the local account in alternative formats.

Relevant and responsive

- This refers to the information being useful, proportionate and informed by people using AHSC, carers and other stakeholders.
- The 2021-22 Local Account content takes into account feedback from respondents that people wanted it to include:

i. What services are available
ii. Our strategy for Adult Social Care
iii. People's experiences of the services they use
iv. How people access services
v. The changes and improvements we plan to make in the year ahead

- It includes an invitation for further/ongoing feedback on the content of future Local Accounts.

Focused on equality

- The 2021-22 Local Account includes sections on: Embracing equalities and diversity, Helping our communities 'speak up' and Changing Futures: co-producing new ways close the gap on inequalities

5.2 <u>Financial and Commercial Implications</u>

5.2.1 The budget information included in The Local Account has been corroborated and provided by Finance and is a true reflection of permanent budgets and expenditure in 21/22.

5.3 <u>Legal Implications</u>

5.3.1 Local Accounts are not a mandatory requirement and are not explicitly part of the statutory duties of the Director of Adult Social Services,

5.3.2 However, the Director does have a statutory duty of accountability and Local Accounts are used by the vast majority of Authorities to help fulfil this duty. They are a key feature in the drive to support improvements

under the Towards Excellence in Adult Social Care programme. Such reports should provide details of numbers of service users, changes from year to year, areas of concerns and anticipated pressures. This report appears to address those matters.

5.4 Climate Implications

5.4.1 There are no significant climate impacts to consider as a result of this report. A Climate Action Plan is planned for March Committee to set out Adult Social Care response and deliverability.

5.5 Other Implications

5.5.1 There are no further implications to consider at this time.

6.0 ALTERNATIVE OPTIONS CONSIDERED

6.1 Not applicable – no decision or change is being proposed.

7.0 REASONS FOR RECOMMENDATIONS

7.1 The Local Account highlights our strengths, areas of challenge and priorities for 2022 to 2023. It emphasises our journey towards enabling people to live the life they want to live and in particular enabling people to live independently at home.

7.2 Having a Local Account builds in transparency and accountability in relation to reporting on adult social care performance.

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Here for you

How did we do?

Sheffield's Adult Health & Social Care Local Account

January 2021 to March 2022

Sheffield City Council

Contents

Foreword

We are delighted to introduce our first local account as the Co-Chairs of the new Adult Social Care Policy Committee. When a new Committee system was voted for by the public in 2021, we made a commitment to making Adult Social Care an open, transparent, and collaborative partnership both politically, strategically, and operationally.

The local account is our summary of what we are doing well and our priorities for adult social care in Sheffield. We have looked at how we responded to the Covid-19 pandemic, and we would like to say a thank you to all staff, partners and communities who worked extremely well together during this time. It's through that partnership working that we will continue to achieve the best outcomes for citizens of Sheffield.

The local account isn't just a way to highlight all the good things, it is an opportunity for us to respond to and build upon what individuals, carers, communities, and partners have told us. We have focused on closing the gap on inequalities, embracing diversity, and looking at ways to maintain individuals' independence and ability to stay at home.

Over the coming months, we will be developing a new model and way of working in adult social care. We want to build our model to make sure that people are at the heart of everything we do, and to shape the best advice, guidance and support that enables people to live the life they want to live. We want to focus on people's strengths and placing peoples' voices at the heart of all we do.

We would like to thank everyone involved in developing our local account, including the people we support, carers, partners, and our workforce.

Councillor George Lindars-Hammond
Co-Chair Adult Social Care Policy Committee

Councillor Angela Argenzio
Co-Chair Adult Social Care Policy Committee

Part 1: Introduction

I am delighted to introduce my first annual report as Director of Adult Social Services here in Sheffield. Since I started in this role in November 2020 I have been so impressed by the hard work, dedication, and commitment of our teams, our partners, unions, experts by experience and unpaid carers.

I want to use this report to say a really big thank you to everyone involved in adult social care.

This year has been a challenging year. We have faced one of the biggest health and care challenges in a century. COVID 19 has had a huge impact on social care across the country and here in Sheffield. We have sadly lost some of the people we support, and many people have been left with long-term health issues.

I want to use this report to say a really big thank you to everyone involved in adult social care.

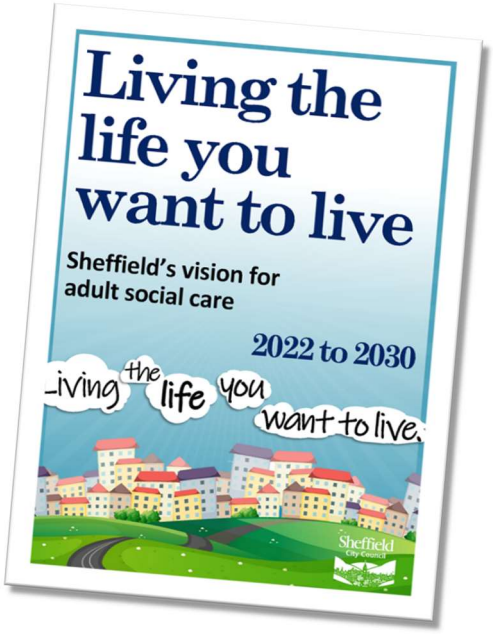
We have had to adapt to new ways of working, trying to enable people to live the life they want to live whilst trying to keep staff safe. One of the positives to come out of it though has been how the sector worked together – and we will continue to build on this.

Another is the incredible dedication and commitment of people across the sector, and I am proud of the fantastic workforce we have here.

I want to use this report to give a summary of adult social care in Sheffield and to celebrate what we do in Sheffield. I know that our workforce across all of adult social care have made a real difference to the lives of thousands of people and this report shares a few of those stories.

The purpose of this report is to provide an overview of what adult social care is, to highlight our performance and impact over 2021 to 2022 and to confirm our priorities for 2022 to 2023. It aims to give more transparency and accountability about adult social care to the citizens of Sheffield.

I also want this report to reflect on where we need to improve. We know that there are things that we can do better, and we want to do the very best we can. This is not always an easy task. We face budget pressures and growing demand on our services. That's why we have developed a new strategy and we are at the start of a transformation journey to make social care in Sheffield the best that it can be.



Our vision for adult social care is that everyone will be able to live the life they want to live. This means that people feel safe in a place they call home, and that they are physically and mentally well for as long as possible.

We know that independence is very important to people and all our work should support people to increase their independence regardless of condition, disability, or frailty. People should feel like they are part of a community, that they are listened to, and that they are supported to do the things they want to do.

To do all of this we need a way of working where all organisations work well together, where people have a choice of good services, and where our workforce are valued and supported. Its my ambition to achieve this for the benefit of citizens across Sheffield.

We want to be able to say that we are delivering supports which feels right and good from the point of view of individuals and carers themselves and which individuals and carers feel they can live the life they want to live.

I hope that you find this report informative and interesting, and I would welcome your comments and views on how we can improve Adult Social Care.

Alexis Chappell
Director of Adult Health and Social Care
Sheffield City Council

find out more

You can read more about the duties of the Director of Adult Social Services (sometimes called the DASS) from the Association of Directors of Social Services website.

The duties of all councils to provide adult social care and wellbeing are explained in the Care and Support Statutory Guidance from the Government website.

An Overview of Health and Wellbeing in Sheffield - An Overview of Health and Wellbeing in Your Area | LG Inform (local.gov.uk).

Part 2: About our city and our people

Sheffield is an amazing and welcoming city which celebrates and values our diversity, culture, history and all the wonderful green spaces across the city. We Sheffielders are really proud of our brilliant city and have big ambitions for the future.

At Team Adult Social Care, we are really proud to serve our residents of Sheffield to deliver excellent quality, valued social care services.

Putting people at the heart of what we do, openness and honesty and equality and inclusion are the key values underpinning the work we do, and there is more about this later in this account. We adopt a person-centred approach, tailored to each individual, so they can achieve the things that matter most to them. This means celebrating differences, treating each person with respect and dignity, and helping them to be safe and socially included, supporting their own sense of identity.

Living Independently in Sheffield

1

In 2021/22 we quickly provided short-term help for 2,271 people so they could continue to live at home. Giving this help quickly meant over 1,000 of these people needed no further support after this.

A third of the people we help choose to buy and manage their own care using a Direct Payment. This gives them more choice and control over how their support is arranged.

2

3

Our City Wide Care Alarm Services gives peace of mind to over 8,000 people in Sheffield, so they can continue to live safely and independently at home.

Almost 9 out of every 10 care homes in Sheffield are now rated GOOD or OUTSTANDING by the Care Quality Commission. And almost 8 out of every 10 community services in Sheffield are rated GOOD or OUTSTANDING too.

4

5

In 2021/22, during the COVID19 pandemic, we supported lots more people so they could continue to live safely at home. In doing this we reduced admissions to care homes by almost a third, and delivered the most amount of home care across England.

In total over 22,000 people contacted us for support in 2021/2022. Almost 6 out of every 10 people were supported so they did not need long-term support.

6

As with everyone across the country, our main priority and focus over the year was to keep people safe and supported during the pandemic. At the same time, we have laid the foundations to deliver accessible, person centred, excellent quality and sustainable social care services.

We continued to deliver face to face care and support throughout the pandemic to enable people to live independently.

find out more

- **Our website has lots of detailed information about our population and the communities we serve.**
- **Our Public Health team produces detailed information about the health of our population and our plans to improve the lives of everyone we serve.**
- **Registered Care Provider Market in Sheffield** - Registered adult social care provider market in Sheffield (Nov 2022) | LG Inform (local.gov.uk)
- **An overview of Health and Care in Sheffield** - Health and care in your area - an overview for lead members | LG Inform (local.gov.uk)

Part 3: What we do

Adult Social Care is a partnership of individuals in need of support, carers, our workforce, our partners, the voluntary and community sector, unions, and our communities. We work together to close the gap on inequalities, prevent or reduce the need for care and support, and develop opportunities for people to live independent and fulfilled lives in their local communities.

We do this by providing information, advice, and guidance, as well as support and services to the following groups of people who are over 18.

- People at risk of harm, including people experiencing domestic abuse, deprivation of liberty.
- People with a learning disability.
- People with autistic spectrum conditions.
- People with a physical or sensory impairment.
- People who use harmful substances (like drugs or alcohol).
- People living with HIV.
- People experiencing mental ill health.
- Older adults and people with dementia.
- People with a long-term health condition.
- People with no fixed abode or who are homeless households.
- People who provide care and support to friends or family.
- Young people supported by our Children's Social Services who are approaching 18 years and may require adult social care support.

How to access us?

This year **over 22,000 people** contacted us about support. Some were referred to us by their GP or another health care professional, and many contacted us directly by calling our First Contact Team.

We take a strengths-based approach, which means our first step is to see what the person can do for themselves, what support they get from friends and family, and what's available in their local community. If formal care is needed, we work to build the person's independence back up and plan to step back when they are ready.

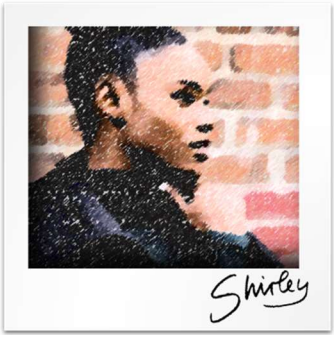
If you need help or support with your adult care needs, please contact **Sheffield's First Contact Team at 0114 273 4908.**

How We Do It

Here's a personal account of one of our front-line social care workers called Emma. This is typical of the stories and feedback we hear regularly about the amazing support people receive.

While we recognise there are times when we can do better, we know in these difficult times, and with such limited resources, we're still able to provide support that changes people's lives through the dedication and commitment of the whole adult social care workforce.

stories of difference



Emma supported a lady who moved back to live with her mum and dad in Sheffield, as there were some issues where she was living.
For the purposes of this account we'll call her Shirley.
The support Shirley received in the supported living home had cost more than £10,000 a year.

Emma supported Shirley to work out what support she needed now she was living in Sheffield. Emma focussed on empowering Shirley, using a strength-based approach to help her to think about what she can do and what outcomes she wanted to achieve.

Shirley was scared to go back to where she was living, but she didn't want to lose the skills and independence she had gained from living with her parents. Emma and Shirley created a Support Plan together.

Emma then arranged support from a company that specialises in helping people develop their life skills, like dealing with people, networking skills and travel training - so she could travel independently. Emma also arranged for an Occupational Therapist to get the right equipment Shirley needed to support her to be independent at home.

Emma also helped Shirley to talk to her mum and dad about the support she wanted from them, and how they could trust her to do things for herself and so help Shirley become more independent.

stories of difference

stories of difference

Overall, Shirley is much happier and is now living the life she wants to live.

Emma's strength-based support enabled Shirley to feel more confident to live the life she wants to live and be in control of her decisions and choices. This improved outcomes at less cost.

Emma is very proud of this work, as all of us are here at the First Contact Team.

stories of difference

Our second example shows the importance of multi-agency working and cooperation, and the key role our hospital social work team has in supporting the work of our hospitals for successful reintegration back into the community.

stories of difference

Mary (not her real name) was admitted to hospital after falling from a window at the property where she lived. Mary couldn't remember how she had fallen. Mary sustained significant internal and external injuries, but it wasn't clear how the fall had occurred.

Mary had been supported in the past by key statutory services like the Police and Adult Protection as she was at risk of serious harm from domestic abuse by her partner.

To begin with the information the hospital team received was very vague, and Mary was not known to adult social care prior to the fall.

Mary's nationality is Romanian, and she did not speak English. Prior to the hospital admission, Mary's mental health had deteriorated, she was unable to work had not claimed benefits, had no money and was in rent arrears.

Mary's adult son told the team he was concerned about his mum, as Mary had told him she thought the medical staff were trying to sexually assault her.

The hospital mental health team concluded Mary was experiencing psychotic depression. The agencies felt Mary had fallen due to a decline in her mental state, not from an assault by her partner. However, they were concerned about ongoing domestic abuse – controlling behaviour and psychological abuse.

stories of difference

stories of difference

What went well? Good information sharing between all the agencies including the hospital team, Police, GP, hospital mental health team and the Department for Work and Pensions.

A key part of the hospital social worker role was to manage risks and coordinate the agencies involved so they were all aware of concerns, and came together to give the best support and protection to Mary.

Mary stayed with her son and his family when discharged from hospital.

Through support from Mary's allocated Student Social Worker and the Home First Prevention Team, Mary gained a tenancy of her own and was supported to access the correct benefits and is now back in employment.

stories of difference

Part 4: Our performance and progress

In March 2022, Sheffield City Council endorsed our new Strategy Living the Life You Want to Live. This set out five outcomes (Safe and Well, Active and Independent, Connected and Engaged, Aspire and Achieve, Efficient and Effective) and six commitments that we said we would work towards.

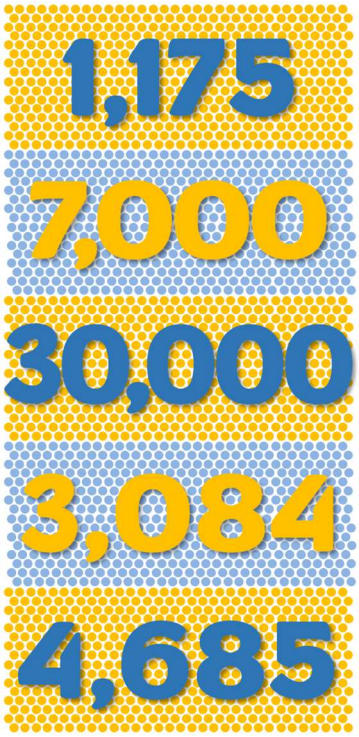
We are reporting on our performance using the outcomes so that citizens of Sheffield can find out if the new strategy is making a difference in their lives. In future years, we will report on individuals I statements, our annual progress against delivering on each of the commitments made and have a published report on our performance.

We gave information on active and independent at part 2 and for this part, we are looking at Safe and Well, Connected and Engaged, Aspire and Achieve and Efficient and Effective.

Safe and Well – Our response to COVID 19

Our main priority and focus was to keep people safe and supported during the pandemic, with a clear focus on prevention of harm. We did this through a focus on promoting vaccinations, providing Personal Protective Equipment (PPE), preventing outbreaks and keeping people at home.

As a city, we came together to support each other with ingenuity and generosity — with some incredible results:



Number of **emergency food parcels** provided to Sheffielders from April to July 2020: 1,175.

Number of **Safe & Well Visits** to vulnerable people needing food, medication and support by community response teams: more than 7,000.

Number of **clinically extremely vulnerable people** contacted to check they were safe and had access to food, medication and support: more than 30,000.

Number of **care home residents double vaccinated** as at 31 March 2022: 3,084. This is 95% of all residents in Sheffield.

Number of **social care staff across Sheffield vaccinated** as at 31 March 2022: 4,685. This is 97% of all care staff in Sheffield.

As with many parts of the country the pandemic created significant demand challenging health and social care services. While we rose to the challenge – for example by providing more home care than any other council in England – the pandemic left us with increased waiting lists for home care, equipment, assessments, and other forms of community support. We're working hard to reduce these and support people dealing with the impact of Long Covid, in part by transforming how we work across the city and by prioritising reducing our backlogs and speeding up assessment timescales in 2022 to 2023.

You can find a range of reports about Sheffield's response to the pandemic on our website, and from our partners in Health, Education, and the Voluntary Sector (links below).

Safe and Well – Working together to keep people Safe

There's a wide range of organisations that work together to help keep people safe in Sheffield, including the Police, Health Services, the Council, our independent sector care providers and the voluntary and community sector. This work is coordinated through the Sheffield Adult Safeguarding Partnership.

Their work is now well established, and is the backbone to the city's efforts to keep people safe, especially in our most vulnerable communities.

Detailed information about the partnership, including annual reports and facts and figures, is available from the partnership website.

During the year 2021 to 2022 there were:

Number of **Safeguarding Concerns** raised: 6,373.

Number of **Safeguarding Enquiries** carried out: 1,988.

Number of times we reduced, or completely removed the **risk of harm** to the person: 8 out of every 10 cases.

A key focus of our recent improvements in safeguarding is called Making Safeguarding Personal. This work is to make sure the person being safeguarded is listened to, especially what they want as an outcome of any safeguarding work we do.

Through detailed and extensive work across all agencies, we have now significantly increased satisfaction – so that the person being safeguarding was satisfied 98% of the time with the process. Similarly, in 9 out of 10 times the person being safeguarded felt that what they wanted as an outcome was either partially or fully met.

For more about the partnership and safeguarding in Sheffield visit: www.sheffieldasp.org.uk.

Connected and Engaged – Our Support to our Sheffield Carers

We estimate there are about 90,000 unpaid carers in Sheffield, providing vital support to friends and loved ones. They're a crucial part of adult social care, so our strategy includes important actions to strengthen the support we give. This work will make sure unpaid carers are plugged in to a network of support that enables them to get support for their own mental health, wellbeing, and needs.

Our key partner for this work is the independent charity Sheffield Carers Centre.

While facing the challenges of the COVID 19 pandemic, in the year April 2021 to March 2022 the Centre supported a record number of carers and **achieved a 99% satisfaction rate from Carers in the support Carers received.**

Number of **carers supported**: 3,591.
A 16% increase on the previous year.

Number of **hours volunteers gave** to support carers: 2,390.
Equivalent to 318 working days.

Number of **new carers** added to the Carers Register: 1,563.
It's vital we connect with new carers early, so they feel supported as they start their carer journey.

For more details about of the fantastic way the Carers Centre has continued to deliver for Sheffield carers read their annual report, available from the Carers Centre website.

Aspire and Achieve – Changing Futures

In partnership with colleagues in housing, voluntary sector and faith groups across the city, Sheffield was successful in gaining £3.26 million over three years to implement the national Changing Futures programme.

Through this programme we want to change the way services work together in the city to better help vulnerable people sooner and enable them to move on positively with their lives.

We partnered with South Yorkshire Housing Association to launch a Coproduction and Peer Volunteer Service in February 2022. This enables the programme to be developed in partnership with people and to build capacity through use of peer volunteers.

Efficient and Effective
How we used our resources in 2021 - 2022

We are committed to delivering excellent quality of care and improving outcomes for people as well as responding to our significant financial challenges created through the pandemic.

47% of our income comes from Sheffield City Council Revenue, such as the Council Tax and the remainder comes from charges to people we support (17%) and Grants and Other Income such as Better Care Fund, Adult Social Care Grant, and Section 75 Agreement with Health (36%). Most of that income (83%) is spent on purchasing care and support for the people of Sheffield who need our help.

Our Income	What We Spent the Money On?
✓ £128m from Sheffield City Council Revenue (e.g. Council Tax) ✓ £45m from charges to people who use our services ✓ £99m from Grants and Other Income ➢ Better Care Fund (£28.5) ➢ Section 75 Agreement with the NHS (£25.7m) ➢ National Adult Social Care Grant and Other Grants (£43m) ➢ Recharges from healthcare (£1.8m)	✓ £227m was spent on purchasing of Care and Support ✓ £40.5m was spend on employees ✓ £4.3m was spent on buying supplies, services, and premises ✓ £1.4m was spent on Transport
Total - £274 million	Total - £274 million

In future reports, we will set out how we are spending our resources aligned to our responsibilities and the strategic shifts we want to make aligned to our new Strategy so that citizens can see the impact of their funds.

How we planned our resources in 2022 - 2023

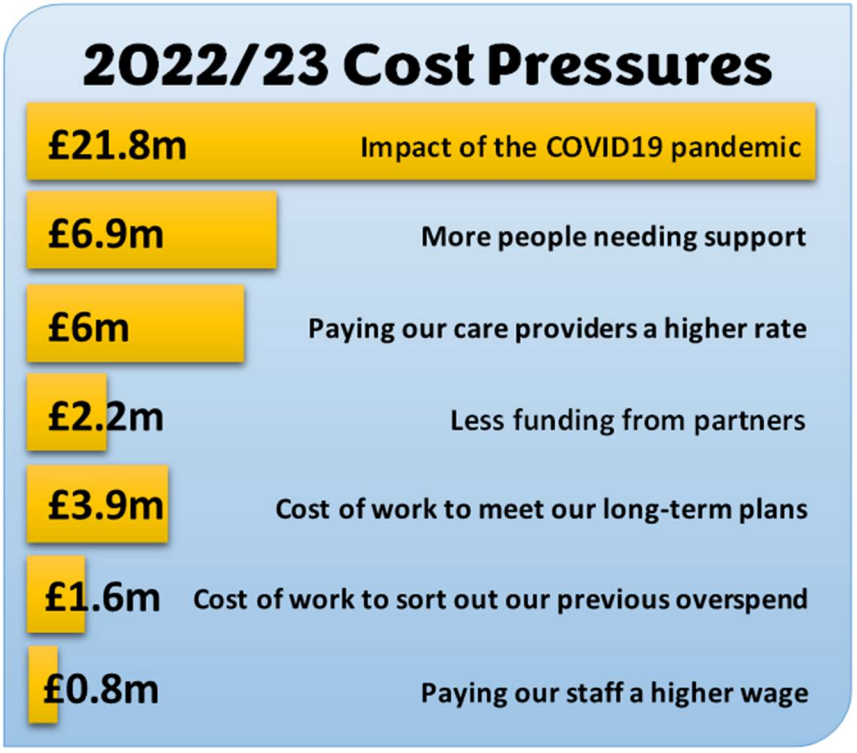
In our work to plan how to spend our 2022 to 2023 budget, we identified a number of extra costs that we needed to address. To help deal with these problems we agreed a range of efficiencies by doing things differently to tackle these extra costs.

These savings came from the great ideas staff across the service gave us, and by working in partnership with other organisations across the city.

This diagram shows the different cost pressures that we faced.

There's detailed information about this in the report we gave to the Council's Health and Social Care Committee.

We'll continue to report to the Committee during 2022/23 as we monitor our progress, so you can follow this too by reading the Committee's papers on our website.



find out more

COVID 19 Pandemic

- **Report on the impact to our health and wellbeing.**
- **Report on young people's experiences.**
- **Report on the response from Sheffield's voluntary and community sector.**
- **Report on Sheffield Hallam University's response.**
- **Report on the Sheffield City Region response to the pandemic.**
- **Report on South Yorkshire and Bassetlaw health and care partners response to the pandemic.**

Safeguarding in Sheffield

- **Website for Sheffield Adult Safeguarding Partnership.**

Sheffield Carers

- **Sheffield Carers Centre website.**

Our finances

- **2022 to 2023 Budget: Committee Report on our 2022 to 2023 budget extra costs.**

Part 5: How we're making a difference—every day

While we've anonymised the names of our staff and the person they supported, these examples of the impact of our work are just a sample of the many instances of thanks, feedback and appreciation we receive every week. It's one of the best aspects of working in adult social care – and something that drives us to do better and develop our service.

stories of difference

Fatima, a 23-year-old student, had studied at Sheffield University. She returned to Sheffield from India to attend her graduation ceremony.

Fatima unfortunately suffered a stroke and after a hospital stay had intensive therapy and rehabilitation at a specialist stroke centre in Sheffield.

Fatima was referred to adult social care to support her discharge home to India.

We arranged for Fatima to stay at our specialist residential unit at Warminster Road, where staff supported her with ongoing rehabilitation and preparation for her return home.

We managed to get some funding from the Talbot Trust to buy a tablet so Fatima could access the internet and stay in touch with her family in India via WhatsApp and Zoom. We then helped Fatima organise her flight home and supported a long-distance friend to accompany her to the airport.

Fatima arrived home safely, and is continuing to progress and improve back home with her parents.

stories of difference

Kath suffered a heart attack followed by a stroke.

Kath received speech and language therapy from our NHS colleagues, and so she was able to keep some limited movement and speech.

Kath hasn't been able to get out much during the pandemic, and hasn't driven since she had a stroke.

She gets some support from her children with online shopping, and her neighbours help her with shopping for other bits she needs. Kath really enjoys spending time in her garden.

A prevention worker visited Kath to see what additional support she might need and helped her apply for Attendance Allowance to pay for a cleaner and a gardener. This bit of extra support meant that Kath could stay living independently in her home.

stories of difference

Gaz is 30 years old and has a learning disability. He lives at home with his dad.

Our Home First Prevention Team carried out a needs assessment to see what support he needed. During the assessment it was clear Gaz was very isolated as he said he only left the house once a fortnight, and didn't have any social connections. Gaz told us he lacked motivation and was in a low mood most of the time. He also wanted help with his personal hygiene.

The team arranged for a small care package of 4 hours a week to help with cleaning the home, support with personal hygiene, and support to access the community on a more regular basis.

The team also held a Multi-Disciplinary Team Meeting with different organisations to address his needs in one place, and made referrals to different organisations to arrange support for Gaz. They also applied for a Personal Independence Payment to maximise his income, and applied for money from the Local Welfare Assistance fund to pay for new furniture and carpets.

The preventative approach the team took meant Gaz now has the care and support he needs. He enjoys spending time with his support workers and playing games with them, and has started to go out into the community.

stories of difference

Debbie had an assessment by the Equipment and Adaptations Team. She needed some support with bathing and showering, was struggling financially, and was feeling isolated.

The team made a referral to an occupational therapist to add a wet room (a bathroom where the water can drain away easily making it easier to wash and shower), and for some equipment to help Debbie when getting dressed.

They arranged some basic DIY jobs to improve her kitchen space, and got her a new oven and microwave. They also requested the Medequip service provide some equipment to raise some of her furniture – making it easier for Debbie to get up from her chair.

They contacted the community transport service to help Debbie get access to the community and shops.

To help with her isolation they asked St Vincent's to help with their befriending service, and set up a telephone listening service so Debbie could talk to someone regularly.

They helped Debbie to access and apply to a local food bank and gave her details of where she could get free/discounted food. And they helped Debbie apply for money from the local assistance fund.

Debbie now feels much happier in her house, and is planning to do some voluntary work soon and attend social groups at St Vincent's.

stories of difference

Rosey is a 60-year-old woman who had been institutionalised for most of her life.

Rosey had lived in a number of secure units over many years, and then was moved to a nursing home. Rosey lived in the nursing home for 8 years – without access to the outside world, and with no friends and family.

After a long search for a more suitable place a small residential bungalow was found. Rosey is now happily settled in her new bungalow, and does her own shopping.

Rosey's now supported to access the community every day, and has already been away on a day trip to the seaside.

Part 6: Embracing equalities and diversity

Our core commitment is to embracing equality and diversity. We value and celebrate the difference across our communities, our workforce, and the people we support.

It's a key priority and focus for adult social care that we deliver culturally appropriate care and have a workforce which reflects our communities. We want to ensure the voices of individuals with a disability, and people from our BAMER communities (our Black, Asian, Minority Ethnic and Refugee communities), are listened to, heard, and acted upon.

We know our care workers have shown their dedication and strength, working throughout the pandemic as the frontline of support to our residents. And our voluntary and independent sector have shown their ingenuity, ensuring people were offered the care and support they needed.

But the COVID 19 pandemic made health inequalities worse, with higher cases of infection in more deprived areas than less deprived ones. Overall, there have been higher rates of death from coronavirus in Black and Asian ethnic groups. This was similar for people with a learning disability.

People with dementia, and people with mental health issues reported poorer experiences of care in hospital in the pandemic. Inequalities were a significant problem before the pandemic, but now we know there is even more to do to overcome the greater effects of the virus on some of our communities as a priority, to truly develop better health and social care.

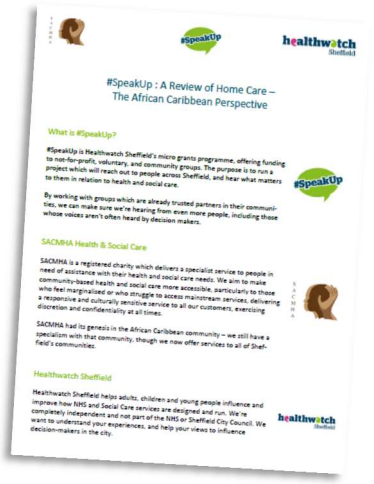
This is why one of our priorities is to truly develop better health and social care for the whole city by closing the gap on inequalities and embracing diversity. We said we would do that by taking learning from the Race Equality Commission launched in summer 2020, our workforce, our providers and benchmarking.

You can read more about the impact of the pandemic on different community groups in our Public Health report called a Health Impact Assessment. There is also a detailed Health and Wellbeing Board report that has assessment reports for related topics including Active Travel, Access to care and support, Domestic Abuse, Education and Skills, Employment, End of Life Care, Health Behaviours, Housing and Homelessness, Income and Poverty, Loneliness, Social Contact and Isolation, Long Covid, and Mental Wellbeing. There's also a shorter document with one page summaries for each of these topics.

And for detailed analysis of the state of Sheffield's health (including how this is different for different areas of the city) read our Director of Public Health's annual report. You can also download an interactive report and watch a summary video from the Director.

Helping our communities 'speak up'

In February 2022, SACMHA (the Sheffield African Caribbean Mental Health Association) launched their 'Speak Up' report, which talked about the experiences of African Caribbean adults accessing homecare. They spoke to people who used home care, their families and carers, as well as African Caribbean social care professionals about their experiences. The report contains detailed experiences and perspectives, which shaped our recommendations to those who design, commission, and deliver home care services.


#SpeakUp : A Review of Home Care – The African Caribbean Perspective

What is #SpeakUp?

#SpeakUp is Healthwatch Sheffield's micro grants programme, offering funding to not-for-profit, voluntary, and community groups. The purpose is to run a project which will reach out to people across Sheffield, and hear what matters to them in relation to health and social care.

By working with groups which are already trusted partners in their communities, we can make sure we're hearing from even more people, including those whose voices aren't often heard by decision makers.

SACMHA Health & Social Care

SACMHA is a registered charity which delivers a specialist service to people in need of assistance with their health and social care needs. We aim to make community-based health and social care more accessible, particularly to those who feel marginalised or who struggle to access mainstream services, delivering a responsive and culturally sensitive service to all our customers, exercising discretion and confidentiality at all times.

SACMHA had its genesis in the African Caribbean community – we still have a specialism with that community, though we now offer services to all of Sheffield's communities.

Healthwatch Sheffield

Healthwatch Sheffield helps adults, children and young people influence and improve how NHS and Social Care services are designed and run. We're completely independent and not part of the NHS or Sheffield City Council. We want to understand your experiences, and help your views to influence decision-makers in the city.

We incorporated the learning from the SACMHA report into our transformation of home care in the city and made sure SACHMA were a valued partner in developing the new specification.

You can read more about our transformation of homecare on the Council website.

find out more

Public Health:

- **Impacts of the pandemic on Black, Asian and Minority Ethnic Communities in Sheffield.**
- **Director of Public Health annual report.**

Health and Wellbeing Board:

- **Impacts of the pandemic on Health and Wellbeing in Sheffield.** ● **One page summaries.**

Speak Up SACMHA report:

- **African Caribbean perspectives on home care in Sheffield.**
- **Transforming home care in Sheffield (Adult Health and Social Care Policy Committee report).**

Race Equality Commission

- **Race Equality Commission overview**
- **Race Equality Commission Final Report**

Part 7: Our plans and priorities for the next year

In the period 2021 to 2022 we co-produced and developed the very first Adult Social Care Strategy. It was agreed by the Council on 16th March 2022 and published on our website.

We also undertook a self-assessment using Local Government Association Towards Excellence in Social Care. The self-assessment identified areas of strength and areas where we needed to improve.

The learning from the development of our Strategy and Self-Assessment helped to inform our Transformation Programme launched in July 2021 and was reported to the Healthier Communities and Adult Social Care Scrutiny Committee on 16th March 2022.

Our strategy helps us to deliver on priorities of the city's Joint Health & Wellbeing Strategy 2019 - 2024.

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

Our strategy is a detailed account of what people told us was important to them and should be a priority for Adult Social Care to focus on. Our priority was to make sure people with lived experience and our partners were listened to, heard, and valued and at the centre of our strategy.

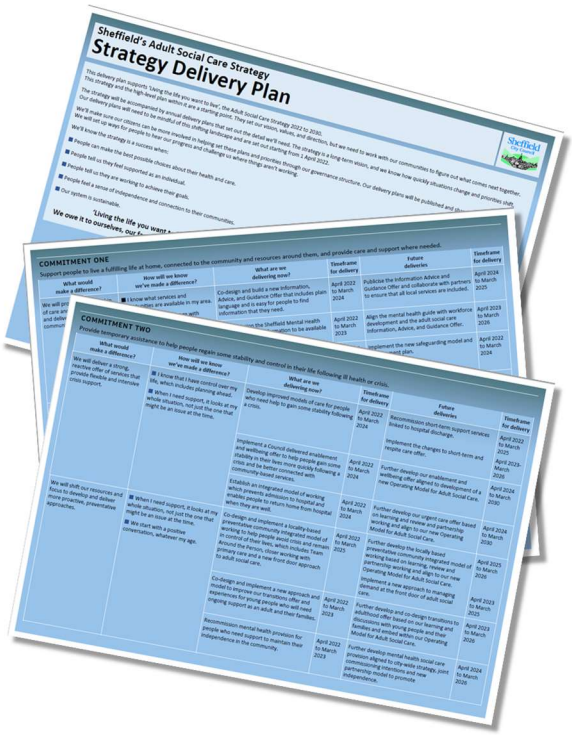
Our strategy sets out strategic outcomes and I Statements based on Think Local Act Personal (TLAP) which will tell us if we are delivering supports which feel right and good from the point of view of individuals and carers themselves, the pressures, and new challenges we face, and our vision and ambition.

Through delivering the strategy and taking the learning from our self-assessment we will achieve real change in the way adult social care operates, how people are supported and how we make sure meaningful co-production and engagement with individuals, carers, and communities.

In Sheffield in 2030, we want everyone in the city will be able to live their lives well, in a safe and comfortable home, or in a homely setting, in their local community.

Everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are – and when they need it, they receive care and support that prioritises independence, choice, and recovery.

Our areas for priority 2022 to 2023



We've published a comprehensive Delivery Plan that describes in detail our work for this year and following years. This work is focussed on helping us achieve the commitments we've made:

- Support people to live a fulfilling life at home, connected to the community and resources around them, and provide care and support where needed.
- Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis.
- Provide care and support with accommodation where this is needed in a safe and supportive environment that can be called home.
- Make sure support is led by 'what matters to you', with helpful information and easier to understand steps.
- Recognise and value unpaid carers and the social care workforce and the contribution they make to our city.
- Make sure there is a good choice of affordable care and support available, with a focus on people's experiences and improving quality.

For each commitment we've described how this will make a difference to the support we provide and to our performance. We also explain how we'll know we've made a difference, timescales for each step along the way – and how we'll take this work further.

Download the Delivery Plan from our main adult social care strategy web page.

In 2022 to 2023 we are prioritising seven main activities based on learning from our strategy, our analysis of our performance, what people told us and our analysis of impact on people. These priorities will lay the foundation for delivering excellent quality adult social care services, delivering upon our outcomes and commitments agreed in our strategy and delivering a more sustainable service.

By April 2023, we will have delivered:

- A new model and range of supports for delivering social care across the City supported by a workforce plan, a new leadership structure and a focus on equalities and embracing diversity.
- A coordinated way of engaging with people who use our services, communities and the public.
- A new model for preventing abuse and harm with our partners
- A new way of working which supports people experiencing mental ill health and their carers.
- Plans which prepare us for introduction of social care charging, fair costs of care, care quality commission assurance and liberty protection safeguards in 2023.
- A reduction in our waiting lists and backlogs so that people can more easily access our services
- Improved governance and reporting on our performance, budgets and quality of services.

find out more

Adult Social Care Strategy: Download from our Vision and Strategy web page.

Our first Delivery Plan: Download from our Vision and Strategy web page.

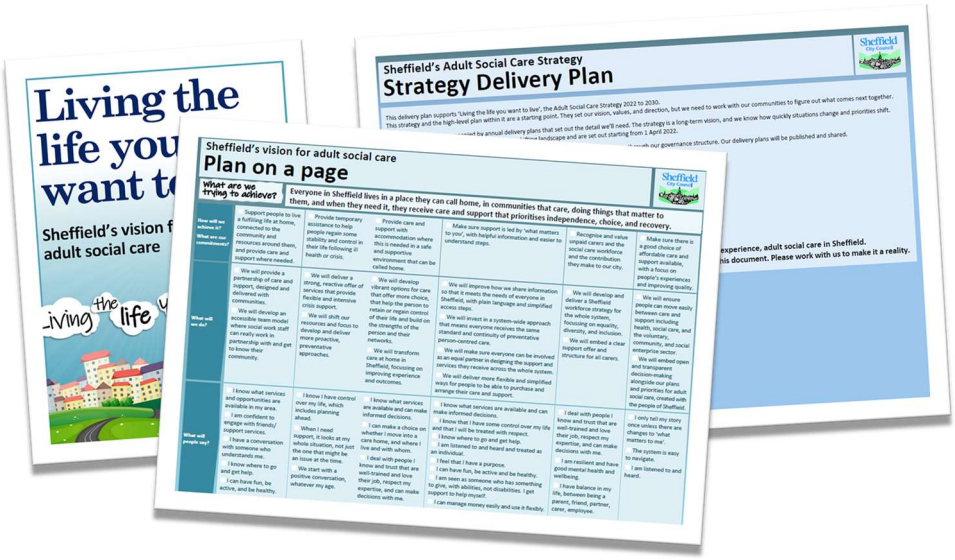
Report on our Change Programme: Download from our Healthier Communities and Adult Social Care Scrutiny webpage.

Find out more

To follow up on any of the topics in this account use these links to get more information, or visit the adult social care section of our website: www.sheffield.gov.uk. You'll also find regular reports about our plans at the Adult Health and Social Care Policy Committee web pages.

How we developed the strategy for adult social care, and our detailed delivery plans, are available from our main Vision and Strategy web page.

We'll continue to update this page with our progress and plans as we complete our improvement plan.



Links in Part 1: Introduction

- ➔ **Duties of the Director of Adult Social Services.** www.adass.org.uk/media/4875/dassstatutoryresponsibilitiesfeb12.pdf.
- ➔ **Duties of councils to provide adult social care and wellbeing.** www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

Links in Part 2: About Sheffield and our people

- ➔ **Detailed information about our population and the communities we serve.** www.sheffield.gov.uk/your-city-council/population-in-sheffield.
- ➔ **Public Health detailed information about the health of our population and our plans to improve the lives of everyone we serve.** www.sheffield.gov.uk/public-health.
- ➔ **An Overview of Health and Wellbeing in Sheffield from LG Inform (local.gov.uk).** https://lginform.local.gov.uk/reports/view/lga-research/lga-research-report-an-overview-of-health-and-wellbeing-in-your-area-1?mod-area=E08000019&mod-group=Core_English_Cities&mod-type=namedComparisonGroup.

Links in Part 4: Our performance and our progress

COVID 19 Pandemic:

- ➔ **Report on the impact to our health and wellbeing.** www.sheffieldccg.nhs.uk/Downloads/About US/CCG Governing Body Papers/2021/14 January 2021/Item 20c Summary of the Impact of Covid on Health and Wellbeing in Sheffield.pdf.

- ➔ **Report on young people's experiences.**
  www.sheffield.gov.uk/your-city-council/young-peoples-experiences-of-covid-19-pandemic.
- ➔ **Report on the response from Sheffield's voluntary and community sector.**
  www.vas.org.uk/wp-content/uploads/2020/06/COVID19-VCS-report.pdf.
- ➔ **Report on Sheffield Hallam University's response.**
  www.shu.ac.uk/-/media/home/about-us/civic/covid-impact-report.pdf?sc_lang=en&hash=AA944807EE4EB7E84D45DBE654F36789.
- ➔ **Report on the Sheffield City Region response to the pandemic.**
  https://governance.southyorkshire-ca.gov.uk/documents/s5687/11 Sheffield City Region Response to the Covid-19 Pandemic v2.pdf.
- ➔ **Report on South Yorkshire and Bassetlaw health and care partners response to the pandemic.**
  https://syics.co.uk/download_file/725/944.

Working together to keep people safe

- ➔ **Website for the Sheffield Adult Safeguarding Partnership.**
  www.sheffieldasp.org.uk

Sheffield Carers

- ➔ **Sheffield Carers Centre website.www.sheffieldcarers.org.uk.**

Our finances

- ➔ **Committee Report on our 2022 to 2023 budget extra costs.**
  https://democracy.sheffield.gov.uk/documents/s52772/12. Report for AHSC Committee - AHSC Budget Update.pdf.

Links in Part 6: Embracing equalities and diversity

- ➔ **Public Health report**
  Impacts of the pandemic on Black, Asian and Minority Ethnic Communities in Sheffield.
  www.sheffield.gov.uk/sites/default/files/2022-07/sheffield-director-of-public-health-rapid-health-impact-assessment.pdf.
- ➔ **Director of Public Health annual report**
  www.sheffield.gov.uk/public-health/director-public-health.
- ➔ **Health and Wellbeing Board report**
  Impacts of the pandemic on Health and Wellbeing in Sheffield.
  https://sheffieldcc.moderngov.co.uk/documents/s42725/The Impact on Health and Wellbeing in Sheffield of the Covid Pandemic.pdf.
  One page summaries.
  www.sheffieldhcp.org.uk/content/uploads/2021/03/Rapid-Health-Impact-Assesments-All-Summaries.pdf.
- ➔ **Speak Up Sheffield: African Caribbean perspectives on home care in Sheffield.**
  www.healthwatchsheffield.co.uk/report/2021-08-23/speakup-2021-sacmha-health-social-care.
- ➔ **Transforming home care.**
  https://democracy.sheffield.gov.uk/documents/s52836/Report for AHSC Committee - Care and Wellbeing Services - Final Version 10 June 2022.pdf.

Links in Part 7: Our plans and priorities for the next year

- **Adult Social Care Strategy.**
  www.sheffield.gov.uk/social-care/our-vision.
- **Our Delivery Plan.**
  www.sheffield.gov.uk/social-care/our-vision.

Get involved!

We hope you've enjoyed reading our local account. If you'd like to get involved in the next report, or in shaping how adult social care works in future, we'd love to hear from you. Please contact Kate Damiral on (0114) 273 4442 or email involvement@sheffield.gov.uk.

Sheffield City Council Adult Health and Social Care Local Account. January 2021 to March 2022.
Photographs used in this report are from the Unsplash website: www.unsplash.com.

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Here for you

How did we do?

Sheffield's Adult Health & Social Care Local Account

Performance data and statistics

Sheffield City Council

Contents

Part 1: Performance Data and the Local Account

One of the main goals we want to achieve through the annual Local Account is to monitor our progress in delivery of the Adult Health and Social Care strategy. This includes establishing the areas of focus for improvement and inviting feedback and challenge from Sheffield citizens.

Part of that process is to provide a regular look at our performance data. This includes national measures that we have collected for the last few years, and allows us to compare our performance to other areas of the country. It also includes measures that we have selected locally because we know they are critical to improving our services.

As we go further down the road of delivering our vision for Adult Social Care in Sheffield, we will be developing performance and quality frameworks that tell us how we are doing against the targets we have set and the outcomes we want to see. Future issues of the Local Account will bring that performance data into the report.

Part 2: Adult Social Care Outcomes Framework (ASCOF) results 2021/22

The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve outcomes that have been agreed as significant national measures, incorporating people's experience of the care they receive as well as the effectiveness of service delivery.

The measures are set out across four domains: quality of life, prevention, satisfaction and safety.

Statistics are generated from a mix of our own records of the people who we provide services to and surveys of people who use services and their carers. The carers' survey is every two years, and this is noted in the table.

The full national report is available at [Measures from the Adult Social Care Outcomes Framework, England, 2021-22 - GOV.UK (www.gov.uk)]

Quality of Life

Measure	15/16 Score	16/17 Score	17/18 Score	18/19 Score	19/20 Score	20/21 Score	21/22 Score	Our Target	National Score	Regional Score
1A: Social care-related quality of life score	18.2	18.1	18.4	18.6	18.0	Postponed (COVID)	**17.5**	19.0	18.9	18.8
1B: The proportion of people who use services who have control over their daily life	71.7	72.6	75.7	74.8	71.2	Postponed (COVID)	**68.1**	78.0	76.9	77.2
1C(1A): The proportion of people who use services who receive self-directed support	85.4	88.0	76.2	77.9	73.2	73.4	**100.0**	n/a	94.5	95.3
1C(1B): The proportion of carers who receive self-directed support	100.0	95.0	83.9	92.1	100.0	100.0	**100.0**	n/a	89.3	83.1
1C(2A): The proportion of people who use services who receive direct payments	37.1	39.8	33.8	28.5	26.5	25.4	**34.5**	n/a	26.7	26.7
1C(2B): The proportion of carers who receive direct payments	100.0	45.6	38.7	23.6	25.6	25.1	**18.6**	n/a	77.6	75.6
1D: Carer-reported quality of life	Biennial Survey	7.1	Biennial Survey	7.0	Biennial Survey	Postponed (COVID)	**7.3**	7.7	7.3	7.4
1E: The proportion of adults with a learning disability in paid employment	3.6	4.3	3.5	4.2	4.0	3.9	**3.6**	7.4	4.8	4.9
1F: The proportion of adults in contact with secondary mental health services in paid employment	5	6	6	7	8	6	**4**	None set	6	8
1G: The proportion of adults with a learning disability who live in their own home or with their family	84.1	77.3	82.2	81.3	78.8	76.5	**72.9**	None set	78.8	79.9
1H: The proportion of adults in contact with secondary mental health services living independently, with or without support	69	74	68	58	54	42	**12**	None set	26	32
1I(1): The proportion of people who use services who reported that they had as much social contact as they would like	40.0	38.3	42.0	43.3	38.3	Postponed (COVID)	**36.5**	47.5	40.6	40.2
1I(2): Proportion of carers who reported that they had as much social contact as they would like	Biennial Survey	28.9	Biennial Survey	26.6	Biennial Survey	Postponed (COVID)	**30.9**	33.0	28.0	31.2

Prevention

Measure	15/16 Score	16/17 Score	17/18 Score	18/19 Score	19/20 Score	20/21 Score	21/22 Score	Our Target	National Score	Regional Score
2A(1): Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population	21.6	24.3	13.6	16.7	22.8	17.0	**24.5**	14.5	13.9	17.5
2A(2): Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	987.9	824.1	657.4	749.5	816.4	588.1	**658.8**	768.0	538.5	611.4
2B(1): The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	76.7	74.7	80.5	83.9	81.2	76.5	**80.5**	80.0	81.8	80.4
2B(2): The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	8.9	6.3	8.0	5.3	7.3	7.8	**6.1**	None set	2.8	2.2
2C(1): Delayed transfers of care from hospital, per 100,000 population	15.7	30.1	19.1	15.4	9.2	Nationally Paused	**Nationally Paused**	Nationally Paused	Nationally Paused	Nationally Paused
2C(2&3): Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population	7.7	12.5	6.4	4.6	5.2	Nationally Paused	**Nationally Paused**	Nationally Paused	Nationally Paused	Nationally Paused
2D: The outcome of short-term services: % not resulting in long term support	72.7	37.2	71.1	30.2	51.1	39.6	**48.1**	None set	77.6	70.5

Satisfaction

Measure	15/16 Score	16/17 Score	17/18 Score	18/19 Score	19/20 Score	20/21 Score	21/22 Score	Our Target	National Score	Regional Score
3A: Overall satisfaction of people who use services with their care and support	52.3	57.9	61.4	61.7	59.1	Postponed (COVID)	**58.7**	65.0	63.9	65.1
3B: Overall satisfaction of carers with social services	Biennial Survey	30.0	Biennial Survey	26.6	Biennial Survey	Postponed (COVID)	**34.7**	30.0	36.3	37.7
3C: Proportion of carers who report that they have been included or consulted in discussion about the person they care for	Biennial Survey	66.0	Biennial Survey	56.0	Biennial Survey	Postponed (COVID)	**62.4**	64.0	64.7	64.7
3D(1): The proportion of people who use services who find it easy to find information about support	66.7	63.0	69.5	64.3	63.9	Postponed (COVID)	**60.1**	73.6	64.6	64.6
3D(2): The proportion of carers who find it easy to find information about services	Biennial Survey	53.8	Biennial Survey	51.2	Biennial Survey	Postponed (COVID)	**53.3**	62.0	57.7	56.3

Safety

Measure	15/16 Score	16/17 Score	17/18 Score	18/19 Score	19/20 Score	20/21 Score	21/22 Score	Our Target	National Score	Regional Score
4A: The proportion of people who use services who feel safe	62.5	60.3	59.6	67.6	63.5	Postponed (COVID)	**56.9**	69.6	69.2	69.3
4B: The proportion of people who use services who say that those services have made them feel safe and secure	87.2	86.6	86.4	89.8	78.8	Postponed (COVID)	**79.4**	88.3	85.6	85.1

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Sheffield City Council Adult Health and Social Care

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Equality Impact Assessment Number:

Part A

Initial Impact Assessment

Proposal name Local Account 2021-22

Brief aim(s) of the proposal and the outcome(s) you want to achieve

The aim of the local account is:

i. to provide an overview of what adult health and social care is,
ii. to highlight our performance and impact over 21-22
iii. to confirm our priorities for 22/23 particularly in delivery of the AHSC strategy.
iv. to give more transparency and accountability to the citizens of Sheffield
v. to reflect on where we need to improve and establish areas to focus on improvement.
vi. Invite feedback and challenge.
vii. Let people know how they can contribute to a healthier city.

From an equality perspective (including our general duties under the Equality Act 2010), we have aimed to ensure the 2021-22 Local Account is:

<u>Accessible</u>
The local report aims to be accessible to people using AHSC, carers and other stakeholders. In Equality Act terms, this includes people sharing protected characteristics of Age (e.g. older people), Disability (e.g. sensory impairment or learning disability) and Race (e.g. people who experience language or cultural barriers).

- It includes the Local Account's language and format, which we have strived to keep as accessible as possible without affecting necessary detail
- We have made an open offer to provide the Local Account in alternative formats. This is particularly important for those who do not have internet access, those who do not have English as their first language and those who are impaired by a sensory or sight/hearing impairment.

<u>Relevant and responsive</u>
Information in the local report is designed to be useful, proportionate and informed by people using AHSC, carers and other stakeholders.

- The 2021-22 Local Account content takes into account feedback from respondents, that people wanted it to include:

i. What services are available
ii. Our strategy for Adult Social Care
iii. People's experiences of the services they use
iv. How people access services
v. The changes and improvements we plan to make in the year ahead

- It includes an invitation for further/ongoing feedback on the content of future Local Accounts.

<u>Focused on equality</u>

- The 2021-22 Local Account includes sections on: Embracing equalities and diversity, Helping our communities 'speak up' and Changing Futures: co-producing new ways close the gap on inequalities

Proposal type
○ Budget ● non-Budget

If Budget, is it Entered on Q Tier? N/A

○ Yes ○ No

If yes what is the Q Tier reference

Year of proposal (s)

● 21/22	○ 22/23	○ 23/24	○ 24/25	○ other

Decision Type

○ Committee (e.g. Health Committee)
○ Leader
○ Executive Director/Director
○ Officer Decisions (Non-Key)
○ Council (e.g. Budget and Housing Revenue Account)
○ Regulatory Committees (e.g. Licensing Committee)

Lead Committee Member George Lindars-Hammond/Angela Argenzio

Lead Director for Proposal

Alexis Chappell

Person filling in this EIA form

Rachel Greenhough

EIA start date 04/11/2022

Equality Lead Officer	
○ Adele Robinson	● Ed Sexton
○ Bashir Khan	○ Louise Nunn
○ Beverley Law	○ Rabena Sharif
	○ Richard Bartlett

Lead Equality Objective

● Understanding Communities	● Workforce Diversity	● Leading the city in celebrating & promoting inclusion	● Break the cycle and improve life chances

Portfolio, Service and Team

Lead Portfolio People

Is this Cross-Portfolio?

○ Yes ● No

Is the EIA joint with another organisation (eg NHS)?

○ Yes ● No Please specify

Consultation

Is consultation required?

○ Yes ● No

If consultation is not required please state why

Before writing the Local Account, a survey was conducted, canvassing the opinions of established co-production groups and the workforce. They were asked the key points of interest that they wished to see in the report. Feedback was received from twenty participants.

They wanted to know:

1. What services are available
2. Our strategy for Adult Social Care
3. People's experiences of the services they use
4. How people access services
5. The changes and improvements we plan to make in the year ahead.

All these aspects are included in the Local Account.

Are Staff who may be affected by these proposals aware of them?

○ Yes ● No

Are Customers who may be affected by these proposals aware of them?

○ Yes ● No

If you have said no to either please say why

Staff and customers have been consulted at the beginning via a survey. All stories of interest have anonymised staff and customers. The Local Account 21-22 includes an invitation to the public to feedback on what they want to see in future reports and it is hoped that a wider and more representative response will inform improvements to the content and format.

Initial Impact

Under the Public Sector Equality Duty we have to pay due regard to the need to:
- eliminate discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relations

For a range of people who share protected characteristics, more information is available on the Council website including the Community Knowledge Profiles.

Identify Impacts

Identify which characteristic the proposal has an impact on tick all that apply

○ Health	○ Transgender
● Age	● Carers
● Disability	● Voluntary/Community & Faith Sectors
○ Pregnancy/Maternity	● Partners
● Race	○ Cohesion
○ Religion/Belief	● Poverty & Financial Inclusion
○ Sex	○ Armed Forces
○ Sexual Orientation	○ Other

Cumulative Impact

Does the proposal have a cumulative impact?
○ Yes ● No

○ Year on Year	○ Across a Community of Identity/Interest
○ Geographical Area	○ Other

If yes, details of impact

Does the proposal have a geographical impact across Sheffield?
○ Yes ● No

If Yes, details of geographical impact across Sheffield

Local Area Committee Area(s) impacted
● All ● Specific

If Specific, name of Local Committee Area(s) impacted

Initial Impact Overview

Based on the information about the proposal what will the overall equality impact?

The Local Account 21-22 includes an invitation to the public to feedback on what they want to see in future reports and it is hoped that a wider and more representative response will inform improvements to the content and format. According to the 2021 Census, Sheffield is home to 556,521 people; just under 1% of the total population of England.

Is a Full impact Assessment required at this stage? ● Yes ○ No

If the impact is more than minor, in that it will impact on a particular protected characteristic you must complete a full impact assessment below.

Initial Impact Sign Off

EIAs must be agreed and signed off by an Equality lead Officer. Has this been signed off?

○ Yes ○ No

Date agreed 08/11/2022 Name of EIA lead officer Ed Sexton

Part B

Full Impact Assessment

Health

Does the Proposal have a significant impact on health and well-being (including effects on the wider determinants of health)?

○ Yes ● No *if Yes, complete section below*

Staff
○ Yes ● No

Customers
○ Yes ● No

Details of impact

There are no health impacts of the publication of a Local Account.

Comprehensive Health Impact Assessment being completed

○ Yes ○ No

Please attach health impact assessment as a supporting document below.

Public Health Leads has signed off the health impact(s) of this EIA

○ Yes ○ No

Name of Health Lead Officer

Age

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

According to ONS census 2021 in Sheffield, 17% (94,800) of residents are aged 65 and over. 8% of those are 75 or older.
According to Census 2021, 92% of adults in the UK are recent internet users. Almost all adults 16-44 (99%) were recent internet users, compared with 54% of adults aged 75 and over.
The Local Account will be initially published on the internet but other forms of it will be available to make it accessible to those 46% of people aged 75 and over without internet access. We have an open offer via a telephone number to provide the report in an alternative format.

Disability

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

The number of UK disabled adults who were recent internet users in 2020 reached almost 11 million or 81% of disabled adults.

In Sheffield 7.11% (41, 886) of residents claim some sort of Disability benefit. The Local Account will be available in a number of formats in order to allow non internet users to access this report. We have an open offer via a telephone number to provide the report in an alternative format.

Pregnancy/Maternity

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

The Local Account is not expected to have significant impact in this area.

Race

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

According to Census 2021, 19.2%(105, 8622) of Sheffield residents are non white British. 4% of Sheffield households do not have English as a main language. The Local Account section 4 explains that embracing equalities and diversity is a core commitment for Sheffield. We have an open offer via a telephone number to provide the report in an alternative format.

Religion/Belief

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

There is expected to be no impact in this area.

Sex

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

According to the Office for National Statistics census 2021, 282,327/50.73% of Sheffield's population is female. Within the Local Account, stories of both sexes being supported by adult social care are represented. Publication of the local report will have no significant impact in this area.

Sexual Orientation

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

Publication of the Local Account will have no significant impact in this area.

Gender Reassignment (Transgender)

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

Publication of the Local Account will have no significant impact in this area.

Carers

Impact on Staff
○ Yes ● No

Impact on Customers
● Yes ○ No

Details of impact

In Sheffield, 2.8% (10,896) of people claim carer's allowance but we estimate that the figure of unpaid carers in Sheffield is about 90,000 people. The local account offers an opportunity to give residents further information on the Adult health and social strategy which includes to improve the carer offer.

Voluntary, Community & Faith sectors

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

Publication of the Local Account will enable residents to link into information from the Voluntary sector through links in the report.

Partners

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

A regional ADASS group for Yorkshire and Humber has been formed in order to promote a consistent approach to Local Accounts across the region. Key elements drawn out through regional workshops have been the CQC Quality statements and the importance of co-production.

The regional approach will have the additional benefit of aiding a look across at our geographical neighbours, with reference to common data and use of common terminology under the new inspection framework.

Cohesion

Staff
○ Yes ● No

Customers
○ Yes ● No

Details of impact

Publication of the Local Account will have no significant impact in this area

Poverty & Financial Inclusion

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Please explain the impact

According to Census 2021, 4.6% (10,582) of Sheffield households are deprived in three dimensions of employment, education, health or housing measures. Providing information in the Local Account how to access support or what support can be available can help support those in need.

Armed Forces

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

Publication of the Local Account will have no significant impact in this area.

Other

Please specify

Impact on Staff
○ Yes ● No

Impact on Customers
○ Yes ● No

Details of impact

Action Plan and Supporting Evidence

What actions do you need to take following this EIA?

There are no actions for this year's report ,however the Local Account 21-22 includes an invitation to the public to feedback on what they want to see in future reports and it is hoped that a wider and more representative response will inform improvements to the content and format.

What evidence have you used to support the info in the EIA?

Office for National Statistics Census 2021

Local insight report 4th November 2021

Detail any changes made as a result of the EIA

No decision or change is being proposed.

Following mitigation is there still significant risk of impact on a protected characteristic. ○ Yes ● No

If yes, the EIA will need corporate escalation? Please explain below

Sign Off

EIAs must be agreed and signed off by an Equality lead Officer. Has this been signed off?

○ Yes ○ No

Date agreed 08/11/2022 Name of EIA lead officer Ed Sexton

Review Date 08/08/2023

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Report to Policy Committee

Author/Lead Officer of Report:
Michael Corbishley, Changing Futures Programme Manager

Report of:	*Director Adult Health and Social Care*
Report to:	*Adult Health and Social Care Policy Committee*
Date of Decision:	*16th November 2022*
Subject:	*The Sheffield Changing Futures Programme Update*

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	x	No	
If YES, what EIA reference number has it been given?				
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:

To update members on the progress of Sheffield's Changing Futures programme.

The programme will transform, over the next 3 years, the support we give to people affected by multiple disadvantages, including being affected by substance misuse, homelessness, domestic violence, crime, and mental illness.

The programme contributes to Commitment 2 and 3 of the Adult Social Care Strategy, to the development of a new operating model for social care and to our new approach to safeguarding.

Recommendations:

It is recommended that the Adult Health and Social Care Policy Committee:

- Notes progress made with delivery of the Changing Futures Programme.
- Endorses the Changing Futures Delivery Plan.
- Requests that the Director of Adult Health & Social Care provides the Committee with updates on progress against the Delivery Plan on a six-monthly basis.

Background Papers

None

Appendices

Appendix 1 – Changing Futures Theory of Change
Appendix 2 – Changing Futures Delivery Plan
Appendix 3 – Changing Futures Programme Impact Statement

<table>
<tr><th colspan="4">Lead Officer to complete:-</th></tr>
<tr><td rowspan="3">1</td><td rowspan="3">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.</td><td colspan="2">Finance: Mark Wassell</td></tr>
<tr><td colspan="2">Legal: Henry Watmough-Cownie</td></tr>
<tr><td colspan="2">Equalities: Ed Sexton</td></tr>
<tr><td></td><td colspan="3">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td colspan="2">SLB member who approved submission:</td><td>Alexis Chappell</td></tr>
<tr><td>3</td><td colspan="2">Committee Chair consulted:</td><td>Councillor Angela Argenzio and Councillor George Lindars Hammond</td></tr>
<tr><td rowspan="3">4</td><td colspan="3">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.</td></tr>
<tr><td colspan="2">Lead Officer Name:
Michael Corbishley</td><td>Job Title:
Changing Futures Programme Manager</td></tr>
<tr><td colspan="3">Date: 5/ 11/ 2022</td></tr>
</table>

1. BACKGROUND

1.1 In December 2020 the Ministry for Housing, Communities and Local Government (MHCLG) announced a new national fund, Changing Futures, aimed at improving the lives of adults facing multiple disadvantages and the systems and services that support them.

1.2 Following a successful Expression of Interest in January 2021, Sheffield worked with key stakeholders across the statutory and voluntary sectors to develop a Changing Futures bid. On 16th July 2021 MHCLG confirmed our bid had been successful and offered a funding award of £3.267m across three years. The Theory of Change and Delivery Programme accepted as part of bid are attached at Appendixes 1 and 2.

1.3 In Sheffield, there are estimated to be around 200 people who fit the description of vulnerable adults facing multiple disadvantages (needing support in three or more of the following areas: Substance use, Mental Health, Housing, Criminal Justice, Domestic Abuse).

1.4 Whilst there is provision for people in these circumstances in (through independent living schemes for Complex needs, Housing First and the new Home at Last Team (HALT)) there is not enough capacity to provide everyone with the intensive, ongoing and specialist support they require. People are often in touch with lots of different services, as they have many different needs. The current system is often unable to address the needs of an individual person in a holistic, consistent, and collaborative way.

1.5 The Changing Futures bid was developed with the intention to act as a change fund for the City, particularly in relation to how we can deliver improved people outcomes for people experiencing multiple disadvantages and enable a greater shift towards prevention of abuse and neglect.

1.6 It establishes an opportunity to accelerate and adding capacity to existing work, developing new long term sustainable resources and evidencing effective practice. Collectively this will enhance and improve our system wide approach to supporting this group of people, and ensure the positive impact is felt beyond the three-year funded programme.

1.7 The Changing Futures programme has 2 broad aims. Firstly, to provide direct intensive and coordinated support to highly vulnerable people to help them escape the difficult circumstances they find themselves sin and move on positively with their lives. Secondly, to change the wider systems and services we have in the city to better help people sooner before their problems get worse and improve the way we support vulnerable people.

1.8 The Programme in consists of several different elements. This includes:

Programme Element	Purpose
Coproduction service and Peer Volunteer Service	to increase the influence of people with lived experience of services and multiple disadvantage, and enable better support of people accessing services and providing a platform for those with lived experience to give something back
A Core delivery team of specialist keyworkers	to engage and coordinate support for 80 people facing multiple disadvantage who have the most complex needs
Enhanced and dedicated specialist resources	to offer new ways of working and reduce waiting times. Main focus is around Mental Health diagnosis, treatment and support but also other healthcare, domestic abuse and housing
Learning and Development	provision to increase the knowledge, skills and capacity across all our services to help people deal with multiple disadvantage and work more effectively
Positive Activities Fund	to increase opportunities for people with multiple disadvantage to engage in activities that are fulfilling and meaningful to support their recovery and enable independence
Data and Systems	to improve ways of recording, sharing and providing access to data. Looking at system wide data solutions that enable prevention and early intervention and help services communicate and collaborate to help people more quickly and effectively
Programme Team inc system change	to ensure effective implementation of the programme, develop and disseminate system learning and help deliver lasting system change

2. PROGRESS TO DATE

2.1 The Programme implementation began in the Autumn of 2021 and is supported by a Governance Board comprised of people with lived experience and partners across health, social work, housing, VCSE, Probation, Police, and non-statutory services across Sheffield.

2.2 The Board is chaired by the Director of Adult Health and Social Care and has been embedded within the Adult Social Care and Housing Strategic Delivery and Change Programmes. It's aimed that this will create the foundations to build long term sustainability for the programme, beyond it's three-year funding, by enabling the approaches, learning and modelling developed from the Changing Futures Programme to be embedded across social care, health and housing governance, operational and strategic arrangements.

2.3 The programme also reports into the Safeguarding Strategic Board and the Drug and Alcohol Strategic Board to enable the Changing Futures Programme to be recognised as a strategic approach which is focused on prevention of abuse and neglect for those experiencing multiple disadvantages.

2.4

A key priority was to demonstrate impact of the programme in improving lives and outcomes of people experiencing multiple disadvantage. To that end, an outcomes framework to enable reporting against outcomes was finalised in May 2022.

2.5 The early indications are that the service has had the following impacts to date:

- Sustained high engagement rates (88%) with a historically hard to engage cohort
- Increased access to and engagement with other mainstream support services
- Increased and faster access to specialist provision such as Occupational Therapy and clinical psychological support
- Improvements in the cohort's basic needs being met (food, healthcare, housing)
- Increased multi agency working to develop collaborative solutions to complex problems

2.6 Following acceptance of the funding, a three-year phased delivery programme was implemented, with the first year focused on implementing the core programme using the funding from MHCLG. Progress has been made as follows:

- Procured our Coproduction and Peer volunteer service which launched in February 2022 and is fully mobilised. South Yorkshire Housing Association and Crisis are the joint delivery partners for this service. This enables the programme to be developed in partnership with people and to build capacity through use of peer volunteers. The programme now has 31 peer volunteers.

- Completed our cohort identification process using a collaborative, cross-sector working group with over 20 organisations involved. This has been flagged by DLUHC as an example of national best practice in identifying need.

- Successfully recruited and inducted the core team who began engaging programme beneficiaries in March 2022. This has included, procuring our psychotherapy support provision with Paradigm Psychological Assessment and Therapy as our delivery partner, procuring our specialist Domestic Violence resource with Cranstoun as our delivery partner, procuring Voluntary Action Sheffield to support with wider VCF engagement in our system change work.

- Procured a Learning and Development service from Project Six to help increase the knowledge, skills, and confidence of staff across the city in supporting adults experiencing multiple disadvantages. Subsequently, a system mapping around Learning and Development and Positive Activities was completed to identify gaps in provision which is helping inform and improve our delivery plans.

- Via CFE Research (a national evaluation partner for the programme) we have completed system mapping around Commissioning, Support Pathways, Learning & Adaption and Workforce Skills. This work is informing our system change delivery plans and the outcomes will be incorporated into the Adult Social Care Target Operating Model to enable long term sustainability of approach in supporting people with multiple disadvantages.

- Started coproduction of our Positive Activities programme, with a joint commission of this provision with the Drug and Alcohol Coordination team, aiming for this service to launch in early 2023.

- Linking in with colleagues in Building Successful Families to work collaboratively on education, training and employment pathways for our cohort; this includes looking at the role of Corporate Social Responsibility in this space.

- Working with colleagues in Sheffield Health and Social Care Trust and from Connecting People, an internationally tested approach to engaging people in meaningful and purposeful activity to see how we can roll this model out in Sheffield

2.7

Co-production has been viewed as core and as a priority for the successful delivery of the programme. To that end, the coproduction and peer volunteer service noted above has quickly connected with existing workstreams across the City with people with lived experience being seen as citizen leaders and equal partners in developing a range of projects, which includes:

- Developing a best practice model for coproduction and peer support, which includes how experts by experience are core to all strategic boards across the City.
- A model for delivery of the Positive Activities fund, this included specific sessions for women and people from ethnic minorities.
- A review of how systems and services work together through system mapping workshops facilitated by CFE Research
- Developing core values and principles for services working with adults experiencing multiple disadvantages.
- Developing a set of standards by which the programme can measure itself against.
- The development of a new women's only temporary accommodation units.
- Establishing a women's only lived experience group in the city to help inform development work around women's support in the city.
- Establishing a BAME lived experience group to help inform support in the city.

2.8 Through the Service, people with lived experience have also taken membership on Sheffield's new citywide Research and Ethics Governance Committee and Sheffield now has 5 expert by experience members in the National Expert Citizens Group, a national co-production service that informs central government policy.

2.9 Future of The Project

2.9.1 Already the project has demonstrated the value of true co-production and partnership working around a common strategic goal. We want to build upon this learning and embed across the City and across Adult Social Care.

2.9.2 The project has already produced good outcomes for people experiencing multiple disadvantage and is enabling learning as to what good looks like in close the gap on inequalities through partnership working. We also want to build on this learning so that this can be cascaded and built upon as we develop our Adult and Housing Target Operating Models.

2.9.3 It's recognised that the funding is short term and so due to this the focus and priority for the next year is to agree as a partnership:

- Learning from the project which can used to develop a What Good Looks Like approach to co-production for use across multiple forums in the City.
- A medium to long term plan which sets out how the Board will sustain its approach to closing gap on inequalities, improving outcomes for people experiencing multiple disadvantages and contributing to safeguarding across the City.
- How learning will be built in and embedded across Adult and Housing Target Operating Models to enable long term sustainability of the approaches.

2.9.4 It's proposed to bring back six-monthly updates on our progress with Changing Futures to the Committee.

3. HOW DOES THIS DECISION CONTRIBUTE?

3.1 <u>Impact on Citizens of Sheffield</u>

3.1.1 The Changing Futures programme will deliver a range of positive outcomes at a system, service and individual level. These outcomes were developed in partnership with key stakeholders and whilst they are primarily focused on improving the lives of adults facing multiple disadvantage, improvements in practice and provision are expected to benefit other cohorts as well.

3.1.2 These outcomes are summarised below:

Area	Outcome Summary
Strategic and System	Improving our understanding of adults facing multiple disadvantage, identifying system barriers and collaboratively developing solutions
Workforce and Development	Trialling new ways of working, testing efficacy and sharing best practice. Improving workforce knowledge, skills and confidence when supporting adults facing multiple disadvantage
Coproduction and Peer Support	Increasing the capacity and resources so that people with lived experience can help design, deliver and evaluate at a strategic and operational level
Data Systems	Improving data recording and information sharing whilst providing greater direct access to those receiving support
Improving operational delivery	Improving the delivery of operational services by collaboratively addressing key fault points (e.g. transitions)
Improving individuals lives	Ensuring that peoples needs are met, that their trust in services increases, their wellbeing and efficacy improves and that they have increased opportunities that reduce their need for formal support services

3.1.3 The full set of intended outcomes are captured within our theories of change and split at a system, service and individual level. These can be found here at Appendix 1.

3.1.4 Across all three levels there are some common thematic benefits:

- Improving access by increasing capacity and navigation, enabling more people to get the help they need when they need it
- A strategic approach to a person-centred, collaborative, joined-up way of working
- Increasing coproduction at all levels
- Improving information sharing
- Workforce development around trauma-informed approaches and knowledge of multiple disadvantage.

3.1.5 The programme itself offers new employment opportunities in the city, both internally within the council and via the services we have and will commission out to providers.

3.2 <u>Adult Social Care Strategy</u>

3.2.1 This proposal supports and links to the commitments stated in the Adult Social Care Strategy, “Living the Life you Want to Live” 2021 in particular

- Commitment 2 - Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis by

ensuring that when individuals are assessed they are given an opportunity to maximise their potential before doing so.

- Commitment 3 - Provide care and support with accommodation where this is needed in a safe and supportive environment that can be called home by offering# a safe and enabling environment which supports their recovery.

The programme also contributes to our ambition towards reducing inequalities across Sheffield.

4. HAS THERE BEEN ANY CONSULTATION?

4.1 During the development of our bid we sought input from a wider range of stakeholders through two online workshops and a number of other conversations. more than 30 partner organisations from statutory, voluntary, community, provider and business sectors provided valuable insights and feedback and helped us build a really strong proposal which helped secure the funding for the City.

4.2 We already had an evidence base about what people experiencing multiple disadvantage wanted and what barriers they faced, which had formed the basis of our EOI. However, we were also able to test out some of our ideas and theory of change with a series of consultation sessions in April 2021, through Zoom meetings and at Cathedral Archer project with people directly experiencing multiple disadvantage.

4.3 A full version of our bid development consultation report can be found at Appendix 4.

4.4 As the programme mobilises we have maintained the approach outlined used during bid development. A multi-agency governance board has been established and a number of multi-agency working groups have been used to progress different elements of the programme. These groups have been operating in an open access and agile manner to facilitate agencies involvement.

4.5 We have maintained our commitment to involving those who use or have recently used services in the city, with lived experience present on our governance board, on our recruitment panels, on our evaluation panels for commercial processes and in the ongoing mobilisation of the wider programme through consultation with lived experience groups in the city.

5. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

5.1 <u>Equality of Opportunity Implications</u>

5.1.1 The proposal is fully consistent with the Council's obligations under the Equality Act (2010). This includes, as set out in the Public Sector Equality

Duty, the requirement for the Council, in the exercise of its functions, to pay due regard to the need to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relations

5.1.2 The Changing Futures programme made concerted effort via its cohort identification process to identify, engage and support individuals from normally underrepresented groups.

5.1.3 As a result, the cohort of people being supported is 50% female, versus similar programmes caseloads typically being 10-15% female. 21% of the cohort are from ethnic minorities. 58% are white British versus a city average of 81%. 5% of the cohort are Muslim versus a city average of 6%. 3% of the cohort are LGBTQ versus an estimated city average of 4%. 45% of the cohort have some form of disability versus an estimated city average of around 10%.

5.1.4 An Equality Impact Assessment covering the Programme is being reviewed and updated.

5.2 Financial and Commercial Implications

5.2.1 Changing Futures Programme Grant (£3.267m) Funding Analysis.

• The project is a jointly funded initiative between MHCLG (subsequently renamed the Department for Levelling Up, Housing and Communities (DLUHC)),and The National Lottery Community Fund (TNLCF) and the annual funding allocations and sources are summarised below:

Year 1 (2021/22)– £955,643	**DLUHC (S31 Grant /MoU)**
Year 2 (2022/23)– £1,243,659	**DLUHC (S31 Grant/MoU)**
Year 3 (2023/24)– £1,067,698	**TNLCF Grant**

• The DLUHC Memorandum of Understanding (MoU) is for 2 years and then TNLCF Terms and Conditions will follow at a later date (tbd).

5.3 Legal Implications

5.3.1 Changing Futures enables the Council to deliver upon its legal obligations as follows: -

The Care Act 2014 Section 2(1) - **Preventing needs for care and support**

(a) contribute towards preventing or delaying the development by adults in its area of needs for care and support.
(b) contribute towards preventing or delaying the development by carers in its area of needs for support.

(c) reduce the needs for care and support of adults in its area.
(d) reduce the needs for support of carers in its area.

***The Care Act 2014 Section 5(1)* - Promoting diversity and quality in provision of services**

(a) has a variety of providers to choose from who (taken together) provide a variety of services.
(b) has a variety of high-quality services to choose from

***The Care Act 2014 Section 6(1)* - Co-operating generally**

(a) their respective functions relating to adults with needs for care and support,
(b) their respective functions relating to carers, and
(c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).

6. ALTERNATIVE OPTIONS CONSIDERED

6.1 The Changing Futures programme is part way through delivery and will continue to adapt as it progresses. A key outcome for the programme will be identifying sustainable options for the programme at end of the funding cycle.

7. REASONS FOR RECOMMENDATIONS

7.1 The reason for the recommendations is to enable the Committee to be sighted on Changing Futures progress and use of funding provide. In addition to set out plans and an opportunity for Committee to provide advice on the Project.

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Sheffield Changing Futures theory of change

System level

Context	Currently, we think the problem is: • Demand outstrips capacity; widespread across system but particular bottleneck in higher-tier statutory services. Underlying issue is underinvestment. • No specific strategy/approach that has buy-in across the partnership. • Some duplication where commissioning only targets one area of need. • Specialist services concentrated in city centre. • People with lived experience are consulted but aren't equal decision-makers • Data spread across systems, inconsistent information-sharing, no-one has a single picture. • Disparities in professional status and different ways of working cause conflicts and 'gatekeeping' of data and services. • Much of the workforce aren't experienced in working with this cohort, lack confidence and don't know what is available.
Inputs	• Changing Futures central leadership, opportunities to influence national policy • Changing Futures funding • Local funding • Shared values and culture • Strategic input from people with lived experience, with an equal stake in commissioning and funding decisions • Open dialogue between commissioners and delivery partners • Updated information-sharing agreements • Support for involvement of people with lived experience recruitment, learning, development • A learning culture, tolerant of some trial and error

Activities	• Develop a system-wide strategic approach, aligning resources. Increase investment where capacity is causing problems. • Establish strategic and operational multi-agency groups specifically around adults with multiple disadvantage • Mapping of funding (current and opportunities) • Mapping the system and use of the system, especially bottlenecks in capacity • Establish baseline of system measures such as collaboration, coproduction, learning • Strategic review of how commissioning could better enable service user choice and control • Identify strategic and operational blockages • In year 3, evaluation of system change led by people with lived experience • Develop vehicle for sharing best practice • Agree common workforce approaches • Assemble and share directory of services. • Co-produce a single assessment and set of person-centred outcomes as basis of support from range of agencies • Develop multi-agency case management and information-sharing system that gives a single view of each individual • Analyse cost to the public purse of multiple disadvantage in Sheffield; monitor how this changes over the programme period • Co-produce and widely deliver training and awareness-raising on multiple disadvantage, trauma-informed and person-centred approaches • Co-produce toolkit on recruitment and CPD
Outputs	• Number of and attendance at strategic and operational meetings, practice-sharing events • Strategic reviews completed • Information-sharing agreements in place/reviewed • Services listed in directory • Assessments completed/reviewed • Records populated on case management system • Cost-benefit analysis

	• Training sessions delivered • Uses of recruitment toolkit • Posts covered by common workforce approach • People with lived experience identified and trained for coproduction
Short-term outcomes	One-year goals: • Increased workforce capacity and assertive outreach in key areas, trialling/modelling a new way of working together • System directory in place, accessible to workforce and service users • A network of people with lived experience trained and prepared to engage in coproduction • Data sharing system developed/procured and in use by core teams • Increased workforce knowledge about multiple disadvantage and effective responses
Longer-term outcomes	Two-year goals: • Wider range of organisations signed up to the agreed way of working; increased confidence and capacity to work with the cohort • Shared ownership of system-wide and person-centred outcomes, with joint commissioning and decision-making • Commissioning strategies prioritise personalisation, choice and collaboration • People with lived experience are involved in codesigning the system • Comprehensive assessment used by all key agencies, underpinned by information-sharing agreements. • Data system widely in use, delivering regular analytical insights • Best practice being shared through informal and formal networks • Value of this programme demonstrated and a plan for how to continue.
Impacts	Five-year vision:

	• Services have the consistency, capacity and confidence to work with people with multiple disadvantage. • Workforce is led by shared values and skilled in working with multiple disadvantage. • All necessary services are linked up effectively around each vulnerable person, avoiding duplication, making transitions smoother • System promotes personalisation and choice. • Recognition that all parts of the system have a role in improving outcomes and share accountability for doing so • Learning from lived experience, frontline delivery and data analysis is used to make evidence-informed decisions. • Regular information sharing contributes to shared assessment of need and risk, shared plan of support for each individual. • Reduced demand on crisis services meaning resources can be shifted to more preventative approaches.
Key assumptions	• Increased capacity for multiple disadvantage can be ring-fenced against other demands • Agencies will be willing and able to agree values and compromise to align priorities, resources and ways of working • People with lived experience will be willing to devote time and energy to coproduction and will have strategic insights • Data protection and security concerns can be overcome to develop shared data system • Training will translate into changes in practice
External factors	• Interaction with strengthened locality approaches • Organisational reforms: how these relate to place-based systems • Changes of local political/organisational leadership/policy • Opportunities/challenges provided by new technologies/applications • Legislative/national policy changes regarding key issues such as benefit entitlements • Economic situation (recession/recovery)

Unintended consequences	Negative: • Resources directed to multiple disadvantage reduce critical capacity elsewhere • Perceptions (correct or not) that people with multiple disadvantage are receiving a ‘special’ service Positive: • Collaborative, person-centred, trauma-informed approaches extend to benefit other cohorts

Service level

Context	Currently, we think the problem is: • High caseloads hinder offers of persistent engagement, intensive support and continuity of care. • Chain of assessments, referrals and waiting times between services. • Support is stepped down once a crisis is resolved, cannot easily be stepped back up. • Services address one need rather than the whole person. • Interventions focused on minimising service user's needs and risks rather than building on their strengths. • Lack of suitable accommodation • Service offers are not always differentiated for characteristics such as gender, age or ethnicity • Harder to engage some service users where workforce does not reflect the population • Unaware who else is working with a service user, what they are doing and what they know. • Not enough knowledge and skills around multiple disadvantage and trauma • Based in 'institutional' settings.
Inputs	• Investment in more capacity • Prioritising continuity of relationships • Alignment of strategic objectives and approach between organisations; expectation to work collaboratively • Agreed cohort for core team • Core team testing and modelling effectives way of working, acting as point of expert reference • Defined expectations regarding coproduction • Support for people with lived experience to participate in coproduction • Reliable single view of a service user's current circumstances and goals

Activities	• Recruit core delivery team; develop operating model, allowing for significant flexibility and creativity • Identify dedicated capacity and differentiated offer for women with multiple disadvantage • Recruit/identify additional posts in areas of most constrained capacity • Source/adapt suitable properties and provide support to maintain/move towards independent living • Identify impact and benefits of core team's way of working and other needs that would be better met this way; modify service models accordingly • Identify/redesign trauma-informed spaces • Multi-disciplinary health and care discussions, enabled by remote meetings/tech • Increase capacity in services to allow continuity of relationships and gradual transitions • Develop out-of-hours contact point and associated information-sharing system • Train and support services to use information-sharing / assessment and outcomes system • Analyse data from this system • Identify potential peer mentors from range of backgrounds; provide training and ongoing support. • Invest in activities that help individuals to grow in confidence, skills and social capital • Workforce development on coproduction, trauma-informed approaches, positive transitions and challenging stigma • Dialogue with communities and businesses
Outputs	• Staff in post • Additional supported housing units • Staff and volunteers with lived experience • MDT discussions taking place • Active users of data system • Number of and attendance at training sessions
Short-term outcomes	One-year goals:

	• Core team working with target cohort, has links to relevant services • Coproduction is valued, helping determine operational decisions in core team • Data system in place, used by core team • OOH contact point being piloted • Greater workforce awareness of multiple disadvantage and effective responses
Longer-term outcomes	Two-year goals: • Shared learning from core team produces service changes elsewhere, including for specific sub-groups of the cohort • Transitions between services are more effective • Multi-agency OOH contact point in place • People with lived experience involved in providing support through different roles • Service users have greater influence in decision-making, beyond core team. • Data system being used by services beyond core team • Workforce more confident in delivering trauma-informed, joined-up support
Impacts	Five-year vision: • Key services have more capacity, and workers have greater skills and autonomy, allowing more meaningful interactions, support that can start rapidly and sustain as required to see transitions through. • Services take a flexible, holistic and strengths-based approach. • Services are better at understanding and meeting the needs of a diverse range of people, with specific offers for sub-groups. • Services are committed to coproduction and (ex-)service users have an equal stake in decision-making. • Services contribute to/access a data system that gives comprehensive, up-to-date view of each individual

	• Increased workforce understanding and confidence about working effectively with people with multiple disadvantage.
Key assumptions	• We will secure other funding to sustain some increased capacity after Year 3 • Some individuals will transition to a lower level of support, allowing new referrals • Commissioning cycles and conditions will allow for the changes we want to see • Providers will be willing and able to work in a more collaborative and holistic way • Sufficiency of suitable properties • People with lived experience will be willing to be involved in coproduction and will have operational insights • Services will see the value of a shared data system and be willing to use it • Training will translate into changes in practice
External factors	• Levels of demand for services, including impact of Covid • Sufficient skilled/qualified and motivated workforce to draw on • Sufficient buildings that can be adapted • Future funding rounds and whether their objectives align
Unintended consequences	Negative: • Upskilled workers leave their posts, impacting continuity of relationships • Requiring providers to work in new ways is more expensive, causing them to withdraw and/or pressure on commissioning budgets Positive: • Workers moving posts take their knowledge and skills to other areas and organisations • Learning/practices of coproduction are used to improve other services Both:

	• Wider awareness and advertising of referral routes and support services could raise expectations of change.

Individual level

Context	Currently, we think the problem for individuals is: • Multiple, interlinked disadvantages, including some that haven't been properly recognised yet. • Usually significant past and ongoing trauma. • Stigma and discrimination, both for multiple disadvantage and other characteristics. • Unable to get effective support due to eligibility/exclusion thresholds and/or inflexible, disconnected service offers. • Distrusting of some offers of help. • Difficult to contact someone who understands their circumstances and support plan out of usual service hours. • Cannot take control of what change they want to see in their lives and how that happens. • May not feel that they belong to a community at all, or may be part of a community which features entrenched substance misuse, crime etc.
Inputs	• Skilled workers with capacity and flexibility to engage, support and see transitions through. • Places to meet individuals which feel safe and welcoming for them • Offer of a suitable and desirable place to live • Coordination, collaboration and real-time information-sharing between agencies. • Clear out-of-hours contact point developed and advertised. • Shared assessments and plans centred on desired outcomes, overcoming barriers to getting them • Peer mentors, from different backgrounds and life experiences, trained and supported in the role • Co-designed services • Data system that allows for input from the individual. • Range of positive activities available • Pathways into learning, training and employment

	• High aspirations for individuals • Workforce aware of multiple disadvantage and how to signpost for support.
Activities	• Workers and peer mentors spend time engaging and building relationships with individuals. • Coproduce support plans based on the individual's own goals, preferences and strengths with family and other support networks • Keyworker navigates and collaborates with other services to deliver appropriate support at pace of the individual. • Develop links to positive social networks and local community. • Plan gradual transitions out of services.
Outputs	• Times engaged with keyworker • Goals achieved on support plan • Reviews of assessment and plan • Calls to OOH contact point, how resolved • Individual users of data system • # positive social connections
Short-term outcomes	One-year goals: • Individuals having trusted relationship with one or more workers • Feeling safe and supported in at least one service • Basic survival and safety needs being met • Improved wellbeing and self-efficacy
Longer-term outcomes	Two-year goals: • Improved trust in services • Individuals feel in control of their plans, confident in achieving their goals • They enjoy a range of positive community links and healthy relationships

	• Each individual's own goals being achieved. Specifics will vary but common themes may be: health, money, safety, housing, family and friends, things to do, plans for the future. • Individuals have access to the information held about them, can add to it and use it as a 'personal profile' to reduce the need to retell their story. • Cohort-level outcomes (reduced offending/victimisation, reduced use of emergency services, fewer housing moves etc) are improving.
Impacts	Five-year vision: • Individuals who have been supported by the improved services are leading safer, more stable and more fulfilling lives. • They make appropriate use of support, rarely using crisis services. They know where to turn if they hit difficulties. • They are part of positive communities. • They can feed their experiences back into the system to co-produce further improvements..
Key assumptions	• Achievable for individuals and workers to overcome barriers to build trusting and effective relationships • Activities and communities exist to match each individual's interests
External factors	• Relationships with family, friends could be positive or undermine progress • Life events could be negative (e.g. being victim of a crime, a new health condition) or positive (e.g. meeting a new partner)
Unintended consequences	Negative: • Some individuals will not engage with the new/improved service offer – potential consequence that they become even more marginalised. Positive:

	• Individuals with high needs, but not multiple disadvantage, can also access and benefit from some of the activities.

Changing Futures Programme: Delivery Plan Template

Version 2

1.1 Area	Sheffield (local authority area)	
1.2 Named contact (a) name (b) main role	(a) Louise Dore	(b) Commissioning Officer, Vulnerable Adults and Youth
1.3 Address	Sheffield City Council Town Hall Pinstone Street Sheffield S1 2HH	
1.4 Telephone number (a) organisation (b) contact	(a) 0114 2734567	(b) 07826 902118
1.5 Email address of named contact	Louise.dore@sheffield.gov.uk	

Guidance notes

- The purpose of this delivery plan is to build on your initial expression of interest, and to set out a theory of change and costed proposals for how you intend to improve outcomes for adults experiencing multiple disadvantage in your area through the Changing Futures programme.

- This delivery plan will be a live document, with flexibility to develop over the course of the three-year delivery period and designated review points. However, we want to have a clear sense of your proposals for involvement in the programme at this stage to inform a robust assurance and final selection process, while acknowledging that implementation and delivery will be an iterative and evolving process.

- Please refer to the Changing Futures prospectus when completing this delivery plan form, including section 2.1 on the aims of the programme; 2.2 on defining the cohort; 2.3. on core delivery principles; and 2.4 on core partnership requirements. Further guidance on each section is also available in the attached guidance document.

- We may share information in your delivery plan, including contact details, with other government colleagues and The National Lottery Community Fund for assessment and for the purpose of developing our understanding and informing wider policy development and best practice.

- Please use black type, Arial font 11. Where additional supporting materials such as the theory of change template are requested, further information is provided in the questions and guidance below. The deadline for submission is 23:55, **Thursday 6 May.**

1. Cohort identification: Who will the programme support?

Please provide information on the cohort you intend to work with over the course of the programme.

Max: 600 words

The purpose of this section is to help us understand the level of need locally, and how you will identify and engage a local cohort of adults experiencing multiple disadvantage who will directly benefit from the programme in order to deliver the individual-level outcomes set out in the prospectus and in your theory of change (see below). Your response should set out:

- *Your understanding of the cohort you expect to benefit from the programme, alongside rationale for any particular focus on priority groups within the cohort definition set out in the prospectus*
- *How you will identify and engage individuals to directly benefit from the programme, and their routes into support – including outreach for those not currently connected with support services.*
- *Anticipated number of direct beneficiaries supported through the programme, with a breakdown of the cumulative total in each year of delivery, taking account of the long-term intervention required for individuals experiencing multiple disadvantages.*
- *How you will take account of diversity and equality considerations, and the need to tailor support to the needs of different groups with protected characteristics.*

Please include reference to eligibility criteria, referral criteria and assessment tools you expect to use and whether you currently operate or anticipate operating a waiting list for joining a specific cohort. This will help inform evaluation design considerations.

Eligibility and routes into support

The key eligibility criteria for inclusion in the local cohort will be:

- meeting the Changing Futures definition of multiple disadvantage; and
- whether an individual currently has access to support that works for them and is improving their outcomes.

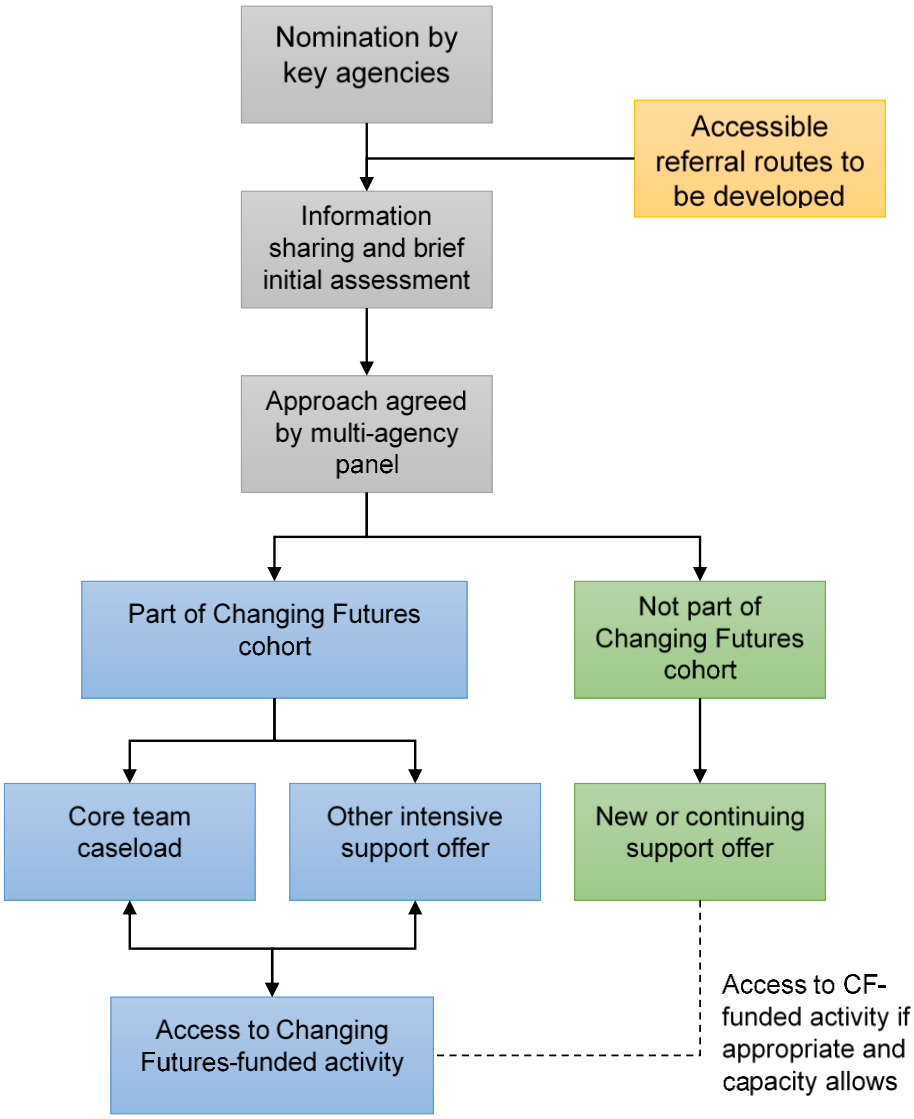
As the cohort of people with multiple disadvantage is relatively small, and well-known to services, we intend to invite nominations from agencies most involved with the cohort. A brief initial assessment and information-gathering exercise, such as the New Directions Team assessment, will be carried out by the service which knows that individual best at that time, and each agency will review their own systems for intelligence. This information will be considered by a multi-agency panel; one of the existing panels with relevant partners represented will expand its remit and/or meet more frequently to do so. They will agree an appropriate service offer, which may lead to inclusion in the Changing Futures cohort, may include receiving a support offer from the core team, and/or may generate a safeguarding response as appropriate.

We do not intend to operate a waiting list as in our experience circumstances change very quickly; individuals will be offered the best option of support that is available at the time, and that will be reviewed regularly. In this way we will be able to offer timely support.

Local intelligence indicates there are few individuals experiencing multiple disadvantage who are not known to services at all; even where they don't currently have support in place, neighbourhood and operational groups are aware of this and try to re-engage them. Working with people with lived experience and grassroots community organisations, we will co-

produce an approach to finding and reaching anyone who is not in touch with services, and develop accessible referral routes for them, including self-referral.

This pathway into support is briefly set out in the following diagram:



Understanding of the cohort

Local data suggests that there are around 200 people in Sheffield who would meet the eligibility criteria for inclusion in the cohort. Around a third of these are women, who, we know from our consultations, require a dedicated service offer to enable them to feel safe, and who often have specific issues including sex work and contact with their children. A high proportion are disabled and/or managing long-term health conditions, as both causes and consequences of their multiple disadvantage. In terms of other characteristics, they reflect the diversity of Sheffield's population. All these needs will be considered as part of a tailored and personalised support offer.

Up to 20% of this cohort is known to change every year, due to recovery, permanently leaving the area, long prison sentences, or death, so the cohort would be regularly refreshed.

We expect all people included in the Changing Futures cohort to benefit in some way from the programme, whether through access to specialist services, taking part in activities, housing or employment pathways, or simply having services be more collaborative, coordinated and trauma informed. We intend around 60 people in total to be on the caseload of the core team. Breakdown as follows:

Year	Cumulative total beneficiaries	Cumulative caseload of core team
1	200	0
2	220	60
3	240	60

2. Outline theory of change: How will the programme achieve improved outcomes at individual, service and system level?

Please set out your outline theory of change at system, service and individual level using the templates provided (annex A). Use the section below to provide a brief overall narrative explaining how you developed the theory of change and how the different levels connect.

Max 2,500 words (templates & summary)

Using the tables at annex A, outline your theory of change with specific activity and outcomes identified at an individual, service and system level. Please also provide a brief narrative in this section covering:

- *How you have developed this theory of change, and how a range of partners – including lived experience expertise – have been involved in shaping the activity set out.*
- *How the different levels (system, service and individual) interact*

A first version of the 'problem' and the 'vision' was developed based on extensive previous engagement with people experiencing multiple disadvantage, our partnership discussions in Sheffield, and themes arising from safeguarding reviews. This was presented at workshops to more than 30 stakeholders from statutory, voluntary and provider organisations. As well as refining these statements, these workshops began discussions on the inputs and activities that could take us from one to the other.

A set of proposed activities was taken to a series of consultation sessions which reached around 20 people with lived experience, recruited through the Sheffield Recovery Forum and at Cathedral Archer Project. We have also made use of the National Expert Citizen Group reports.

There are common themes running through the three levels, which can be summarised as:

- Improving access by increasing capacity and navigation
- A strategic approach to a person-centred, collaborative, joined-up way of working

- Increasing coproduction at all levels
- Improving information sharing
- Workforce development around trauma-informed approaches and knowledge of multiple disadvantage.

Theoretically, the three levels interact in a roughly linear fashion, with the outcomes of the system level becoming the inputs for the service level, and the outcomes of the service level becoming the inputs for the individual level. However, there is also feedback that goes back up the levels, in the form of learning and coproduction, so that in reality change will be iterative.

(Theory of change annex submitted as a supporting document).

3. Delivery plan: What will you deliver as part of the programme?

Please set out your plan to deliver the activity in your outline theory of change over the three-year delivery phase.

Max 1,250 words

The purpose of this section is set out your plan to deliver the activity in your outline theory of change over the three-year delivery phase. Building on the initial delivery proposals set out in your EoI, your response should:

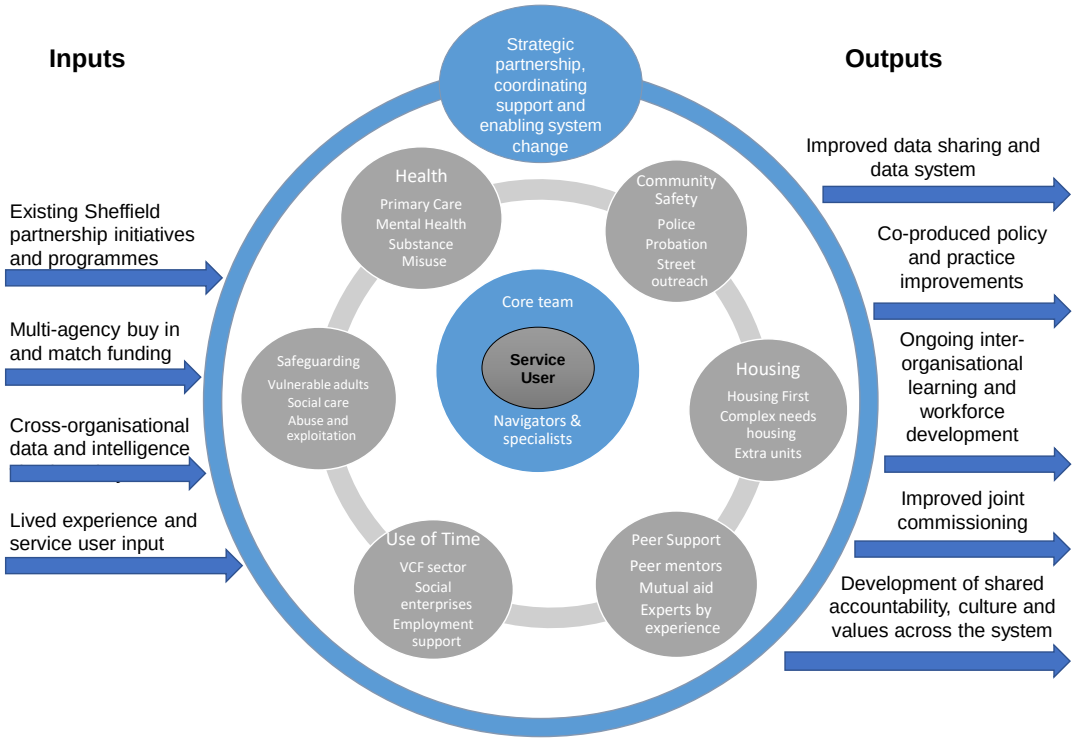
- *Provide a brief summary of your delivery approach and wider partnership strategy, based on your theory of change and taking account of the delivery principles set out in the prospectus*
- *Set out key milestones and timeline for delivering the activities set out in your theory of change, covering the individual, service and system levels.*
- *Identify key risks to successful, timely implementation of the delivery plan, and how these will be mitigated*

Further guidance on the kind of activity in scope for grant funding is available in section 4 of the guidance attached.

Partnership strategy

Our partnership strategy is to use the Changing Futures programme as a ‘change fund’ to move from where we are now towards our longer-term strategy and the funding basis for that. Alongside our existing services, we will invest in more dedicated capacity for adults with multiple disadvantage so that we can test and demonstrate the benefit of an enhanced and different way of working. We will also invest significantly in developing and embedding co-production and trauma-informed approaches which will be key contributors to lasting system change. Our intention is to grow existing good practice, connect systems and interventions together in a more coordinated way, and overlay a coherent system approach to supporting people on their journey of recovery.

This diagram gives an outline of how our proposal will improve outcomes at a system, service, and individual level:



Delivery approach

This is a summary of the features and key activities of our delivery model:

- Coproduction, to increase the influence of people with lived experience
    - Facilitate coproduction by working with existing service user and lived experience networks, and developing new ones where needed
    - Provide training, personal development and ongoing support
    - Advocate for coproduction and prepare organisations to adopt it
    - Work towards a recognised and professional coproduction service
    - System change evaluation in final year
- A core team, to engage people with multiple disadvantage and coordinate support for them.
    - A team of case-holding workers would engage the service user intensively; walk alongside them, providing trusted support and, where necessary, appropriate challenge; coordinate support plans; and oversee a lengthy period of transition and aftercare.
    - Offered to individuals who do not have access to a similarly intensive key-work service.
    - A team of 12 would hold cases of 4-5 each, working with 60 people over the course of the programme. 4 would be women's workers.
    - Service users could also access a personalisation budget and advocacy.
    - Providing a point of expert reference for other agencies and taking part in workforce development activities.
- Enhanced/dedicated specialist capacity, to offer new ways of working and reduce waiting times
    - Expanding on the existing specialist mental health team for homeless people (HAST) to provide a rapid pathway for psychiatric assessments and treatment and trauma-informed psychological therapies
    - Assertive engagement to assess social care needs, review plans and conduct safeguarding enquiries

    - Sharing information and coordinating health and care responses to an individual's needs
    - Testing an outreach model to meet other health and care needs, taking therapeutic support directly to people where they are rather than being clinic-based
    - Providing bespoke interventions to domestic abuse perpetrators and victims with complex needs, including where there are allegations of mutual abuse
    - Coordinating plans and providing specialist advice around rehousing and preventing homelessness
- Peer support and volunteers, to provide a route for people with lived experience to give something back where they want to, and for people currently struggling to benefit from this empathy and credibility
    - Work with existing programmes for mentors, buddies, ambassadors etc, and develop new ones where needed
    - Provide training, personal development and ongoing support
    - Seek and develop paid employment opportunities
- Learning and development, to increase knowledge, skills, and capacity to deal with multiple disadvantage
    - Training and awareness-raising on a sliding scale from basic to intensive
    - Probably using a 'train the trainer' or 'champions' approach
    - Sharing information and good practice through networking events and an up-to-date directory of resources
    - Wider awareness-raising campaigns and communications
- Positive activities and use of time, to increase opportunities for people with multiple disadvantage
    - Connecting to existing and developing new opportunities for positive activities, and introducing them to interested individuals
    - Sourcing donations to support activities and individuals
    - Investing in a range of VCF organisations to enhance their offer of positive activities to this cohort. Activities would usually be open to others too, to extend social networks.
    - Strengthening or developing pathways for this cohort into skills and employment support offers
    - Engaging with employers and business to increase openness to people with complex histories
- Data system and information sharing, to improve our ability to support individuals and our understanding of the cohort
    - Identify and develop appropriate case management / database software, building on or linking to what is already in use
    - Training and technical support to use systems
    - Information sharing agreements and processes
    - Analysis of cohort characteristics, needs and outcomes, and how use of services changes over programme
- Supported accommodation, to increase choice of suitable homes
    - Source or adapt properties suitable for people with high and complex needs, often including disabilities and health conditions, by expanding existing services
    - Provide intensive support to maintain their home, address related needs, and progress towards more independent living
- System change team, to ensure effective implementation of this delivery plan, particularly its transformation and sustainability ambitions
    - Programme leadership and administration posts

Timelines

We will sequence our delivery so that the groundwork is laid for a system-wide approach and our capacity for coproduction is increased first; this will then influence how the other activity is mobilised and increase its chances of success. Key milestones are:

Time period	Activity
July-September 2021	• Procure coproduction service, potentially in combination with another of the functions above • Consolidate programme governance and facilitate partnership discussions in order to define strategic approach and core values • Baseline system mapping and measures, begin work on service directory • Development work on data system and information sharing agreements • Make arrangements for positive activities fund • Prospective work on pathways, policies and procedures, job descriptions etc. Explore options for co-location and mobile working.
October-December 2021	• Coproduction service in place. Co-design phase for other activities including operating model for core team and dedicated specialists; peer support model; objectives of positive activities funding. • Identify initial cohort. • Some specialist posts recruited. • Launch of learning and development programme.
January-April 2022	Core team and remaining specialist posts recruited and mobilised.
April 2022 onwards	Full delivery continues, adapting to learning and interdependencies
April 2023 onwards	• System change evaluation, led by coproduction service • Celebration and learning events • Plans for sustaining and continuing change finalised and put into operation

Risks and mitigations

Risk	Mitigations
Unable to break down organisational barriers, perhaps due to overwhelming other demands	• Investment in capacity • System leadership • Alignment of commissioning priorities
Change is not sustained after Changing Futures programme period	• Sustainability workstream from start • Creative thinking about resources • Investment in system change activities i.e. governance, coproduction, learning • Proactively identify evidence for future business cases
Delay in securing coproduction input and support which is fundamental to the rest of our plan	• Use existing network for early identification of appropriate people • Use existing training packages and published best practice

Eligible individuals experiencing multiple disadvantage are missed from the cohort	• Eligibility criteria agreed by partnership • Initial cohort selected by multi-agency panel • Future referral routes coproduced
Confusion on roles and responsibilities across support offers	• Agree target operating model before start, with input from partners and potential service users
Demand on core team and specialist capacity is overwhelming	• Support offers, including Changing Futures, agreed by multi-agency panel
People supported by the core team and/or specialist capacity do not move on	• Transition planning and other support options introduced at the earliest opportunity, but implemented gradually
Changes in partners' structures and/or funding	• Agreed strategic approach and joint priorities • Sustainability workstream
Data systems not compatible so difficult to share information	• Data analyst and system architect to resolve issues across partnership

4. Funding requirement

Please set out costed proposals for how you intend to use Changing Futures grant funding to support the activity set out in your theory of change and delivery plan, using the spreadsheet attached at annex B.

Using the attached excel spreadsheet at annex B, your response should:

- *Set out how much grant you are requesting in total.*
- *Provide a costed list of activities in priority order, setting out expected cost for that activity across the whole three-year delivery period.*
- *For each costed activity, set out whether this is scalable - by scalable, we mean whether it is a fixed cost or whether you could scale the level of activity up or down with more or less funding (e.g. service delivery reaching more of fewer individuals if a different level of grant is provided).*

There is no minimum or maximum grant amount. It is envisioned that the average grant size over the three years will be in the region of £2.5-£3.5m, and that grant amounts may vary significantly between areas.

(Spreadsheet submitted as a supporting document).

5. Partnership and governance arrangements

Please set out your partnership and governance arrangements for the programme.

Max: 750 words, not including table and any supporting diagrams

Set out your governance arrangements, showing how all of the core statutory and voluntary sector partners required in the prospectus (section 2.4) are meaningfully bought in to and providing

oversight of the programme, and how partnership working is embedded at strategic and operational level. This should include:

- *Relevant strategic priorities or objectives that are shared between key partners*
- *Your strategic arrangements for governance and oversight of delivery*
- *Your operational partnership arrangements that will support delivery of the programme*

You may provide a diagram if helpful to support the information provided in this section. Further guidance on partnership requirement is in section 2.4 of the prospectus and the guidance document attached.

Please also set out the named leads required in the partnership in the table below.

Role	Named Lead	Organisation	Email address
Political lead	George Lindars-Hammond	Sheffield City Council	george.lindars-hammond@councillor.sheffield.gov.uk
Senior Responsible Officer	Sam Martin	Sheffield City Council	Sam.martin@sheffield.gov.uk
Partnership Lead	Alexis Chappell	Sheffield City Council	Alexis.chappell@sheffield.gov.uk
System change lead			
Data and digital lead	To be appointed under the programme		
Lived experience lead	To be appointed under the programme		

Strategic objectives

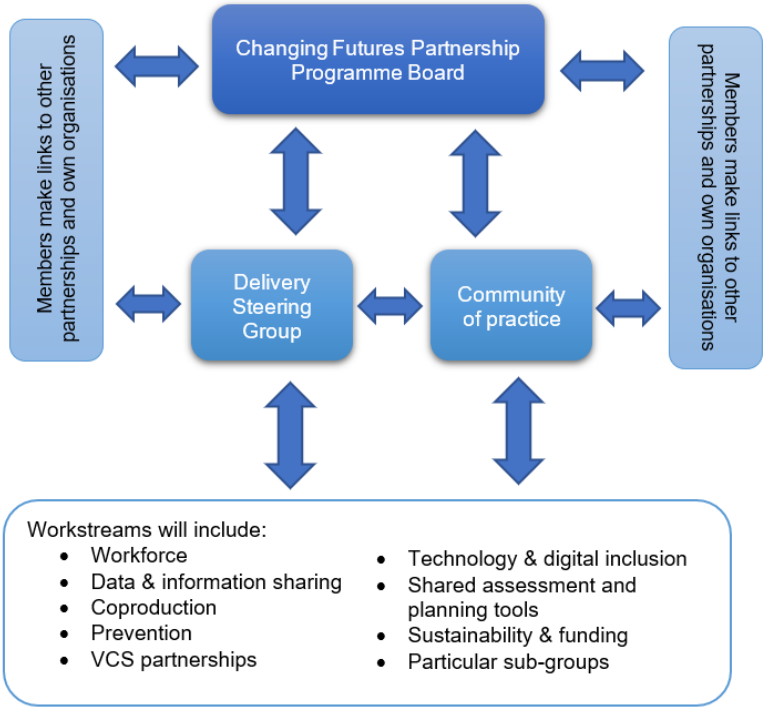
The Changing Futures programme will help to deliver a number of strategic objectives that are shared between key partners, such as:

- Joint commissioning intentions between Sheffield City Council and CCG 2021/22: Improve access to healthcare and health outcomes for most marginalised groups
- Homelessness Prevention Strategy 2017-22: strengthen partnerships to support adults with complex and multiple needs
- Community Safety Partnership Plan 2019-21: domestic abuse and hate crime
- Joint Health and Wellbeing Strategy 2019-24: all is relevant. Ambitions include “Everyone has access to a home that supports their health” and “Everyone has equitable access to care and support shaped around them”
- Sheffield Safeguarding Adult Board Strategic Plan 2020-23: all is relevant. Priorities include “working in partnership” and “engage and empower”.
- South Yorkshire Police and Crime Plan 2017-21 and its successors. Current plan priorities are all relevant, including “protecting vulnerable people” and “treating people fairly”.
- South Yorkshire Violence Reduction Strategy: most are relevant. Priorities include “Encourage all professionals and organisations to continue to work toward becoming trauma-informed” and “Work in partnership to improve the mental health of the

population, and advocate for those who need support to receive it in a timely manner".

Governance and partnership arrangements

The strategic and operational partnership arrangements for the Changing Futures programme are summarised in this diagram:



Partners involved in these arrangements include:

- Key statutory agencies i.e. local authority, CCG, police, Office of the PCC, probation, Jobcentre Plus
- Provider organisations (commissioned or not)
- Voluntary, community and faith sector representatives
- Coproduction representative roles - to be developed under this programme

Partnership Board

The Changing Futures partnership board, meeting bi-monthly, will have responsibility for oversight of the programme and ensuring the delivery of our intended outcomes at a system, service, and individual level. The board will consist of senior colleagues from key stakeholders including a coproduction representative (developed via this programme). Strategically, they will agree core values and principles, and members will share accountability for putting these into practice and removing barriers to the successful delivery of the wider programme. They will direct available resources towards the collective strategy and collaborate to secure the legacy of the programme through future business cases and bids for funding. The partnership board will have oversight of the operational parts of the Changing Futures programme and will take collective high-level decisions as required.

Delivery Steering Group

This operational group will be formed of colleagues from organisations responsible for, or closely connected to, the delivery of the programme's outcomes. They will meet formally once a month ahead of the partnership board and in smaller groups as and when required. Immediately responsible for the planning, delivery and reporting around each of the

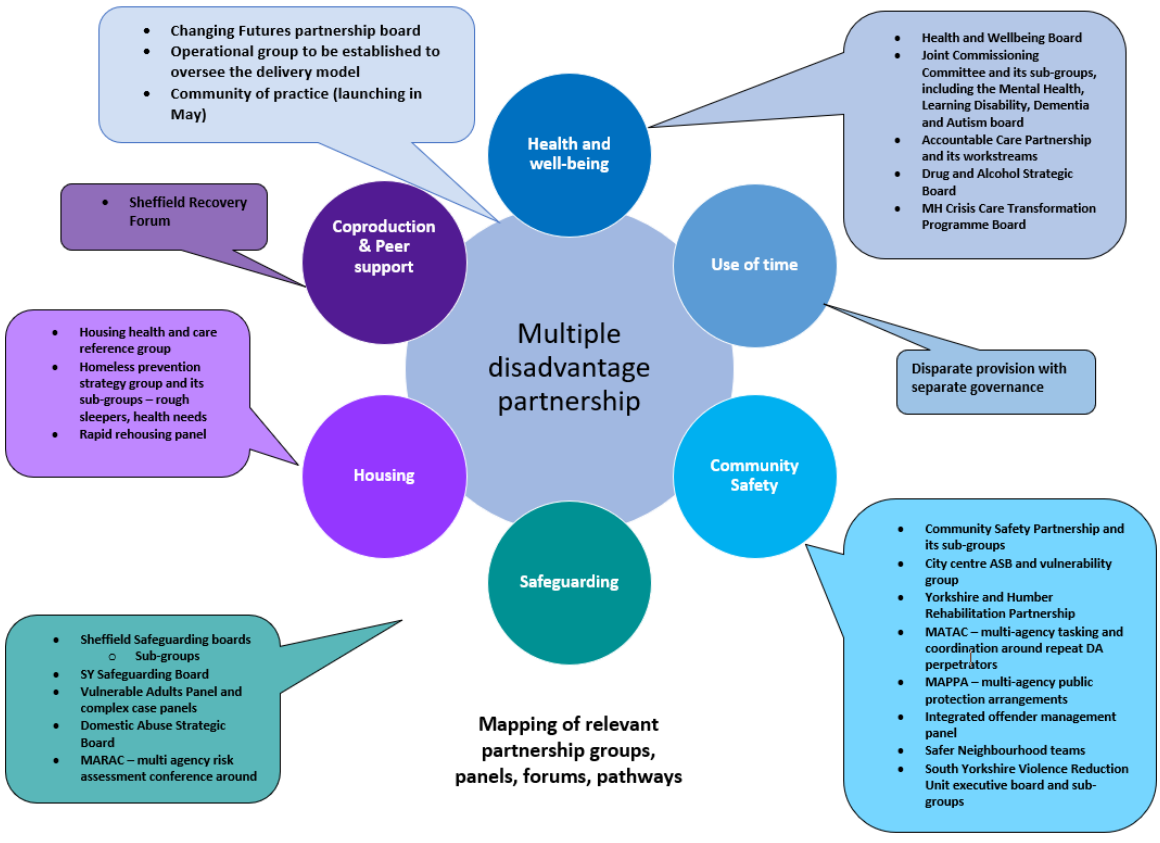
programme's elements, the group will also undertake risk management and service improvement activities and will act as the intelligence hub for our identified cohort.

Community of Practice

This is a sector-led group for anyone working with people with multiple and complex needs in Sheffield, including those with lived experience. It will provide an open opportunity for people and organisations to share best practice and learning, and think together about how we address the challenges in making sustainable change for people with multiple and complex needs. The group will feed back into the delivery steering group and the Partnership Board, providing direct input into programme planning and future strategy development.

Links to other partnership arrangements

The Changing Futures partnership arrangements are distinct from other partnerships due to their focus on *multiple* disadvantage – i.e. considering a range of needs and how they intersect – and on the system change ambitions of our programme. However, they have members in common with all the relevant multi-agency governance structures, and part of the terms of reference includes linking with and influencing those other partnerships. In many cases they will have workstreams in common and work under Changing Futures will also help to deliver that partnership's objectives, or vice versa. These are summarised in the diagram below (also submitted as a supporting document).



Mapping of relevant partnership groups, panels, forums, pathways

6. Interaction with other projects and programmes

Please set out how the planned activity in your delivery plan will complement and enhance other programmes and interventions underway or planned that impact on adults experiencing multiple disadvantage, while avoiding duplication.

Max: 750 words, not including any supporting diagrams

Your response should set out:

a) *Any wider contributions from local partners to your approach, demonstrating how Changing Futures is part of a wider local strategy on multiple disadvantage and how changes will be sustained beyond the life of the programme*
b) *How activity supported through the Changing Futures programme is complementary and additional to other funding, projects and programmes working with adults experiencing multiple disadvantage, while avoiding duplication.*

You may provide a diagram or visual representation of other relevant programmes and funding as a supporting document to help illustrate this answer. Further examples of the type of government and local programmes you should take into account are set out in the guidance document.

We intend to use the Changing Futures funding to accelerate system transformation in Sheffield: testing where enhanced capacity can make a difference, demonstrating the benefits of different ways of working, and embedding ongoing drivers for change such as coproduction and workforce development. From the start, we will proactively look for learning from the programme, share this with stakeholders, and use it to inform business cases for sustaining and building on change.

This investment will sit alongside the range of existing services either specifically targeted to adults experiencing multiple disadvantage, or open to all but accessed frequently by them. In developing our delivery model, we have made reference to these and to the plans and proposals in the pipeline for the next three years; this will continue to develop as new opportunities and imperatives arise.

Locally-funded contributions to our approach include:

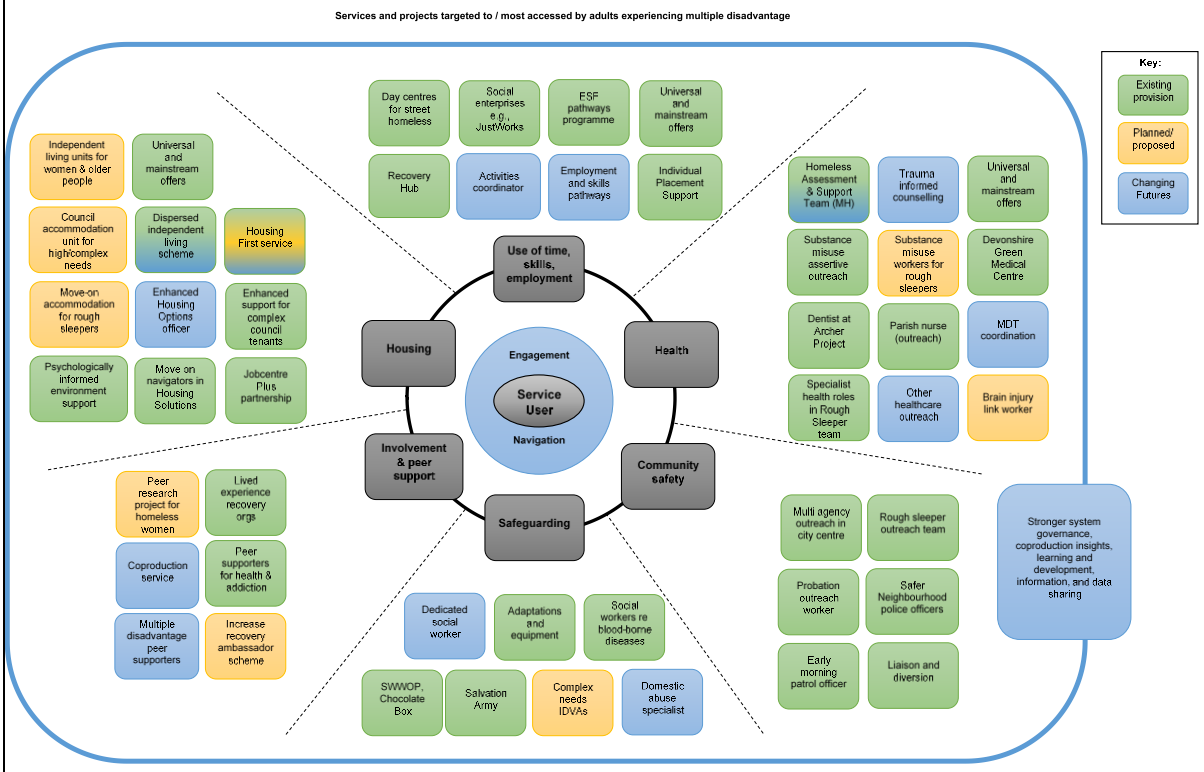
- The Homeless Assessment and Support Team is commissioned to provide access to healthcare and support services for homeless people who have mental health problems. Through Changing Futures we intend to extend its remit and capacity to deal with more people experiencing multiple disadvantage.
- Additional Safer Neighbourhood Service police officers have been deployed to deal with the most complex vulnerable adults
- A multi-agency outreach team which operates in the city centre
- A number of supported and independent living schemes for people with complex needs, and psychologically-informed environment and therapeutic support commissioned to enhance those services
- Recovery communities and ambassador schemes.

There is some interdependency between our Changing Futures proposal and other government programmes which are still being developed or under consideration. These include:

- Yorkshire and Humber Rehabilitation Partnership – MoJ Prison Leavers project
- Bid for complex needs Independent Domestic Violence Advocates – MoJ fund
- Rough Sleeping Initiative bid to continue current provision and extend Housing First and supported accommodation offer
- Bid to Rough Sleepers Accommodation Programme to be submitted this summer.

We will adapt our delivery depending on the outcome of these decisions, scaling up or scaling back as required, and ensuring that these other programmes are linked to our partnership arrangements.

The place of the Changing Futures investment alongside the other services and projects in the city is summarised in the following diagram (also submitted as a supporting document).



As well as supporting the delivery of the strategic objectives listed in section five, as they mature the Changing Futures partnership arrangements will have a growing influence om the development of a wider shared strategy on how Sheffield can improve its offer to vulnerable people. This strategy will be jointly owned by statutory, non-statutory, provider organisations, Voluntary Community and Faith organisations, people with lived experience and private businesses, expressing collective intentions on how to strengthen, improve, or develop interventions that prevent the escalation of need.

This approach will allow us to make best use of the resources and opportunities available to each sector including fundraised and grant income from the third sector, corporate social responsibility funding and services in kind from the private sector, and central government funding available to statutory providers. Shared ownership of developing and delivering this strategy will enhance our city-wide service offer, facilitate future match funding arrangements and lead to more effective use of resources.

7. Data

Please set out how you intend to develop the collection, sharing, analysis and use of data to drive service improvement and measure outcomes set out in your theory of change.

Max: 600 words exc tables

Your response should set out:

- *A) A brief summary of: what data you already hold on the cohort, what data sharing agreements you have in place locally, and how you intend to develop the collection, sharing, analysis and use of data to drive service improvement and achieve better outcomes for adults experiencing multiple disadvantage*
- *B) Using the tables below, the data available to measure improvement in outcomes set out in your theory of change (even if you don't currently hold it), where there are key gaps and how you might go about filling those (this might involve a variety of options, not limited to existing administrative data).*

There is data held about the cohort across the systems used by key services. For the most part, this is shared on an ad-hoc basis, in multi-agency meetings, not systematically, meaning that it is not possible to access a single, up-to-date view of an individual. There have been attempts to gather information about the cohort for research and service development purposes, but these are snapshots in time, and incomplete.

There are existing data sharing agreements between statutory agencies and with providers for other multi-agency programmes and projects: Successful Families, Team around the Person and the Housing Support Pathway for example. We will be able to adapt/extend these to Changing Futures;. Similarly, there is already more than one system in use in the city which allows for multi-agency access and use, case management and tasking, and operational and strategic reporting, so we will identify the most appropriate existing system and build on that.

Our delivery model includes investment in a systems architect in the first year of the programme, and an ongoing analyst post. We will adopt a structured approach with system development being driven by learning from the project as it progresses.

All the service users assigned to the Changing Futures cohort will be registered on one system so that there is centrally controlled information. The data analyst for the programme will ensure that timely data collection is taking place and produce reports that inform decision-making at service and individual level.

The systems architect will work with key delivery partners to identify opportunities to link systems together, ensuring data agreements are in place as required. Training will be offered where needed on how to use the shared data system so organisations can be licensed to access those elements that are relevant to their service delivery.

Our aspiration is that individuals will be able to access to the information held about them on this system, and contribute to it, perhaps through journal entries, photos and videos. If they wish, they will be able to use some or all of it as a ‘passport’ to introduce themselves to new workers or agencies, reducing the need to retell their story

By year three we will know more about our service users' and partner agencies' needs and accessibility issues, and therefore have a clear specification for systems that are easy to use, have a logical interface for different users and have some interconnectivity. This will enable us to pursue our ambition as a legacy from this programme of having a single system available to the partnership organisations and delivery teams that will enable a good flow of information and reduce the need for any duplication. This will support the work of the partnership as it continues to deliver beyond the end of the programme and be a key resource in demonstrating improvement in cohort-level outcomes and therefore a cost-benefit analysis.

The tables below set out how we propose to measure the outcomes from our theory of change. While this will require us to collect a lot of data that is not currently held, most of this is straightforward and will be routinely collected in the course of casework and administrative activity. Some of the system change outcomes are an exception to this and a priority at the start of the programme will be to agree suitable measures and carry out a baseline assessment.

Table 1: short-term outcomes

Level	**Short-term Outcomes**	**Proposed measurement metric**	**Current availability (data held/data collected but not held/new data required)**
System	Increased capacity in key areas	FTE posts	New
	System directory in place	# entries	New
	Network for coproduction	# trained participants	New
	Data system in use by core team	# records	New
	Workforce knowledge of MD	Self-assessment	New
Service	Core team working with cohort	Caseload	New
	Coproduction determining decisions in core team	Decision records/minutes	New
	Data system in use by core team	# records	New
	OOH contact piloted	# calls	New
	Workforce awareness of responses to MD	Self-assessment	New
Individual	Trusted relationship with 1+ worker	Self-report/evaluation	New
	Feels safe and supported in 1+ service	Self-report/evaluation	New
	Basic safety needs met	NDT assessment	New
	Wellbeing and self-efficacy	Assessment	New

Table 2: long-term outcomes

Level	**Longer-term Outcomes**	**Proposed measurement metric**	**Current availability (data held/data collected but not held/new data required)**
System	Increased confidence across organisations	Change against baseline in evaluation	New
	Shared ownership of outcomes		New

	Commissioning priorities		New
	Codesigned system		New
	Shared assessment in use	# accessed	New
	Data system in use	# users	New
	Best practice shared	Learning events	New
	Value for money	Costs avoided	New
Service	Learning leads to service changes	Decision records/minutes	New
	Effective transitions	Representations	Held
	OOH contact in place	# calls	New
	Peer support in place	# participants	New
	Coproduction influencing decisions more widely	Decision records/minutes	New
	Data system in use	# users	New
	Workforce confidence in responding to MD	Self-assessment	New
Individual	Trust in services	Self-report/evaluation	New
	Feels in control of plans	Self-report/evaluation	New
	Positive community links and relationships	Assessment	New
	Personal goals achieved	# achieved in plan	New
	Access and use data	# users	New
	Cohort-level outcomes – increased use of planned/preventative and decreased use of emergency services	Average use of services	Collected but needs cleansing and analysis

Appendix Three – Changing Futures Programme Impact Statement: March 2022 – March 2023

*Direct work with the Changing Futures cohort began in March 2022 with a staggered mobilisation of the programmes cohort capacity finalising in September 2022.

Year One Outcomes	Progress to date
Increased workforce capacity and assertive outreach in key areas, trialling/modelling a new way of working together	The programme is supporting 82 of Sheffield's most vulnerable people who are facing multiple-disadvantage and have a history of non-engagement in support services. The programme has funded the creation of a new co-located multi-disciplinary team which includes: • 12 support workers delivering strength based, personalised support using an assertive outreach model, employed by SCC • A specialist domestic abuse perpetrator worker, via Cranstoun • Clinical psychology support via Paradigm • An Occupational Therapist and Community Mental Health Nurse via the Sheffield Health and Social Care Trust Recruitment has also been attempted and is currently live for: • A Social Worker, Senior Psychologist /Senior Psychotherapist and a Non-Medical Prescriber via the Sheffield Health and Social Care Trust • A Senior Housing Options officer via SCC
System directory in place, accessible to workforce and service users	The programme has undertaken a citywide mapping exercise of support services and pro-social activities for vulnerable adults across the city. This involved over 380 services/activities across 70+ organisations. The programme team is working with SCC's Information Team and using our mapping work to support the development of the 'Connect to Services' platform that is due to be launched in October 2022. This online platform has been designed to improve opportunities to promote services and activities in Sheffield.
A network of people with lived experience trained and prepared to engage in coproduction	Prior to Changing Futures there were limited opportunities for lived experience people to be involved in the design, delivery and evaluation of support services. With no co-production offer city wide, nor a co-coproduction service specific for Multiple Disadvantage. Changing Futures commissioned a new Coproduction and Peer Support service that is increasing the presence and voice of lived experience in services, via South Yorkshire Housing Association. Since the service launched in February 2022 over 60 people with lived experience have participated in coproduction and peer support activities. This includes specific groups aimed at women and those from ethnic minorities.
Data sharing system developed/procured and in use by core teams	Following a system selection process the programme opted to utilise the existing Housing Solutions Pathway system given its current use by a wide range of key stakeholders. We have negotiated access to the system for partners across the multi-disciplinary team. Custom development of the system has been completed and the system is in active use. Changing Futures have been able to customise the system with the support off the Application Development Manager, to ensure all the relevant data is captured.
Increased workforce knowledge about multiple disadvantage and effective responses	The programme mapped the current citywide learning and development offer and subsequently commissioned a service to fill recognised gaps in provision. Project 6 have been commissioned to build and enhance the skills, confidence and capability of staff and volunteers to better meet the needs of adults experiencing multiple disadvantage. The service is delivering a multi-faceted L&D offer using a mixture of face to face, online and digital content. This service was commissioned in August 2022 and is launching its L&D offer in Dec 22.

	On an ongoing basis the core team is producing Learning Reports that demonstrate the efficacy of their support model and outline how these approaches could be adopted more widely.

Year Two outcomes

- Wider range of organisations signed up to the agreed way of working; increased confidence and capacity to work with the cohort
- Shared ownership of system-wide and person-centred outcomes, with joint commissioning and decision-making
- Commissioning strategies prioritise personalisation, choice and collaboration
- People with lived experience are involved in codesigning the system
- Comprehensive assessment used by all key agencies, underpinned by information-sharing agreements.
- Data system widely in use, delivering regular analytical insights
- Best practice being shared through informal and formal networks
- Value of this programme demonstrated and a plan for how to continue.

Impact

- Services have the consistency, capacity and confidence to work with people with multiple disadvantage.
- Workforce is led by shared values and skilled in working with multiple disadvantage.
- All necessary services are linked up effectively around each vulnerable person, avoiding duplication, making transitions smoother
- System promotes personalisation and choice.
- Recognition that all parts of the system have a role in improving outcomes and share accountability for doing so
- Learning from lived experience, frontline delivery and data analysis is used to make evidence-informed decisions.
- Regular information sharing contributes to shared assessment of need and risk, shared plan of support for each individual.
- Reduced demand on crisis services meaning resources can be shifted to more preventative approaches.

Service

Year One Outcomes	Progress to date
Core team working with target cohort, has links to relevant services	The programme has successfully engaged its target cohort and is supporting them to engage in existing mainstream service support offers. The team is well connected to the relevant services and present on a wide range of operational boards and groups across the city.
Coproduction is valued, helping determine operational decisions in core team	Changing Futures commissioned a new Coproduction and Peer Support service that is increasing the presence and voice of lived experience in services, via South Yorkshire Housing Association. Since the service launched in February 2022 over 60 people with lived experience have participated in coproduction and peer support activities. This includes specific groups aimed at women and those from ethnic minorities. The coproduction service has and is informing a range of work across the city including: - Ongoing coproduction of Sheffield City Councils Homelessness Prevention strategy - Completed a coproduced review of remuneration for people with lived experience - Reviewing ways of working within the core Changing Futures team e.g. the way Personalisation budgets operate - Membership of our governance board is ongoing with the coproduction model currently under review - We have held five workshops to coproduce the delivery of our Positive Activities fund with over 40 attendances so far - We had five experts by experience take part in system mapping workshops - Ongoing coproduction of Values and Principles for services working with adults experiencing multiple disadvantage - Coproduced workshop on the services Theory of Change to produce the evaluation standard the service will measure itself against - Taken membership on Sheffield's new citywide Research and Ethics Governance Committee - Working with housing colleagues to coproduce the development of a new women's only temporary accommodation units

	- Sheffield now has 5 expert by experience members in the National Expert Citizens Group, a national co-production service that informs central government policy - We have created a women's only lived experience group - Developing a BAME lived experience group with one meeting taken place so far - One Sheffield expert by experience is involved in the national CF Peer Researchers work - We are currently exploring ways to embed experts by experience on different strategic boards across the city (see **appendix three**)
Data system in place, used by core team	Following a system selection process the programme opted to utilise the existing Housing Solutions Pathway system given its current use by a wide range of key stakeholders. We have negotiated access to the system for partners across the multi-disciplinary team. Custom development of the system has been completed and the system is in active use. Changing Futures have been able to customise the system with the support off the Application Development Manager, to ensure all the relevant data is captured.
Greater workforce awareness of multiple disadvantage and effective responses	The programme mapped the current citywide learning and development offer and subsequently commissioned a service to fill recognised gaps in provision. Project 6 have been commissioned to build and enhance the skills, confidence and capability of staff and volunteers to better meet the needs of adults experiencing multiple disadvantage. The service is delivering a multi-faceted L&D offer using a mixture of face to face, online and digital content. This service was commissioned in August 2022 and is launching its L&D offer in Dec 22. On an ongoing basis the core team is producing Learning Reports that demonstrate the efficacy of their support model and outline how these approaches could be adopted more widely.
Year Two Outcomes	
- Shared learning from core team produces service changes elsewhere, including for specific sub-groups of the cohort - Transitions between services are more effective - Multi-agency OOH contact point in place - People with lived experience involved in providing support through different roles - Service users have greater influence in decision-making, beyond core team. - Data system being used by services beyond core team - Workforce more confident in delivering trauma-informed, joined-up support	
Impact	
- Key services have more capacity, and workers have greater skills and autonomy, allowing more meaningful interactions, support that can start rapidly and sustain as required to see transitions through. - Services take a flexible, holistic and strengths-based approach. - Services are better at understanding and meeting the needs of a diverse range of people, with specific offers for sub-groups. - Services are committed to coproduction and (ex-)service users have an equal stake in decision-making. - Services contribute to/access a data system that gives comprehensive, up-to-date view of each individual	
Individual	
Year One Outcomes	**Progress to date*** We have data from our baseline (June 2022) but are awaiting data from our last return to be returned back to us by DLUHC
Individuals having trusted relationship with one or more workers	• 92% of the cohort told us that they do not feel able or only occasionally feel able to trust others. • 39% said if they needed someone to talk to they had no one

Feeling safe and supported in at least one service	• 77% of the cohort were unsure or not confident they would be in stable accommodation in 6 months time • 39% said if they needed someone to talk to they had no one • 50% of the cohort who experienced Domestic Abuse in the last three months felt unable or were unwilling to contact the police • 65% of the cohort reported feeling generally unsafe • 58% felt unsafe in their current accommodation • 53% of the cohort said they didn't feel listened to by services • 53% of the cohort said services did not explain things clearly • 50% of the cohort said they did not feel treated with respect by services • 65% of the cohort said the services did not understand their situation • 53% of the cohort said the service did not make the effort to see what was important to them • 61% of the cohort did not feel involved in the decisions made about them by services
Basic survival and safety needs being met	• 35% of the cohort had slept rough in the last three months • 50% of the CF cohort said their overall goal was to find safe, suitable accommodation • 46% of the cohort had been a victim of violent crime within the last three months • 77% of the cohort reported feeling unable to cope • 69% of the cohort felt their life was not worth living • 20% of the individual's personal budgets have been used to purchase food with a similar amount used to purchase clothing. • 69% said they had physical health support needs and were currently experiencing physical pain • 31% of our cohort are not registered with a GP, a further 18% are supported through specialist provision at Devonshire Green • 46% of the CF cohort have been unable to access dental treatment in the first quarter of the programme. • 57% of the CF cohort were not registered with a dentist in the first quarter of the programme.
Improved wellbeing and self-efficacy	• 61% of the cohort did not feel involved in the decisions made about them • 77% of the cohort felt they couldn't do the things they wanted to do • 69% said they had physical health support needs and were currently experiencing physical pain • 93% had experienced mental health difficulties in the last 3 months • 77% of the cohort reported feeling unable to cope • 69% of the cohort felt their life was not worth living • 81% said they do not feel able to manage their mental health • 85% of the cohort found it difficult to get started with everyday tasks • 23% of the cohort said their goal was to reduce or stop substance use. • 19% of the CF cohort said their goal was to continue in education. • 19% of the CF cohort said they want to volunteer or seek employment. • 15% of the cohort said they wanted to improve health and self-esteem.

Year Two Outcomes

- Improved trust in services
- Individuals feel in control of their plans, confident in achieving their goals
- They enjoy a range of positive community links and healthy relationships
- Each individual's own goals being achieved. Specifics will vary but common themes may be: health, money, safety, housing, family and friends, things to do, plans for the future.
- Individuals have access to the information held about them, can add to it and use it as a 'personal profile' to reduce the need to retell their story.
- Cohort-level outcomes (reduced offending/victimisation, reduced use of emergency services, fewer housing moves etc) are improving.

Impact

- Individuals who have been supported by the improved services are leading safer, more stable and more fulfilling lives.
- They make appropriate use of support, rarely using crisis services. They know where to turn if they hit difficulties.
- They are part of positive communities.
- They can feed their experiences back into the system to co-produce further improvements.

Case studies

Case Study One – Kate

Changing Futures first met Kate in April 2022 and as we got to know Kate, she told us she had been abused as a child, addicted to substances since she was 16, scarred by the loss at birth of her first child and later by the death of her partner. She is the mother of three more children, all of whom had been taken away from her and had been in and out of temporary accommodation and occasionally custody over the last 25 years. In 2019 Kate met Tom in a homeless hostel and become pregnant with her fifth child. Forced to leave the hostel during pregnancy, she had ended up living jointly with Tom in temporary accommodation on the third floor of a council block in north Sheffield.

During childbirth (this child also removed from her care) she developed a hernia, which, along with the problems with her legs caused by extended drug use, reduced her mobility considerably. In the absence of outside support, she became more and more dependent on Tom and in late 2021, Tom attempted to strangle her. Kate reported this to the police, and he spent some time on remand before he convinced her to withdraw her statement. Tom moved back in, and they resumed their drug-related co-dependency. Kate had not engaged in meaningful support with any agency for several years and her mobility issues prevented her from accessing primary care and support around her substance use.

Changing Futures initial support was focused on developing a relationship based on trust. Our assertive approach took support to her, we negotiated alternative access routes into support services – such as telephone appointments with the substance use service and accompanied Kate to appointments with her GP.

We supported Kate as she went in and out of hospital (including long stints waiting in A&E) with recurring blood clots and infections in her legs. Our visits helped her retain some positivity about her future and we encouraged her to pursue her interest in history by providing a tablet to complete online history courses whilst in hospital wards. We supported to resolve her script issues which in turn has reduced her use of heroin.
A Changing Futures Peer Support worker also started supporting her and this led to Kate taking part in a coproduction session exploring how the council can better design accommodation for women. The programmes in house Occupational Therapist (OT) visited Kate in her home and quickly got some mobility aids installed providing Kate with greater independence - she is now able to cook for herself again. The (OT) and her Changing Futures support worker managed to secure more appropriate accommodation for Kate, a ground floor flat, and we are now working with Kate to connect her into her new local community.

Since Changing Futures started supporting Kate she has begun losing weight for the first time in years; her legs have begun to heal and her mobility improved. She is now able to move easily around her flat and even walk short distances unaided. Her dependence on Tom has significantly reduced and we are supporting Kate to explore volunteering opportunities as well as going to study, likely history, at Barnsley College. Kate has said this about the Changing Futures programme “I have received more support in a few months from you than all the support combined over the years”

Case Study Two – Trevor

When Changing Futures met Trevor, a 48-year-old Black African man originally from Burundi, he was living in a squalid privately rented property in a poor state of repair. His mental health was very poor, he was extremely anxious and had recently experienced a burglary making him feel unsafe in his home. He was consuming large quantities of alcohol daily and had lost his permanent employment due to presenting at work intoxicated. Trevor wasn't engaged in any support services at the point we met him and was struggling to cope with everyday occurrences such as cooking, cleaning and opening mail.

Trevors property was deemed uninhabitable, and he was found temporary accommodation in a Bed and Breakfast. He remained there for approximately three months and during this time the relationship with his Changing Futures support worker was strengthened through regular contacts and visits.

Trevor began to share details of his financial issues, he had failed to pay the majority of his bills and as a result had amassed approximately £11000 of debt. Trevor had limited understanding around this, much of the debt linked to Trevor not notifying agencies when he was in and out of work. Changing Futures supported Trevor to organise his paperwork and took him to Citizens Advice, he gave written permission for both his Changing Futures worker and Citizens Advice to advocate on his behalf and as a result we have secured a Debt Relief Order which will eventually eliminate his debt. In the meantime, we continue to support Trevor to process his mail, we helped him open a bank account and set up direct debits to pay for all utility bills and avoid further debt. His Changing Futures support worker has negotiated utility discounts and got him onto several companies "priority list" should he need assistance in the future.

Trevor has now moved into a secure tenancy with SCC and his support worker helped him to apply for a local assistance grant and some furniture from a local charity. His Changing Futures personalisation budget has helped to pay for decorating materials and other charitable funds supported him to get a TV so his house is now becoming a home. Changing Futures have reconnected Trevor with his GP who following assessment suspects Trevor is suffering from Brain Atrophy (brain shrinking) due to sustained alcohol abuse. Trevor scored very low on a memory function test. Trevor is now undergoing further medial assessments, but we suspect that his neurological disabilities will mean he requires long term care to manage his finances and other areas of daily living. Changing Futures in-house Occupational Therapist has been working with Trevor including providing evidence towards his new benefit claim for Personal Independence Payments.

Trevor has been linked in with a Changing Futures Peer Support worker who is helping him engage in positive activities. Trevor enjoys playing the keyboard and his peer worker now takes him to a music group each week for adults with mental health needs. Changing Futures supported Trevor to get his bike repaired and safety checked by a charity so that he can use that to get around to appointments.

There are ongoing issues with his benefit claim and it is clear that without support from Changing Futures Trevor would not be able to cope with the complexity of the welfare system. Trevor, whist recognising that he has alcohol support needs, is not yet ready to access support. However, he is becoming more open to discussing it with his support worker and it is hoped that he will be ready to access support around his substance use shortly.

Report to Policy Committee

Author/Lead Officer of Report:
Jo Pass Assistant Director Ageing Well,
Die Green Service Manager Adaptations Housing and Health

Tel: 0114 266 4406

Report of:	Director of Adult Health and Social Care
Report to:	Adult Health and Social Care Committee
Date of Decision:	16th November 2022
Subject:	Adaptations Housing and Health Update and Delivery Plan

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	X	No	
If YES, what EIA reference number has it been given? *(1070)*				
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 outlines the demand position of the Adaptations, Health, and Housing services as they emerge from the covid pandemic. It will update the Committee as to the impact that has been made through the recovery plan agreed in August 2021. This report will then detail the measures proposed to continue the recovery and delivery plan for these services.

Recommendations:

It is recommended that Adult Health and Social Care Policy Committee:

- Note the Adult Health & Social Care Equipment and Adaptations performance update.
- Endorse the Equipment and Adaptations Delivery Plan at Appendix 2.
- Endorse the Adult Health & Social Care Equipment and Adaptation Financial Recovery Actions identified at section 3.2.12.
- Requests that the Director of Adult Health & Social Care provides the Committee with updates on progress and outcomes in relation to the performance and financial spend on a six monthly basis.

Background Papers:

None

Appendices

Appendix 1 – Overview of Occupational Therapy, Adaptations Housing and Health Services
Appendix 2 – Equipment and Adaptations Delivery Plan
Appendix 3 – Equalities Impact Assessment

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: Ann Hardy – Revenue Damian Watkinson – Capital (DFG)
		Legal: Patrick Chisholm *Service Manager*
		Equalities & Consultation: Ed Sexton – Equalities Lead
		Climate: Jessica Rick
	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 – Director Adult Health and Social Care.
3	**Committee Chair consulted:**	Councillor George Lindars-Hammond, 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: Jo Pass Die Green	**Job Title:** Interim Assistant Director Living and Aging Well Service (North) Service Manager - Adaptations, Housing and Health services.
Date: 10/10/2022	

1 PROPOSAL

1.1 The Adult Health and Social Care Strategy Living the Life You Want to Live and subsequent Delivery Plan agreed at Committee on 15th June 2022, made commitments towards improving lives and outcomes for Adults across the City and to set out we will deliver, personalised support which feels right and good from the point of view of people themselves and our communities.

1.2 Adaptations Housing and Health emerged from the covid pandemic with significant customer waiting lists. In August 2021, a recovery plan backed by an invest to save was implemented to reduce assessment times, reduce hospital stays and improve health and wellbeing of people accessing the service.

1.3 The report explains how new ways of working are impacting positively to change practices and notes new models under development, aligned to our wider adult social care strategy. This paper sets out a Delivery Plan and key milestones to deliver upon a commitment towards achieving an accessible, responsive and outcome focused equipment, adaptations service.

1.4 The Committee are asked to comment upon and approve the Adult Health and Social Care Equipment, Adaptations Delivery Plan and agree a schedule that they are updated upon progress against it.

2 BACKGROUND

2.1 Promoting and enabling independence is our wider vision and commitments for adult health and social care described in our strategy, Living the Life You Want to Live:

Everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are - and when they need it, they receive care and support that prioritises independence, choice, and recovery'.

2.2 The Adult Social Care Strategy made a commitment towards enabling individuals to live independently safe and well at home. As part of this Commitment, Adult Social Care made a priority this year towards reducing our waiting times and focusing on practice developments so that we can enable people to live the life they want to live.

2.3 A core service and support across Adult Social Care which enables and promotes independence is our Occupational Therapy and Adaptations, Housing and Health Teams. The team receive 5500 applications per year which is a 22% increase in demand since pre- pandemic application levels and a reflection of the essential and core needs across Sheffield. This is set against a standstill budget set at pre pandemic levels.

2.4 The Adaptations, Health & Housing service is an essential adult health and social care service who delivered critical services throughout the pandemic to people needing equipment, adaptations or to move home. More information about the service and supports provided can be found at Appendix 1.

2.5 In line with the vision and our commitments made and our statutory duties, a self-assessment was undertaken in 2021 using *ADASS Towards Excellence in Social Care*, a review of our performance, review of ways of working to identify our current position, areas of strength, development, and opportunities to improve the lives and outcomes of people of Sheffield by promoting independence.

2.6 Following on from this, an *Adaptations, Housing and Health Delivery Plan* was developed to coordinate our activities as a Council to promote independence of people in need of care and support across Sheffield. It's been developed in partnership with colleagues in NHS and Housing to support a partnership approach to implementation. The Delivery Plan can be found at Appendix 2.

3 OUR PERFORMANCE, RECOVERY AND DELIVERY PLAN

3.1 Equipment and Adaptations Service

3.1.1 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.

3.1.2 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.

3.1.3 The Royal College Occupational Therapists that Occupational Therapy outcomes for people are maximised by early intervention within 6 weeks of people identifying an issue. Our ambition is to create a service for the people of Sheffield where they can access the assessment and equipment, they require within 6 weeks.

3.1.4 We believe that achieving this target will not only delivery better outcomes for people, but we will see a reduction in prescribing expensive adaptations. For example, being able to prescribe a bath board rather than a level access shower major equipment and adaptations. When Health and Housing can award medical priorities early enough, we can rehouse

people where major adaptations are not needed and their independence is maintained.

3.1.5 We are ambitious in the development of the equipment and adaptations service moving forward – recognising the enormous contribution it can make to supporting people to live as independently as possible for longer and to deliver upon our Adult Social Care strategy.

3.1.6 In line with the Council financial recovery programme, it was recognised that our challenge is to deliver an excellent service, improve outcomes and our performance but within the financial envelope available to Adult Social Care. In response, a recovery programme was implemented in 2021 and progress is detailed next.

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

3.1.8 At the same time, the focus on early help and prevention means in practice that 17% of people referred need adaptations or equipment. Before the pandemic this was 11% but the effects of the pandemic has increased this need by 6%. The early help offer includes the team providing a range of information and advice and early enablement support and practical solutions.

3.1.9 The increase in need is reflective of a 22% increase in demand since pre pandemic levels with the team receiving pre covid on average 4100 applications per year (342 per month). At 2022, the service is now seeing annual applications of 5474 (456 per month).

3.1.10 However, the funding envelope has not increased commensurate to demand, inflationary costs, and cost of living costs due to a standstill budget being implemented. This means that new models and ways of working are needed which enables the service to deliver a high performing service, respond to increased demand but within financial resource available.

3.1.11 At October 2022, the service is making good progress towards achieving a target that individuals are seen within 6 weeks and clearing our waiting list by:

- Reducing the earliest date people are waiting for an OT assessment from 18 months to 6 months.
- Reducing the backlogs of people waiting for an assessment by 27%, so its now at 2092.
- Implementing use of additional agency support with clear milestones to escalate pace of reducing backlogs, with a target set that the waiting list will be down to 400 by June 2023 alongside

implementing a new operating model to achieve long term sustainability of approach to new referrals.

- Introducing a duty system from November 2022 where an Occupational Therapist will triage 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 are responded to quickly. This then releases Occupational Therapists to focus on more complex assessments.
- Benchmarking with other areas to learn from good practice and inform continuous improvement.

3.1.12 To develop an accessible, sustainable, and high performing equipment and adaptations service and reach our ambition of completing assessments within 6 weeks in the long term, practical operational actions are underway as follows:

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

3.2 Disabled Facilities Grant Provision

3.2.1 The Service also 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.

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

3.2.3 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.

3.2.4 In January 2020 changes to the private sector housing policy were agreed to enable critical Accelerated Adaptations, like stairlifts, hoists, and level access showers to be delivered without means testing up to £10K for a disabled person or child.

3.2.5 This local policy was agreed to supplement the DFG legislation governed by the Housing Grants, Construction and Regeneration Act 1996 and included a local policy decision to increase the mandatory DFG grant for major adaptations of £30,000 by an additional £20,000 at the discretion of the Director of Adult Health and Social Care.

3.2.6 However, the Director has been required to use the additional discretion to award funds significantly in excess of this which has contributed to an emerging pressure on the DFG budget. Lead Members are aware of the particular nature of the discretion.

3.2.7 This policy change was to streamline the DFG process, which DFG team were not able to deliver through the Covid pandemic, and to enable adaptations recommended by Occupational Therapists to be delivered to people who had already waited up to 18 months for necessities of life, like a wash, or being able to get safely in and out of their home.

3.2.8 In accordance, with the government guidance during the covid pandemic the DFG team were only able to deliver critical need adaptations to children and adults. This subsequently resulted in both a waiting list and a DFG underspend. The DFG underspend was 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.

3.2.9 Through the recovery work noted above undertaken by Occupational Therapists in the Equipment and Adaptations Team, to address the waiting list, over 2500 people have been assessed since April 22. Addressing the waiting list as well as responding to the 22% increased demand noted above and the subsequent increase in provision of equipment and adaptations has in turn generated additional financial pressure on the DFG grant.

3.2.10 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 and this is placing pressure on the mandatory statutory DFG spend. This limits the funding available to meet the demand for level access showers and extensions for people needing that major adaptation living in owner occupied and private rented households.

3.2.11 As the waiting list recovery plan gains momentum, more equipment and adaptations are likely to be recommended to the DFG team. Due to this, its likely that between addressing the waiting list, responding to increased demand and complexity there is a risk of an overspend on the Grant.

3.2.12 To respond to the financial pressure, a financial recovery plan is included as part of the Equipment and Adaptations Delivery Plan to enable fair and equitable provision of equipment and adaptations across all tenures but within current resources available. The Financial Recovery Plan includes introduction of an:

- Eligibility Criteria for equipment and adaptations which will be brought to Committee in December 2022. The Criteria will set out proposals for what will be funded, timescale for when equipment and adaptations are provided, information on funding streams and alternative provision so that we are managing our finite resources in a fair, equitable and transparent way.
- Means test for major adaptations for consideration by Committee in December 2022 to offset costs associated with rising demand.
- Scrutiny function in relation to use of the mandatory DFG grant for major adaptations and approval of any high value decisions over £50k.
- Review of DFG spend other than use of adaptations. This review seek approval for future allocation of and use of current funding for consideration by Committee in February 2022.

3.2.13 The service works in close partnership with colleagues across social care, housing, voluntary sector, health to deliver the most efficient service to the citizens of Sheffield.

3.2.14 The developments described within this paper support a positive staff culture – to quote staff from the Equipment, Health, and 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.

4. HOW DOES THIS DECISION CONTRIBUTE?

4.1 This proposal meets the Commitments 1 and 2, ASC outcome/s that are set out in the ASC Care Governance 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.

4.2 This proposal 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 Sheffield: One Year Plan –* under the priority for Education Health and Care, Enabling adults to live the life that they want to live
- *Conversations Count*[10]: our approach to adult social care, which focuses on listening to people, their strengths, and independence.
- *Our new ASC Operating Model* - this aligns to that new arrangement by reimaging a living and ageing well service.
- *Team around the Person*[11]: where professionals work together to find the best solutions when someone's needs have changed, or a situation escalated.
- *ACP 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.

5. HAS THERE BEEN ANY CONSULTATION?

5.1 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.

5.2 To enable this, the governance structures will include the voices of those receiving care, carers, partners, and care providers so that we ensure we deliver what matters to people of Sheffield. This includes co-developing a mechanism (e.g., Citizens Board) so that people with lived experience are equal partners.

5.3 An overall approach to coproduction and involvement is also a key element of the delivery plan, ensuring that the voice of citizens is integrated into all major developments ahead. A dedicated item on this is proposed as part of the Committee's forward plan

6. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

6.1 Equality Implications

6.1.1 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.

6.1.2 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.

6.2 Financial and Commercial Implications

6.2.1 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.

6.2.2 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.

6.2.3 The current outturn position is that SCC is forecast to be £197k overspent at Month 6 which means the SY ICB contribution is forecast to be £394k overspent bringing the total overspend to in the region of £591k against the budget of £3.72m.

6.2.4 High value equipment over £500k is capitalised to the Disabled Facilities Grant and that cost this year is currently forecast to be circa £1m. In addition up to £400k of costs relating to Citywide Telecare Alarm installations and equipment are also capitalised.

6.2.5 The DFG funding available for 2022/23 is £8.7m which is made up of £5.1m allocation for this financial year and a reserve unspent from prior years of £3.6m.

6.2.6 The current forecast commitments against this capital funding will expend the whole grant within 2022/23. Therefore, in future years there will only be the allocation received available to spend as all reserves will have been exhausted. The allocation is expected to remain at the level of 2022/23 £5.1m.

6.2.7 To stabilise the backlog of Accelerated Adaptations Grants, the current forecast expenditure for 2023/24 would be overcommitted by £2m (estimate). To reduce the backlog of all smaller adaptations the budget would be overcommitted by £4m (estimate) based on current operating model and criteria.

6.2.8 The above information only reflects the activity required on Accelerated Adaptations Grants capital works. There are approx. 50 people waiting for high value extensions to be assessed for DFG funding. The value of these works is unknown and still requires scoping but clearly would put further pressure on the DFG, estimated maximum costs at £2.5M

6.3 Legal Implications

6.3.1 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.

6.3.2 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.

6.3.3 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.

6.3.4 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.'

6.4 Climate Implications

6.4.1 The review of DFG spend 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.

6.5 Other Implications

6.5.1 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.

6.5.2 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.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 The alternative options considered were:

7.2 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.

8. REASONS FOR RECOMMENDATIONS

8.1 An approved delivery plan gives a structured approach to the promotion of independent living through equipment and adaptations 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 will do this.

8.2 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.

Appendix 1 – **The Adaptations, Housing and Health Services.**

1 Introduction

The Adaptations Housing and Health services are 3 separate services which were brought together through an MER in 2009: the Equipment and Adaptations team, the Disabled Facilities Grants team, and the Health and Housing service.

Their common purpose is to enable people to live as independently as possible in their own homes and to identify and deliver what support is needed to ensure people can continue to do so, either by providing equipment or adaptations, or by enabling people to move to a home more suited to their situation.

2 The Equipment and Adaptations Team

The Equipment and Adaptations Team consists of Occupational Therapists (OT) and Occupational Therapy Assistants who visit people and complete functional Occupational Therapy assessment to identify and recommend support people need with the tasks of daily living. The team support people of all ages including children

This includes providing information and advice, support and equipment like grab and stair rails, bath boards, stairlifts, hoists or ramps enable people to remain independent safe and well in their own homes.

OTs also recommend more major adaptations like 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.

Equipment and Adaptations are tenure neutral; we help people if they own their own homes, are staying with someone or rent from the council or a registered provider (housing association).

3 The Disabled Facilities Grants Team

The Disabled Facilities Grants Team administers and delivers the Disabled Facilities Grant.

The Disabled Facilities Grant is provided from central government which 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.

The Disabled Facilities Grant delivery is governed by legislation in the Private Sector Housing policy, the Housing Grants, Construction, and regeneration act 1996. Disabled Facilities Grants Delivery: Guidance for local authorities in England (2022) and the private sector housing policy.

The Council Housing Asset Management Service deliver adaptations to council tenants as adaptations to council tenants is not in scope of the Disabled Facilities Grant.

4 The Health and Housing Team

The Health and Housing Team consists of 5 assessment officers who assess award and manage medical priorities for rehousing in accordance with Sheffield City Council Allocations policy.

The Health and Housing Team receive over 2000 applications a year and support rehousing for up to 400 people a year including a significant number of people where Equipment and Adaptations cannot adapt the property as it's not possible, or feasible, or its not reasonable or practical to adapt.

Health and Housing is tenure neutral; we help people if they own their own homes, are staying with someone or rent from the council or a registered provider (housing association) and with people of all ages including children.

The Team works in partnership with Sheffield Teaching Hospital and Sheffield City Council Social Work teams, Home First and Housing to ensure people are discharged as quickly as possible from hospital to new homes, when their current home is no longer suitable for their emerging health issues.

Adult Health and Social Care

Equipment and Adaptations Delivery Plan 2022/24

Adult Health and Social Care: Equipment and Adaptations Delivery Plan 2022 - 2024

Our Vision and Ambitions for people of Sheffield

Our vision is that 'everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are - and when they need it, they receive care and support that prioritises independence, choice, and recovery.

The vision is centred around delivery of five outcomes and six commitments. The commitments and outcomes are the guiding principles we will follow and how we deliver the strategy. They show how we'll achieve our outcomes and highlight what we want to do better. These commitments are:

1. Support people to live a fulfilling life at home, connected to the community and resources around them, and provide care and support where needed.
2. Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis
3. Provide care and support with accommodation where this is needed in a safe and supportive environment that can be called home.
4. Make sure support is led by 'what matters to you', with helpful information and easier to understand steps.
5. Recognise and value unpaid carers and the social care workforce, and the contribution they make to our city.
6. Make sure there is a good choice of affordable care and support available, with a focus on people's experiences and improving quality.

Our Commitment to Independent Living through Equipment and Adaptations

The Equipment and Adaptations service is a core service supporting across Adult Health and Social Care and children's services which promotes independence through holistic Occupational Therapy interventions offering advice, guidance, practical solutions and sometimes the prescribing of Equipment or Adaptations tailored to a disabled persons needs to enable them to maintain dignity and independence and reduce the need for long term care and support services. Our aim is to improve outcomes of Adults and Carers across Sheffield.

To that end its our ambition that Adults in need of Care and Support can live safely and well, in a place they call home.

The Delivery Plan is structured to deliver on the outcomes needed for Adaptations Housing and Health services to recover their position post covid and transition to agreed performance outcomes which will ensure timely service delivery to people, partners and other services who all rely on the service provision being available. The delivery plan outlines the associated development areas, and opportunities for improvement aligned to them.

This Delivery Plan aims to support the ambitions and governance roles of the Committee by setting out clear: -

- ✓ Performance and governance milestones so people and Carers experience timely and effective support from Adaptations Housing and Health to achieves their outcomes.

- ✓ Involvement milestones so that Adults, Children and Carers feel involved in planning and development of services aimed to promote independent living
- ✓ Delivery milestones which promote multi-agency approaches towards independent living and achievement of personalised outcomes.

What is Independent Living?

There are a series of guides to the Care Act 2014 that have been developed by the College of Occupational Therapists and funded by Dept of Health the link is here Adass

Care Act 2014 Guidance for Occupational Therapists

There are a series of guides to the Care Act 2014 that have been developed by the College of Occupational Therapists, funded by the Department of Health and endorsed by ADASS. They aim to assist occupational therapy practitioners, to understand and deliver some of the key concepts and duties within the Act. They may also be useful to commissioners and others within the health and social care workforce.

The topics currently covered within the series are:

- Wellbeing
- Prevention
- Disabled Facilities Grant
- Transitions; custodial settings; employment; education and training.

Within each topic, the guides look at the selected areas which potentially have the most implications for the work of occupational therapists. The Care Act 2014 ensures that the focus of the individual and their needs, and their chosen goals or outcomes. Its underpinning precept is that 'the core purpose of adult care and support is to help people achieve the outcomes that matter to them in their life' (DH 2016, section 1.1).

The Act gives adults and their carers a legal entitlement to care and support to meet their eligible needs, recognising that these are different and personal to each individual. Local authorities must consider how to meet each person's specific needs. This requirement is reinforced by a number of principles which must also be incorporated into the care and support activities that are carried out by the local authority. implementation of the Act will require a significant change in practice for many involved in health and social care services, including occupational therapists.

Much of the work Occupational Therapists undertake can be viewed prevention – preventing, reducing and delaying needs. The following example illustrates how Occupational Therapists support in meeting the components of eligibility described within the 2014 Care Act in a way that promotes independence and delivers the best financial value.

If customers have needs caused by physical or mental impairment or illness, the local authority must consider whether the effect of the adult's needs is that they are unable to achieve two or more of the following specified outcomes:

a) Managing and maintaining nutrition Local authorities should consider whether the adult has access to food and drink to maintain nutrition, and that the adult is able to prepare and consume the food and drink. *OT can support with specialised equipment or advise as to where to purchase specialised equipment. We can advise about shopping, make suggestions re organising a kitchen or even adapting a kitchen or providing equipment to make food preparation and consumption easier*

b) Maintaining personal hygiene Local authorities should, for example, consider the adult's ability to wash themselves and launder their clothes. *Level access showers, bathing equipment, wash and dry toilets advice re small equipment such as flannel straps or long handled equipment.*

c) Managing toilet needs Local authorities should consider the adult's ability to access and use a toilet and manage their toilet needs. OT's can assess and provide *Equipment such as raised toilet seats, WC frames, wash and dry toilets advise.*

d) Being appropriately clothed Local authorities should consider the adult's ability to dress themselves and to be appropriately dressed, for instance in relation to the weather to maintain their health. *Advise re clothing and equipment to assist*

e) Being able to make use of the adult's home safely Local authorities should consider the adult's ability to move around the home safely, which could for example include getting up steps, using kitchen facilities or accessing the bathroom. This should also include the immediate environment around the home such as access to the property, for example steps leading up to the home. *Adaptations to the property, stair lifts, grab rails etc*

f) Maintaining a habitable home environment Local authorities should consider whether the condition of the adult's home is sufficiently clean and maintained to be safe. A habitable home is safe and has essential amenities. An adult may require support to sustain their occupancy of the home and to maintain amenities, such as water, electricity and gas. *Advice re: equipment to help for example: long handled dustpan and brushes.*

g) Developing and maintaining family or other personal relationships Local authorities should consider whether the adult is lonely or isolated, either because their needs prevent them from maintaining the personal relationships they have or because their needs prevent them from developing new relationships. *Referring for walking aids or wheelchairs and advice re community resources such as Community transport etc.*

h) Accessing and engaging in work, training, education or volunteering Local authorities should consider whether the adult has an opportunity to apply themselves and contribute to society through work, training, education or volunteering, subject to their own wishes in this regard. This includes the physical access to any facility and support with the participation in the relevant activity. *Referring to access to work, walking for work*

i) Making use of necessary facilities or services in the local community including public transport and recreational facilities or services Local authorities should consider the adult's ability to get around in the community safely and consider their ability to use such facilities as public transport, shops or recreational facilities when considering the impact on their wellbeing. Local authorities do not have responsibility for the provision of NHS. *Advice re local resources , community transport, advice re shopping, refer for walking aids (NHS)*

The above examples are illustrative and not a definitive list.

What Does Good Look Like?

We have started this delivery plan by setting out some initial indicators of what we think good looks like and to improve individuals and carers outcomes and experiences of the Adaptations Housing and Health services. The plan is to continue to develop these indicators in partnership with the people we support, carers and partners as we develop and embed our approach to Occupational Therapy in the city.

Leadership & Governance

- ✓ Strategic leaders work together, and evidence joined up visible and effective leadership around a shared vision and plan
- ✓ Staff, Adults, Children, Carers and Partners are and feel confident about the support, leadership and plans in place.
- ✓ Continuous improvement, quality assurance, policies and audit processes and delivery on improvements identified are embedded and evidenced throughout all levels of the service and publicly available.
- ✓ There are periodical self-evaluations, effective multi-agency audits and thematic reviews to determine areas for improvement and then delivery of the improvements identified.

Confident Practice

- ✓ All staff are appropriately trained and qualified in Occupational Therapy. They are supported through managers RCOT and local OT forums to deliver innovative and excellent outcomes with people.
- ✓ Our approach to the management delivery of Equipment and Adaptations is collaborative and inclusive, we are not a “one size fits all” service and utilise the “OT Big Brain “to deliver what people need.
- ✓ Our assessments are clearly evidenced and recorded and shared with people; we utilise the best in technology to empower people to self-assess and engage fully we use best practice from our professional with service delivery.
- ✓ We utilise best practice guidelines from OT professional forums to inform our best offer for people

Quality & Outcomes

- ✓ People are kept informed about their application all the way through.
- ✓ People are consulted on the criteria, timescale and funding for equipment and Adaptations.
- ✓ We listen to people and improve service delivery as a result and feedback the changes to people.
- ✓ We aim to assess people within 6 weeks of the application being made, or 5 days for critical needs
- ✓ Benchmarking with other areas to learn from good practice and inform continuous improvement

Providing Enablement

- ✓ We have daily, accurate screening of all applications to Equipment and Adaptations by managers.
- ✓ We have duty Occupational Therapists triaging all applications daily 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 are responded to quickly, releasing occupational therapists to focus on more complex assessments.
- ✓ We develop specialist Occupational Therapists in our teams working ith people with dementia, transitioning young people from Children’s to adult services, care handling specialist OT's : the knowledge of the specialist workers supports better outcomes for people and a tailored response to requests from individuals and carers

- ✓ People have appropriate advice and support at the right time, including exploration of digital self-assessment tools and video calls to enable lower risk equipment and adaptations to be assessed and delivered quickly

Equipment and Adaptations Delivery Plan

Ambition: Adults in Need of Equipment and Adaptations to be able to live safely in their chosen home

Context: The Royal college of Occupational Therapists state that occupational therapy outcomes for people are maximised b early intervention within 6 weeks of people identifying an issue. Our ambition for Equipment and Adaptations is to create a service for the people of Sheffield where they can access the assessment and equipment they require within 6 weeks.

We believe that achieving this target will not only deliver better outcomes for people, but we will see a reduction in prescribing expensive adaptations. For example being able to prescribe a bath board rather than a level access shower.

Accountable Officer: Director Adult Health and Social Care	**Accountable Committee/ Board:** Adult Health and Social Care Policy Committee

Performance picture	**Baseline**	**Current**	**Target**	**Direction of travel**	**RAG**
Number of people being assessed within 6 weeks of applying to Equipment and Adaptations.	342 people assessed monthly (Q1 21/22)	Currently 456 people assessed monthly	(Y & H Q1 22/23 average)		
Satisfaction with Equipment and Adaptations process	76.7% (Q1 22/23)	As baseline	(Y & H Q1 22/23 average)		
Accessibility of Services: Equipment and Adaptations waiting lists - time waiting for an assessment	8 months (Q1 22/23)	6 months (Oct 22)	6 Weeks (May 23)		
Accessibility of Services: Equipment and Adaptations waiting lists	2900 (July 21)	2029 (Oct 22)	400 (May 23)		

Theme	**Milestone/action**	**By when**	**Lead**	**RAG**
Leadership and	Establish routine performance and risk reporting to Policy Committee, Performance & Delivery Board, Performance Clinics including	October 2022	AD Living and Ageing well South / Service	Green

Governance	Benchmarking with other authorities and improvement activities and recommendations in response to learning.		Manager Adaptations Housing and Health	
	Commission a thematic and benchmarking audit of Equipment and Adaptations to establish areas for learning and improvement.	January 2023	Service Manager Adaptations Housing and Health	Green
	Review current Equipment and Adaptations Referral process to ensure in line with benchmark and best practice and take learning and recommendations to the Performance and Delivery Board.	December 2022	Service Manager Adaptations Housing and Health	Green
	Recruit to the Principal Occupational Therapist to build dedicated capacity to deliver on the Adult Health and Social Care Equipment and Adaptations Delivery Plan, benchmarking with other authorities and coordination of strategic Occupational Therapy performance and improvement activity across the service.	March 2023	AD Living and Ageing well South / Service Manager Adaptations Housing and Health	Green
	Implement regular communications and updates about Equipment and Adaptations activities and practice updates.	December 2022	AD Living and Ageing well South / Service Manager Adaptations Housing and Health	Green
	Implement learning and development for Strategic Leaders, Members and Senior Leaders to enable joined up and visible approaches to Occupational Therapy services across Sheffield.	June 2023	AD Living and Ageing well South / Service Manager /Principal Occupational Therapist Adaptations Housing and Health	Green
Outcomes and Experiences	Further support Citizens Involvement to support and enable co-production and engagement with people who use our services and their families and carers.	March 2023	Service Manager Adaptations Housing and Health	Green
	Equipment and Adaptations Waiting list reduced to acceptable risk levels (ie 6 weeks)	May 2023	Service Manager Adaptations Housing and Health	Green

	Equipment and Adaptations Critical needs Waiting Lists reduced to acceptable risk levels (i.e. 5 working days)	May 2023	Service Manager Adaptations Housing and Health	Green
	Support the Disabled Facilities grant provision to deliver major adaptations within the statutory and discretionary funding envelope (i.e., £30K mandatory grant and £20k discretionary grant)	ongoing	AD Living and Ageing well South / Service Manager Adaptations Housing and Health	green
	Support the Disabled Facilities Grants team to manage people's expectations who have been assessed as needing Adaptations, but are waiting a significant time for them to be delivered due to funding pressure on the DFG	ongoing	AD Living and Ageing well South / Service Manager Adaptations Housing and Health / Capital and Revenue Finance colleagues	RED

Risks

- *An increase in demand prevents waiting list being reduced*
- *Ongoing response the pandemic and winter pressures reduces focus on prevention across social care.*

Other issues

- Ongoing challenge in recruiting to Occupational Therapists reduces impact on addressing waiting lists.

Equality Impact Assessment

Introductory Information

Budget/Project name Equipment and Adaptations

Proposal type
- ☐ Budget
- ☐ Project

Reference number 1070

Decision Type
- ☐ Cooperative Executive
- ☐ Leader
- ☐ Individual Cooperative Committee Member
- ☐ Executive Director/Director
- ☐ Officer Decision (Non-Key)
- ☐ Council (e.g. Budget and Housing Revenue Account)
- ☐ Regulatory Committee (e.g. Licensing Committee)
- ☐ Local Area Committee

Lead Cooperative Executive Member George Lindars-Hammond, Angela Argenzio, Steve Ayris

Entered on Q Tier
☐ Yes ☐ No

Year(s)

☐ 18/19	☐ 19/20	☐ 20/21	☐ 21/22	☐ 22/23	☐ 23/24	☐ 24/25	☐ 25/26

EIA date 2 November 2022

EIA Lead

- ☐ Adele Robinson
- ☐ Annemarie Johnston
- ☐ Bashir Khan
- ☐ Bev Law
- ☐ Ed Sexton
- ☐ Louise Nunn
- ☐ Richard Bartlett
- ☐ Rosie May

Person filling in this EIA form Die Green

Lead officer Alexis Chappell

Lead Corporate Plan priority

☐ An In-Touch Organisation	☐ Strong Economy	☐ Thriving Neighbourhoods and Communities	☐ Better Health and Wellbeing	☐ Tackling Inequalities

Portfolio, Service and Team

Cross-Portfolio

☐ Yes ☐ No

Portfolio

People

Is the EIA joint with another organisation (eg NHS)?

☐ Yes ☐ No

Brief aim(s) of the proposal and the outcome(s) you want to achieve

EIA updated Oct 2022

This proposal is included in Business Planning 2022-23.

Through the investment in a team of temporary additional staff, a backlog of people waiting for an assessment by the Equipment & Adaptations service will be addressed and cleared during 2022-23 and normal Pre-Covid levels referral demand will then be managed within expected timescales.

As a result of these assessments, as well as providing timely assistance to support people's continued independence at home, savings are expected to be achieved. This will potentially be possible by reductions in the cost of some care packages, either through avoiding the need for new packages or reducing the cost of existing ones where people are waiting for an assessment.

Impact

Under the Public Sector Equality Duty we have to pay due regard to the need to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relations

More information is available on the Council website including the Community Knowledge Profiles.

Note the EIA should describe impact before any action/mitigation. If there are both negatives and positives, please outline these – positives will be part of any mitigation. The action plan should detail any mitigation.

Overview

Briefly describe how the proposal helps to meet the Public Sector Duty outlined above

The proposal supports the Duty, specifically advancing equality of opportunity of older people and disabled people to continue to live independently at home. This has associated benefits, including around health and wellbeing, mental health and social and financial inclusion.

Impacts

Proposal has an impact on

□ Health	□ Transgender
□ Age	□ Carers
□ Disability	□ Voluntary/Community & Faith Sectors
□ Pregnancy/Maternity	□ Cohesion
□ Race	□ Partners
□ Religion/Belief	□ Poverty & Financial Inclusion
□ Sex	□ Armed Forces
□ Sexual Orientation	□ Other

Give details in sections below.

Health

Does the Proposal have a significant impact on health and well-being (including effects on the wider determinants of health)?

□ Yes □ No *if Yes, complete section below*

Staff
□ Yes □ No

Impact
□ Positive □ Neutral □ Negative

Level
□ None □ Low □ Medium □ High

Details of impact

Customers
□ Yes □ No

Impact
□ Positive □ Neutral □ Negative

Level
□ None □ Low □ Medium □ High

Details of impact

The proposal is expected to benefit around 2000 customers in the E&A backlog and the monthly throughput of 500+ people being assessed, (which, in context, compares to around 7,500 total AHSC customers as of January 2022). It therefore represents a significant proportion of all AHSC clients. There are clear health benefits to people being able to maintain independence at home in comparison to hospital or other care/health settings, which may include:

- self-esteem and personal decision-making;
- mental health;
- physical health and activity;
- healthy lifestyle and diet;
- physical space and outdoor space;
- enhanced social interaction and community access;
- increased contact with, and care from, family.

Living at home reduces risks of infections and other poor health outcomes associated with communal environments shared with unwell people.

Comprehensive Health Impact Assessment being completed

☐ Yes ☐ No

Please attach health impact assessment as a supporting document below.

Public Health Leads has signed off the health impact(s) of this EIA

☐ Yes ☐ No

Health Lead

Age

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

The proposal will potentially benefit a significant number of older people. As a proxy, in Oct 2022, 59% of all AHSC clients were aged 65 and above and 47% were aged 75 and above.

Benefits may include health, wellbeing, lifestyle, environment and inclusion.

Disability

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

The proposal will potentially benefit a significant number of disabled people. By nature of the fact that everyone who will benefit has health and social care support needs, the vast majority of people would be classed as sharing the protected characteristic of disability. This applies to beneficiaries of all ages. However, disabled people of working age (under 65) represented 41% of all AHSC clients in Oct 2022.

Benefits may include health, wellbeing, lifestyle, environment and inclusion.

Pregnancy/Maternity

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Race

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

White British people are likely to be significantly overrepresented in the beneficiaries of the proposal, making up 81% of all AHSC clients where ethnicity is known in Oct 2022

Religion/Belief

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Sex

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Sexual Orientation

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact
There is no evidence of any disproportionate impact.

Transgender

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

There is no evidence of any disproportionate impact.

Carers

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Unpaid carers will derive some health and wellbeing benefit from family members / cared-for people receiving equipment and/or adaptations to help them maintain or increase independence at home. It is likely to reduce aspects of the caring role no longer required, as well as reducing anxiety.

Voluntary/Community & Faith Sectors

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Cohesion

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Partners

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

The proposal will help people to live independently at home, reducing the risk of / need for hospital admissions, and potentially supporting hospital discharge. Potential or actual NHS patients will therefore benefit, with consequential positive impacts on other patients/people/services/capacity. There may be other direct or indirect benefits for housing tenants or people accessing other services/provision.

Poverty & Financial Inclusion

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

The proposal will potentially financially benefit people who may otherwise have needed to spend their own resources to purchase equipment or adaptations themselves, if they were able to. It may also save household expenditure in other ways – e.g. adaptations may reduce energy bills.

There are no financial implications for critical provision – hoists, stairlifts, ramps. Means-testing for non-critical provision (extension and level access showers) will continue as now.

Armed Forces

Staff
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Customers
☐ Yes ☐ No

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact
There is no evidence of any disproportionate impact.

Other

Staff
☐ Yes ☐ No *Please specify*

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact
The recovery plan increases capacity, helping to relive pressure on staff, through:
- new officer roles in Disabled Facilities Grant and Asset Management teams
- increased technical support with adaptations (quantity surveyor, architect) and new contracts 20 or so adaptations

Customers
☐ Yes ☐ No *Please specify*

Impact
☐ Positive ☐ Neutral ☐ Negative

Level
☐ None ☐ Low ☐ Medium ☐ High

Details of impact

Cumulative Impact

Proposal has a cumulative impact

☐ Yes ☐ No

☐ Year on Year	☐ Across a Community of Identity/Interest
☐ Geographical Area	☐ Other

If yes, details of impact

Proposal has geographical impact across Sheffield

☐ Yes ☐ No

If Yes, details of geographical impact across Sheffield

Local Partnership Area(s) impacted

☐ All ☐ Specific

If Specific, name of Local Partnership Area(s) impacted

Action Plan and Supporting Evidence

Action Plan

Supporting Evidence (Please detail all your evidence used to support the EIA)

Consultation

Consultation required

☐ Yes ☐ No

If consultation is not required please state why

The proposal is invest-to-save, providing support for people in need to maintain independence.

Are Staff who may be affected by these proposals aware of them

☐ Yes ☐ No

Are Customers who may be affected by these proposals aware of them

☐ Yes ☐ No

If you have said no to either please say why

Summary of overall impact

Summary of overall impact

Summary of evidence

Changes made as a result of the EIA

Escalation plan

Is there a high impact in any area?

☐ Yes ☐ No

Overall risk rating after any mitigations have been put in place

☐ High ☐ Medium ☐ Low ☐ None

Sign Off

EIAs must be agreed and signed off by an Equality lead Officer. Has this been signed off?

○ Yes ○ No

Date agreed 03/11/2022

Name of EIA lead officer Ed Sexton

Review Date 10/04/2023

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Report to Policy Committee

Author/Lead Officer of Report: Jon Brenner, Principal Programme Manager

Report of:	*Director of Adult Health & Social Care*
Report to:	*Adult Health & Social Care Policy Committee*
Date of Decision:	*16th November 2022*
Subject:	*Future Design of Adult Social Care*

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	✓	No	
If YES, what EIA reference number has it been given? *Covered by EIAs 1148 and 1281*				
Has appropriate consultation taken place?	Yes	✓	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	✓
Climate Impact Assessments are being completed for individual parts of the new operating model, allowing more detailed assessment of the impacts.				
Does the report contain confidential or exempt information?	Yes		No	✓
If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-				

Purpose of Report:

To provide the Committee with further information on plans to deliver the Adult Health & Social Care Strategy 'Living the Life you Want to Live" through a new operating model and design for adult social care in Sheffield.

Recommendations:

It is recommended that the Adult Social Care Policy Committee:

1. Approve the future direction of adult social care operating model, and confirm it aligns with the Committee's strategic direction.

2. Agree that the Director of Adult Health and Social Care brings a six-monthly report noting update and progress made with implementation of the model to Committee.

Background Papers:

Joint Health & Wellbeing Strategy 2019-2024
Adult Health & Social Care Strategy 2022-30, Living the life you want to live
Adult Health & Social Care Strategy Delivery Plan
Our Sheffield Delivery Plan 2022-23
Adult Social Care Budget Programme 2023/2024
Adult Social Care Market Shaping Statement 2022
Adult Social Care Benchmarking Data September 2022
Achieving Change 555a & 555b – Restructuring Social Work Teams

<table>
<tr><th colspan="3">Lead Officer to complete:-</th></tr>
<tr><td rowspan="4">1</td><td rowspan="4">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.</td><td>Finance: Ann Hardy</td></tr>
<tr><td>Legal: Patrick Chisholm</td></tr>
<tr><td>Equalities & Consultation: Ed Sexton</td></tr>
<tr><td>Climate: Jessica Rick</td></tr>
<tr><td></td><td colspan="2">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>SLB member who approved submission:</td><td>Alexis Chappell, Director of Adult Health & Social Care</td></tr>
<tr><td>3</td><td>Committee Chair consulted:</td><td>Cllr George Lindars-Hammond; Cllr Steve Ayris, Cllr Angela Argenzio</td></tr>
<tr><td rowspan="3">4</td><td colspan="2">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.</td></tr>
<tr><td>Lead Officer Name:
Jon Brenner</td><td>Job Title:
Principal Programme Manager</td></tr>
<tr><td colspan="2">Date: 28th October 2022</td></tr>
</table>

1. PROPOSAL

1.1 Strategic Direction

1.1.1 In March 2022 Sheffield City Council approved a new Adult Health & Social Care Strategy 'Living the life you want to live'. It sets out the ambitions for adult social care this decade, supporting the city's Health & Wellbeing Strategy.

1.1.2 It was followed by the Adult Health & Social Care Strategy Delivery Plan, which was approved by this Policy Committee at its inaugural meeting in June 2022.

1.1.3 The strategy and delivery plan set out the direction to improve how we deliver our statutory duties, set out the Care Act 2014 and associated legislation. The ethos of this legislation is to improve individual outcomes through maximising independence and control, and reducing need – which aligns closely with our strategic intentions.

1.2 What Is the Problem We're Trying To Solve?

1.2.1 Adult Social Care is facing unprecedented challenges. These include increasing demographic pressures, workforce pressures from the cost of living, ever increasing financial challenges and new legislation.

1.2.2 In Sheffield we have incredible staff, partners and providers doing amazing work. However, we know that this is not enough on its own. There needs to be a coherent system to work within, one that works effectively around the needs of the individuals we support, their family members and carers and our communities.

1.2.3 We know this because:

- the feedback from people we support, and their carers shows that there is significant room to improve. This aligns with our benchmarking data, performance data and review of LGA inform data that tells us our satisfaction levels and outcomes have been low;
- feedback from our workforce is that we need to do better, many suggestions received on how we improve our overall adult social care system and offer to our workforce;
- demand for adult social care continues to rise above comparator authorities, meaning it is significantly harder for us to create a sustainable performance, quality and financial model for adult social care;
- our strategic review highlights that the advent of national reforms for adult social care will generate further demand and complexity which we have to prepare for.
- our self-assessments have indicated significant areas of performance and compliance that we need to improve upon.

1.3 What Are We Doing About This? – A New Design for Adult Social Care.

1.3.1 To enable and support a way forward a self-assessment was carried out in 2021 alongside significant engagement to develop an Adult Social Care Strategy, Adult Social Care Delivery Plan, and a Care Governance Strategy, all of which have been approved by Committee.

1.3.2 These provided a strategic mandate to take forward a change programme focused around addressing these areas of areas of improvement and take us on the journey towards an effective and sustainable social care system, which delivers supports and services which matter and feel good from the point of view of individuals and communities themselves.

1.3.3 Part of the strategic mandate was to deliver a model for Adult Social Care, which would enable us to deliver upon our vision and commitments made in the Strategy, strengthen our collaboration with partners and contribute towards the Council's and wider partnerships overall aims and objectives.

1.3.4 In doing so, the new model is aimed to improve our impact on people, establish a more sustainable social care market, improve our workforce offer and establish long term sustainability. This is called a Target Operating Model. The Operating Model describes the way Adult Health and Social Care operates to deliver upon its vision, strategy, and strategic outcomes.

Fig 1 Generic Operating Model

1.3.5 The first stage of developing the model has been about the organisational design and implementing new workforce, adult commissioning, and leadership arrangements. This is so that we can create the foundations and cultures which enables individuals and carers to:

- Feel that their views, experiences, strengths, and outcomes are at the centre, with their choices leading connections to the communities and supports that matter to them.
- Easily access a range of preventative, early intervention, and short-term targeted support, information and advice which enables people to live independently, healthier, and safely at home for longer.
- Experience long term support, where this is needed, which is connected around communities, primary care networks and multi-agency working so that people don't have to tell their story multiple times, they experience joined up, seamless support centred around what matters to them.

1.3.6 This has involved considerable engagement with our workforce across the Council, commissioned providers, voluntary sector and with individuals and carers in a range of different forums and conversations over this past year.

1.3.7 The outcomes and commitments in the strategy reflect what people told us they wanted us to prioritise and provide confidence that we would deliver upon. It has also informed a future model of adult social care which is reflected below:

1.3.8 This design reflects a model which is focused on delivering a greater range of preventative, enabling and self-help activities with partners so that we are targeted in the provision of and our use of long-term support for those who need it.

1.3.9 This design will promote and emphasize greater independence and choices for individuals and families as well as a more sustainable long term adult social care service. It becomes more sustainable because it sets to reduce the forecasted pressures in relation to growth of long-term support.

1.3.10 The intention is that this design is framed around portfolios of Living & Ageing Well, Adults with a Disability, Mental Health & Wellbeing, Adult Commissioning and Care Governance in which all assessment and care management, council and commissioned social care provision are led by a dedicated portfolio Assistant Director and who act as one community connected social care team.

1.3.11 It's planned that through this model, the community connected social care team are empowered to work innovatively together to develop local solutions which matter to people. In turn its planned that this then reduces duplications of discussions with individuals and supports effective use of our totality of social care resources around care groups.

1.3.12 Key to the model is partnership working and collaboration with individuals, carers, and integrated approaches with our many partners which includes health, housing, police, voluntary sector, faith sector, skills for care, academia, and our communities in a targeted way. These will be fostered and built upon as our model is embedded.

1.3.13 Key enablers underpinning the design as follows:

- Culture and Leadership – A culture and leadership model which is empowering, compassionate and creates conditions and environment for strengths based & enabling practice, innovation, embracing diversity and collaboration with partners. It also creates conditions and embeds co-design and co-production as the core to how we manage and deliver change.

- Valued Workforce - All of our social care workforce – Council, Independent, Faith and Voluntary Sector - feel valued, engaged, and confident to deliver the best quality support, information, and advice.

- Outcomes Based Commissioning – An outcome based, person led commissioning approach in line with national best practice, which is focused on long term sustainability, choice of provision and joint approaches with health, housing, and wider partners.

- Quality and Outcomes - A focus on embedding good governance, quality improvement and feedback from our workforce, experts by experience and stakeholders across the sector to enable an annual cycle of assurance and continuous improvement regards the performance and quality of adult social care.

- Communications – Delivering clear communications, information, advice, and guidance so that individuals, carers, our partners, and stakeholders can easily access help and are kept up to date with our developments.

- Technology – Use of digital systems, automation and technology enabled care to optimise our processes and systems which support greater efficiency and joined up working as well as support to individuals through technology enabled care.

1.3.14 It's aimed that each of these enablers contributes towards adult social care closing the gap on inequalities we see in the City and reducing avoidable demand. Reducing avoidable demand is defined as: - *"Demand caused by not doing something, or not doing something right first time.*

2.0 STEPS TO DEVELOPING AND IMPLEMENTING THE NEW DESIGN AND MODEL

2.1 To enable implementation of the new design, a project delivery plan has been produced aligned with the Strategy Delivery Plan approved at Committee in June 22.

2.2 A high-level timeline and milestones are below which supports implementation:

Milestone	Action	RAG
Leadership (Nov 21 – July 2022)	Complete a leadership restructure within Adult Social Care, following on from transfer of adult commissioning, mental health social work and business planning to Adult Social Care.	
Community Connected Commissioned Services (June 22 – June 23)	Recommission homecare, supported living, day services, extra care and mental health using outcome-based community connected commissioning approach and to enable long term sustainability and improved social care workforce offer for provider services. Re-tenders are now underway with expected completion of June 2023.	
Information and Advice (Jan 22 – March 23)	Complete design and configuration of an improved information, advice, and self-help offer.	

Community Connected Adult Social Care Service (Jan 22 – June 23)	Complete design, pathways, and re-configuration of Sheffield City Council Adult Social Care into the portfolios of Living & Ageing Well, Adults with a Disability, Mental Health & Wellbeing, Adult Commissioning and Care Governance and around communities and primary care with aligned Assistant Directors, Sheffield Council Teams, Contracted Services and Budgets.	
Early Help and Prevention (Nov 22 – Nov 23)	Recommission, co-develop, and implement our early help, enablement and prevention offer aligned to new portfolios and design and guidance.	
Community Connected Residential Provision (Dec 22 – Dec 23)	Recommission residential care provision using outcome-based community connected commissioning approach and to enable long term sustainability and improved social care workforce offer for provider services.	
Community Connected Collaborations and Teams (March 23 – June 24)	Organisational design and facilitation to develop joined up local social care offer by portfolio aligned to targeted partnerships and collaborations.	
Processes and Systems of working (Jan 23 – Dec 23)	Review our processes, and update practice guidance to establish a lean and efficient system of working.	
Enablers (Jan 22 – June 23)	Develop enablers – workforce offer, technology enabled care, governance, response to national reforms and communications.	

2.3 Each milestone activity is being incrementally designed based on feedback from people receiving services, social care providers, and partners, along with the quantitative data we have collected.

2.4 There has been a particular focus on established a more joined up and connected adult social care model where all parts of adult social care work together and with partners so that individuals and carers experience seamless support and advice.

2.5 It has also involved input from every team in adult social care system, along with partners, to identify where there are opportunities to be more effective for people we support and reduce avoidable demand. Input from individuals came from multiple sources and engagements, including learning from contents of complaints.

2.6 The below diagram, taken from the Adult Health & Social Care Strategy, shows the many of the wide range of components involved in the overall social care system in Sheffield with the person supported rightly at its centre. This informs our engagement and activity through each of the milestones.

Fig 2 Components of the Adult Social Care System

2.7 Overall Individuals Journey

2.7.1 Aligned to the timescales set out and the development of a new model of working, the proposed overall customer journey through the adult social care system is below, with a summary the planned changes for citizens through the operating model work.

2.7.2 In combination with other elements of the overall change programme, it will result in better and faster response to people and better outcomes.

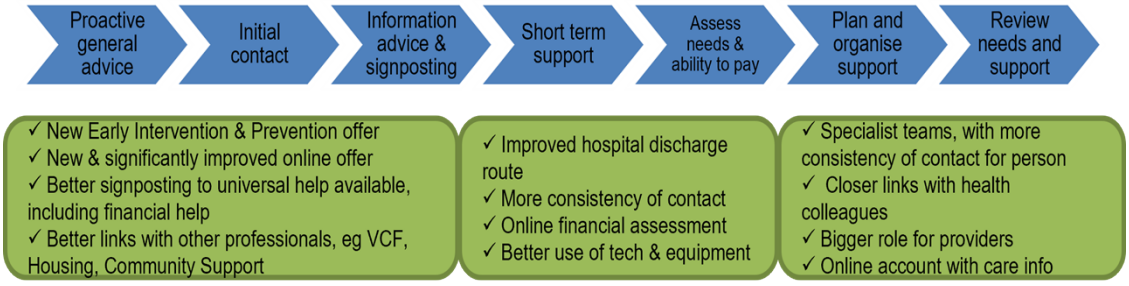

Fig 2 Customer Journey with summary of improvements

2.8 Social Work teams Update

2.8.1 A key milestone set out above has been to develop community connected teams and to look at our pathways. Since Autumn 2022 we have been working with staff and trade unions improving how long-term social work teams are set up.

2.8.2 The entry routes into the adult social care system remain broadly unchanged, i.e., directly from someone in the community, through a hospital episode or transition to adulthood from children's services. The functional diagram sets out improved pathways through the adult social care system based on the activity.

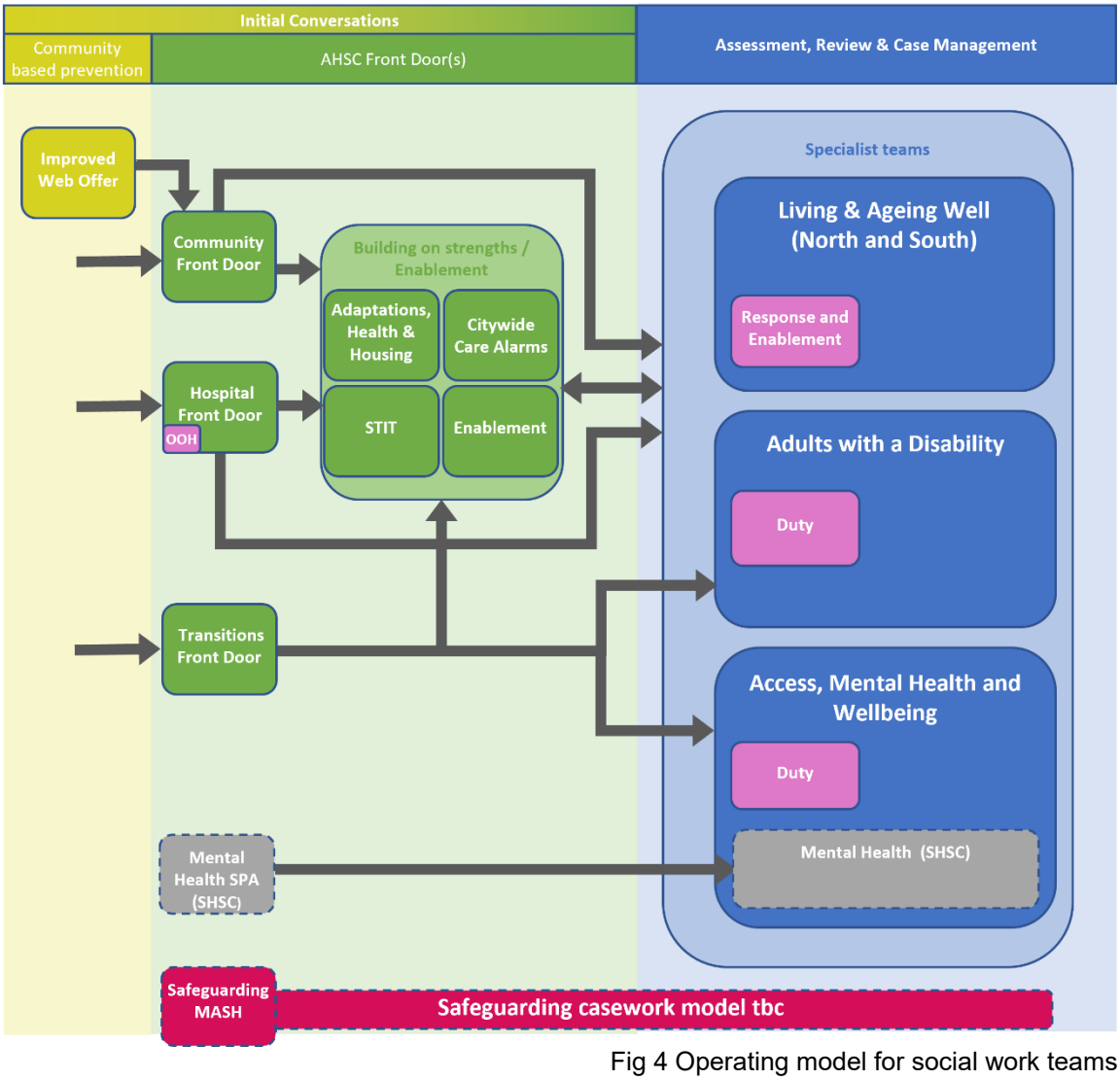

Fig 4 Operating model for social work teams

2.8.3 This model has led us to a restructure of social work teams, that staff and trade unions were consulted upon over summer 2022, and is currently in process of implementation.

2.8.4 For long-term work, with people already receiving care, this moves from the current structure with a Localities Service covering most

of the long-term caseload based on geographic boundaries and a smaller Future Options Service who concentrate on working with people with a high level of need in residential and nursing care.

2.8.5 These services will be replaced by three portfolios, to support and embed the model described above:

- **Access, Mental Health and Wellbeing** – which supports people new to adult social care, vulnerable adults, those with safeguarding needs, and those with mental health needs. As part of the new service, a multi-agency safeguarding hub (MASH) is under development.

- **Living and Ageing Well** - includes older adults and people with dementia and those accessing occupational therapy, hospital support, and enablement services. Community teams aligned to Primary Care Network (PCN) boundaries. Homecare contracts will also be structured around the PCNs and aligned to this service.

- **Adults with a Disability** - focused around promoting and enabling adults to live as independently as possible and be connected to their own communities. Aligned to commissioned services model and closer integrated working with health and other partners.

2.8.6 These structural changes are partnered with work to better our support and develop our workforce, build better partnerships around individuals and ensure that our teams can build expertise in the specialist supports which individuals may need and build expertise in ensuring individuals and carers voices are at the centre of all we do.

2.9 **What difference will this make for people experiencing the adult social care system?**

2.9.1 The design of the new system is rooted in improving the experience of people through the care system and maximising their independence wherever possible.

2.9.2 These changes are based upon removing avoidable demand, i.e. demand caused by a failure to do something or do something right for the customer.

2.9.3 Therefore, by its nature it is aimed at improving people's experiences. This is focussed on ensuring the system is effective, rather than individual processes being efficient without consideration of cumulative impact for individuals.

2.9.4 So, for instance, we know there some people who must explain their situation to several different workers before resolution. This is a poor experience for the individual, and inefficient for the system as a whole.

2.9.5 By building a system based on more consistent knowledge and relationships it is both better and more cost effective – not least as this support a more preventative approach through earlier and more timely resolution.

2.9.6 Another example is improving the alignment and relationships with partners. So, we are designing more consistent relationships for care providers through our recommissioning exercises, so their experience and expertise becomes more integrated in care planning, and their insight is more systematically trusted.

2.9.7 This will be realised through the new homecare, supported living and day services framework agreed by the Committee which includes a higher degree of involvement from providers in planning and reviewing care, and initial conversations with care homes about trialling new ways of working.

3. HOW DOES THIS DECISION CONTRIBUTE ?

3.1 Organisational Strategy

3.1.1 The Adult Social Care Strategy 2022- 2030, *Living the life you want to live',* will drive the implementation of our ambitious plans for social care in Sheffield over the next decade.

3.1.2 The strategy meets the obligation in Our Sheffield One Year Plan 2021/22 to 'Produce a long-term strategic direction and plan for Adult Social Care which sets out how we will improve lives, outcomes and experiences and adults in Sheffield'.

3.1.3 A new operating model for adult social care is a fundamental part of the delivery plan for the strategy.

3.2 Quality and Performance Improvement

3.2.1 The operating model aim to achieve improved outcomes and experiences of citizens and family carers through improved effectiveness and efficiency. This is routed in our statutory duties and reflected in the Council's Delivery Plan 2022-23.

3.2.2 To evidence improvements the programme management governance arrangements map the actions to deliver the new operating model in a controlled and phased way, ensure that stakeholders influence the plans and are kept well informed of progress against them.

3.3 Financial Sustainability

3.3.1 The implementation of the operating model will realise operational savings of £1.5m identified as part of the 2022/23 budget.

3.3.2 These savings come from different parts of the social care system; however, they are built on the premise of removing a proportion of the significant avoidable demand currently experienced – i.e. demand caused by a failure to do something or do something right for the customer.

3.3.3 This will be achieved by more consistent contact with individuals, better operational processes and more specialist staff arriving at the right solution for the individual quicker and first time.

3.3.4 However, the key contribution to financial sustainability is by the new operating delivering better outcome by being more preventative and removing avoidable demand, which is a substantial enabler for managing the total amount spent on care provision in the years and decades ahead.

3.4 Health & Care System Alignment

3.4.1 Across the programme, we are working with health partners across the city and region to ensure that our strategies continued to be aligned as they are put into practice.

3.4.2 Key components of the operating model is better alignment with health colleagues on the ground, forming a multi-disciplinary approach.

3.4.3 Examples include how the Living and Aging Well teams work with GPs, specialist teams work with health infrastructure, dedicated a transition team and improved discharge experience.

4.0 HAS THERE BEEN ANY CONSULTATION?

4.1 The proposals in the operating model have been built on significant co-production and consultation activity with people receiving care, carers, providers, partners, staff and trade unions over the last 18 months.

4.2 Formal consultation took place on the adult health and social care strategy, which has heavily informed the operating model. Staffing changes involve formal consultation with affected employees and trade unions and will continue to follow agreed established procedures.

4.3 Throughout the design stage feedback has been actively sought and responded to. This will continue through implementation and beyond as a fundamental ethos of how adult social care operates

going forward. This has included staff, providers, partners and of course people receiving care.

5. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

5.1 Equality Implications

5.1.1 As an overall process, the changes in operating model will be benefit all people in the adult social care system through a more effective system. This specifically addresses points raised through the Partnership Boards covering LD and Autism. A more focussed offer to older people and those with dementia will also support that client group.

5.1.2 Significant individual elements of the operating model will have different equality impacts, so will be subject to separate assessments and mitigating action.

5.1.3 Staffing structural changes have been subject to a specific equality impact assessment, and we have noted some areas of under-representation to consider in future recruitment. The HR processes have been designed with trade unions to minimise any opportunity for unconscious bias to affect outcomes.

5.1.4 Improving equality through the adult social care system is important to us. As a whole adult social care system we know there is more work to do around ensuring equity of access to services across all our communities, and in particular from BAME backgrounds.

5.1.5 There is a lot still to do, and we are grateful to our partners who are helping us develop an understanding on how to approach improvement. A future report to this committee will cover equality issues in more depth.

5.2 Financial and Commercial Implications

5.2.1 The new operating model is an important building block of a financially sustainable social care system. Specific financial implications are covered as part of the Committees budget setting process, including elsewhere on this agenda.

5.3 Legal Implications

5.3.1 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.

5.3.2 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.

5.3.3 The Living the life you want to live – Adult Social Care Strategy which was approved in March 2022 set out the high-level strategy to ensure these obligations are met. This report builds upon that by setting out how the aims of the strategy will be delivered through the operating model.

5.4 Climate Implications

The climate implications of the overall changes to the operating model are multi-faceted. The basic premise is that supporting people to maximise independence with timely, good quality social care will reduce the need for care provision in the system as a whole – which carries a significant carbon footprint.

Detailed climate impact assessments continue to be completed for all significant components of the change programme.

6. ALTERNATIVE OPTIONS CONSIDERED

6.1 **No new operating model** - There is an alternative available to not specifically design a new operating model. However, this would result in a less coherent adult social care system, and would also lack the accountability and transparency of informed decision making required in a democratic organisation.

6.2 **A different delivery plan** - The real options for the operating model are around the individual elements, which will be worked through as part of the constituent pieces of work. These will be worked through in different ways, with some of them resulting in their own future reports to the Committee

7. REASONS FOR RECOMMENDATIONS

7.1 The operating model gives a structured design for the vision, outcomes and commitments set out in the overall strategy. It will also provide greater accountability and transparency of how will do this.

Report to Policy Committee

Author/Lead Officer of Report: Martin Smith, Deputy Director Planning and Commissioning, NHS South Yorkshire Integrated Care Board Sheffield
Alexis Chappell Director of Adult Health and Social Care

Report of:	*Director Adult Health, and Social Care and Director Commissioning Developments, South Yorkshire Integrated Care Board.*
Report to:	*Adult Health and Social Care Policy Committee*
Date of Decision:	*16th November 2022*
Subject:	Better Care Fund Update

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	X	No	
If YES, what EIA reference number has it been given?				
Has appropriate consultation taken place?	Yes		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 gunder Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:

To update the Committee on the background, progress to date of the Sheffield Better Care Fund, and ambitions for utilising pooled budgets to support Sheffield Health and Social Care to deliver the right service, at the right time, in the right place, in response to the changing population and changes in their needs.

The report provides a summary of the integrated care journey with a core focus on supporting individuals to achieve their personal goals and removing the need for people and their families to repeatedly tell their 'story' to multiple staff from different organisations.

Recommendations:

It is recommended that the Adult Health and Social Care Policy Committee:

1. Note the Better Care Fund overview, background, and expenditure.
2. Note the Better Care Fund Plan 2022/ 2023
3. Note the Better Care Fund Annual Report 2021 - 2022
4. Agree that Director of Adult Social Care brings back 6 monthly reports on the implementation of the Better Care Fund Plan 2022/2023 and Hospital Discharge Improvement Activity.

Background Papers:

None

Appendices:

- Appendix 1 – Better Care Fund Background and Overview
- Appendix 2 – Better Care Fund Planning Requirements
- Appendix 3 – Better Care Fund Plan 2022/ 2023
- Appendix 4 – Better Care Fund Annual Report 2021 - 2022
- Appendix 5 – High Impact Change Model

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: Liz Gough
		Legal: Patrick Chisholm and Sarah Bennett
		Equalities & Consultation: Ed Sexton
		Climate:
	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*
3	**Committee Chair consulted:**	*George Lindars Hammond and 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: Martin Smith Alexis Chappell	**Job Title:** Deputy Director Planning and Commissioning Director of Adult Health and Social Care
Date: 5th November 2022	

1.0 PROPOSAL

1.1 Our vision is that everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are and when they need it, they receive care and support that prioritises independence, choice, and recovery.

1.2 The Sheffield Adult Health and Social Care Strategy and delivery plan sets out the vision for 2022 to 2030, called 'Living the life you want to live', which sets out how as a System we work together to help the people of Sheffield to live long, healthy and fulfilled lives.

1.3 The Better Care Fund aligns to all six of the commitments in the strategy. The fund is focused upon reducing barriers between health and social care funding streams to support the successfully delivery of integration of health and social care services in a way that is person-centred and focused on reducing inequalities and improving outcomes for people and carers in Sheffield.

1.4 Following on from the financial update provided to September Committee and the report to the Health and Wellbeing Board on 29th September, the purpose of this report is to provide an overview of the Better Care Fund and its benefits for Sheffield citizens.

2.0 BETTER CARE FUND OVERVIEW

2.1 The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires integrated care boards (ICBs) and local government to agree a joint plan for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act 2006.

2.2 As a start to this process four funding streams were identified at a national level:

- minimum allocation from ICB Allocations towards jointly commissioning social care services
- disabled facilities grant paid via a Local Authority grant to enable housing and equipment adaptations
- social care funding (improved BCF or iBCF) paid as a local authority grant
- winter pressures grant funding which has been added to the iBCF Local Authority grant

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

2.4 The Annual Report 2021 -2022 was discussed at the Health and Wellbeing Board on June 2022[1] and the benefits of the programme were noted and highlighted. It was highlighted that the BCF supports the ambitions of the Sheffield Joint Health and Wellbeing Strategy, Shaping Sheffield and the NHS Long Term Plan ambitions through delivery of the Joint Commissioning Intentions Plan and Programmes.

2.5 Building on the partnerships, that have become well established locally, the aim is to continue to develop and improve individual outcomes and personal experience of Health and Social Care in Sheffield through our joined up and health and care approach locally.

2.6 It's planned to give a further update on our progress with improving outcomes and closing the gap on inequalities in partnership with health colleagues, aligned to the actions agreed for Adult Social Care in the Council's Delivery Plan approved by Strategy and Resources Committee on 30th August 2022 at December Committee.

2.7 An overview of the history and benefits of the Better Care Fund in Sheffield is attached at Appendix 1 and the Annual Report 2021 – 2022 is attached at Appendix 2 for the Committee information and context.

2.8 Better Care Fund 2022/23 Update

2.8.1 On 19th July 2022 the Department of Health and Social Care published the 2022 to 2023 Better Care Fund Policy Framework[2] setting out the core requirements included the development of a narrative plan explaining current programme delivery against local objectives, explanation of local structures and governance and confirmation of agreed expenditure in compliance with the requirements of the fund.

2.8.2 The Better Care Fund Policy Framework for 2022 – 2023 notes four national conditions attached to it:

- National condition 1: a jointly agreed plan between local health and social care commissioners and signed off by the HWB.
- National Condition 2: NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution
- National Condition 3: Invest in NHS commissioned out-of-hospital services
- National condition 4: implementing the BCF policy objectives

2.8.3 As an assurance to Committee, the following has been undertaken to implement these national conditions:

[1] Better Care Fund Update to HWBB - Draft Protocol for Cabinet Reports (sheffield.gov.uk)
[2] Better Care Fund Policy Framework - 2022 to 2023 Better Care Fund policy framework - GOV.UK (www.gov.uk)

- The Better Care Fund Plan update for 2022/23 was developed in partnership with senior managers and service leads across the system, agreed by the Health and Wellbeing Board, and submitted back to NHS England on 26th September 2022 in line with the national timescales. This meets National Condition 1 and the Plan is attached at Appendix 3.

- The NHS minimum contribution to the Better Care Fund has been achieved in 2022/23 at £44,998,236, which meets National Conditions 2 and 3. The minimum contribution is set across a Health and Wellbeing Footprint and includes two specific elements which must be met or exceeded:

    - Funding to jointly commission adult social care services must be a minimum of £18,847,224. Within Sheffield this is currently £22,250,371. Adult Social Care acts a lead commissioner for these services, which includes homecare provision.
    - Funding of community-based out of hospital services must be a minimum of £12,787,222. Within Sheffield this is currently £ £22,747,865. The ICB acts as lead commissioner for these services.
    - The ICB makes a total contribution to the Better Care Fund of £276,775,244.

2.9 Better Care Fund 2022/ 2023 National Condition 4 - Policy Objectives Implementation

2.9.1 National condition 4 requires areas to agree a joint plan to deliver health and social care services that support improvement in outcomes against the fund's 2 policy objectives:

- enable people to stay well, safe, and independent at home for longer
- provide the right care in the right place at the right time

2.9.2 To meet these objectives and as an assurance to Committee, the Sheffield plan 2022 – 2023 focuses on:

- Taking steps to enable person centred care which promotes independence and addresses health, social care and housing needs of people who are at risk of reduced independence, including at risk of admission to hospital or long-term residential care.
- Ensuring people are discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes. This includes continued implementation of the High Impact Change Model for Transfers of Care, which is the basis of the Better Care Fund requirements around supporting discharge. The High Impact Change Model is attached for information at Appendix 4.

2.10 Better Care Fund 2022/ 2023 Targets Implementation

2.10.1 Beyond the 4 conditions (and grant conditions), areas have flexibility in how the fund is spent over health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the following BCF 2022 to 2023 metrics which are:

- avoidable admissions to hospital
- admissions to residential and care homes
- effectiveness of reablement
- hospital discharges that are to the person's usual place of residence

2.10.2 From April 2022, the discharge ready data collected by hospitals systems has become a required collection and will be used to collect better data on the date that people in acute hospital are ready to return home compared to the date of discharge. This will support the collection of more accurate data on delayed discharges.

2.10.3 A metric in relation to this data on delayed discharges will be adopted as a formal BCF metric from April 2023. It's planned that Systems should work together to ensure that this information is recorded accurately and for all individuals as soon as possible. Reducing length of stay remains a priority of the BCF.

2.10.4 To this end, the locally agreed metrics to meet the national targets for 2022/ 2023 are:

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

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

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

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

2.10.5 To support and enable evidence of the local and national targets regards hospital discharge are being met and readiness for new approaches from April 23, a report will be brought outlining the social care discharge delivery plan to the December Committee. The associated funding will also be considered as part of this report.

3.0 GOVERNANCE OF BETTER CARE FUND

3.1 Adult Social Care Policy Committee Governance Arrangements

3.1.1 Given the focus on integrated working and in particular the focus of the fund and targets relate to hospital discharge, it's important that the fund has appropriate oversight and scrutiny from the Committee, given most of the funding provided to the Local Authority through the fund sits within the remit of the Adult Social Care Policy Committee.

3.1.2 To enable appropriate joined up working to implement the ambitions of the Better Care Fund its proposed that updates regarding progress of implementation of the Better Care Fund Annual Plan and associated Hospital Discharge Improvement Activity are brought to Committee on a six-monthly cycle.

3.1.3 It's planned that this will also give Committee members an opportunity to comment upon the Better Care Fund activity and inform the annual cycle of planning in a timely way prior to submission to the Health and Wellbeing Board. It's aimed that this will provide assurances to the Chairs of the Health and Wellbeing Board of the robustness and timeliness of information provided.

3.2 Sheffield City Council Assurance

3.2.1 The Better Care Fund was audited by the Sheffield City Council Internal Audit Team on 16 August 2022 at the request of the Director of Adult Health and Social Care. The purpose of the audit was to provide an independent opinion as the effective management and mitigation of operational risks associated with Better Care Fund, and whether the objectives were likely to be achieved.

3.2.2 Substantial Assurance was given by the audit team who highlighted that there is an effective system of internal control in place designed to achieve the Service objectives.

3.2.3 Minor issues being identified which stemmed from changes to process during the Covid-19 pandemic command and control structure are highlighted as require improvement as previous processes have not yet fully been reimplemented. An action plan was developed as part of the audit outcomes, and this is being actioned to improve the processes around the Better Care Fund.

3.3 NHS England Assurance

3.3.1 NHS England are undertaking a full planning round in 2022 to 2023. Better Care Fund plans and their delivery must comply with the set conditions as part of the delivery of ICB duties relating to the promotion of integration, acting effectively and efficiently, the improvement of the quality of services and the reduction of health inequalities under the NHS Act 2006.

3.3.2 Assurance of the Sheffield Better Care Fund plans is being led by the Yorkshire and Humber Better Care Manager with input from NHS England and Local Government Agency representatives. It was a single stage exercise based on a set of key lines of enquiry (KLoEs). On 14 October 2022 Sheffield's plan was approved by the regional assurance panel and sent to for approval at the cross-regional calibration meeting to be held on 01/11/2022.

3.3.3 Following the calibration meeting, the recommendation for approval will be made by NHS England Regional Directors – this will include confirmation of the assurance process and that Local Government representatives were involved in assurance and agree the outcomes and any recommendations.

3.3.4 NHS England, as the accountable body for the NHS minimum contribution to the fund, will then write to areas to confirm that the NHS minimum funding can be released. Assurance letters should be received by 30/11/2022. Following this notification, the Section 75 agreement can then be revised to include the 2022/23 plans and values. Committee will be updated through the Financial Update report provided to each Committee as to confirmation of the sum received.

3.5 Annual Report

3.5.1 From the outset the focus has been the maximisation of benefits to citizens in Sheffield, with decisions around any requirements for health and social care taken once and in collaboration to maximise outcomes delivered for the available resources.

3.5.2 An annual report on the activities of the Better Care Fund is provided to the Health and Wellbeing Board. It provides an opportunity to understand impact of the funding in relation to the national and local metrics and funding received.

3.5.3 In going forward the Annual Report on the outcomes of and impact of the Better Care Fund will be brought to Committee for assurance on use of funds within Adult Social Care to promote better integrated working with health for the benefit of citizens of Sheffield. This will also provide an evidence base for the annual Adult Social Care Local Account.

4.0 HOW DOES THIS DECISION CONTRIBUTE?

4.1 This report is written to demonstrate that the Sheffield Better Care Fund is a key enabler to meeting Adult Social Care outcomes that are set out in the Adult Social Care Strategy. At the heart of the plans is the principle to ensure care is delivered that enables citizens to remain:

- Safe and well
- Active and independent
- Connected and engaged

4.2 That each programme is inspirational and transformational in its aims and the outcomes intended for the service users while ensuring at each step the effective and efficient use of resources across the Sheffield System.

4.3 The programmes within the Sheffield Better Care Fund are based upon personalised care being delivered in a sustainable way and co-produced to ensure the needs of people, staff and carers are met.

4.4 This report is written to demonstrate that the Sheffield Better Care Fund is a key enabler to meeting Adult Social Care outcomes that are set out in the Adult Social Care Strategy. At the heart of the plans is the principle to ensure care is delivered that enables citizens to remain:

- Safe and well
- Active and independent
- Connected and engaged

4.5 That each programme is inspirational and transformational in its aims and the outcomes intended for the service users while ensuring at each step the effective and efficient use of resources across the Sheffield System.

4.6 The programmes within the Sheffield Better Care Fund are based upon personalised care being delivered in a sustainable way and co-produced to ensure the needs of people, staff and carers are met.

4.7 By jointly commissioning services across Health and Social Care the aim is to ensure market stability at each stage and the procurement of integrated socially responsible services.

4.8 It supports the Council statutory responsibilities for Adult Social Care including the following outcomes for the people of Sheffield:

- promotion of wellbeing
- protection of (safeguarding) adults at risk of abuse or neglect
- preventing the need for care and support
- promoting integration of care and support with health services
- providing information and advice
- promoting diversity and quality in providing services

4.9 The governance arrangements proposed will support a culture of accountability, learning and continuous improvement which will enable the Council to deliver upon its vision and strategy for Adult Social Care, deliver better outcomes and an improved experience for people and a more sustainable adults social care service for the future.

4.10 One of the commitments under the strategy is to “Make sure support is led by ‘what matters to you’, with helpful information and easier to understand steps.” The improved governance arrangements aim to promote and ensure quality of support and practice which matters to individuals.

5.0. HAS THERE BEEN ANY CONSULTATION?

5.1 The Better Care Fund update describes a foundation for the governance of the fund in relation to the Adult Health and Social Care Policy Committee. Due to this the update has not been formally consulted on.

5.2 There is lots of work currently underway to strengthen the direct involvement of people in the decision making and co-production of adult social care services and functions. The intention is that this will be formalised in a co-produced and co-designed dedicated document which will set out the different ways that people are able to engage with the Council from complaints and surveys to board membership and performance challenge sessions.

6.0. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

6.1 Equality of Opportunity Implications

6.1.1 A key function of the Better Care Fund is to ensure equality of opportunity for all because it is designed to give assurance about the delivery of the Council's statutory responsibilities for adult health and social care.

6.1.2 The Equality Act 2010 gives legal status to various protected characteristics which people have – these include Age and Disability, characteristics which are central to the core activity of Adult Health and Social Care. As a Public Authority, the Council has legal requirements under the Equality Act. These are specified in the Public Sector Equality Duty, which includes a requirement to consider if and how we can advance equality of opportunity between people who share a protected characteristic and those who do not.

6.1.3 The aims of the Better Care Fund are consistent with these equality duties – this report identifies ways in which it can contribute to these ends, for example, in the Better Care Fund Targets section relating to older people.
.

6.2 Financial and Commercial Implications

6.2.1 A key function of the Better Care Fund update is to support the delivery of a financially sustainable Adult Health and Social Care Service. because it is designed to give assurance about the delivery of the Council's statutory responsibilities for adult health and social care.

6.2.2 These duties include ensuring a sustainable care market and the ability to meet eligible care needs. The ongoing resourcing of Adult Health and Social Care is a key challenge for Sheffield City Council and Local Authorities nationally.

6.3 Legal Implications

6.3.1 The main responsibilities of Adult Health and Social Care are set out in the following main pieces of legislation: the Care Act 2014, the Mental Capacity Act 2005, the Human Rights Act 1998, the Health and Care Act 2022, and Domestic Violence Act 2021. This legislation directs Adult Health and Social Care to:

- promote wellbeing
- protect (safeguarding) adults at risk of abuse or neglect
- prevent the need for care and support
- promote integration of care and support with health services
- provide information and advice
- promote diversity and quality in providing services

6.3.2 As previously described the key function of the report today is to provide an overview of the Better Care Fund and to set out how the Council will ensure that Adult Social Care is statutorily compliant.

6.4 Climate implications

6.4.1 The Better Care Fund Plan in future years will ensure that climate impacts are considered in decision making as this is a part of the Effective and Efficient Outcome in the Adult Health and Social care vision and strategy.

6.4.2 The Better Care Fund officers will therefore be tasked with measuring the achievement of the service in the delivery of this ambition and identifying actions as and when performance falls short.

7.0 ALTERNATIVE OPTIONS CONSIDERED

7.1 The alternative options considered are more or less frequent updates to Committee. However, it is felt that the current proposals provide the right balance enabling oversight but also ensuring that there is progress for the Director of Adult Health and Social Care to Report on.

8.0 REASONS FOR RECOMMENDATIONS

8.1 The report aims to provide an overview of the Better Care Fund for Committee attention following on from the Use of Resources report provided to Committee in September 2022.

8.2 It's aimed that this approach to the Better Care Fund will promote an annual cycle of assurance and continuous improvement, which can then provide assurance to Committee regards our focus on effective use of the funds.

Appendix 1: Overview and Benefits of the Better Care Fund

1 Background to the Better Care Fund in Sheffield

When the Better Care Fund was nationally mandated in 2015, most areas chose just to pool resources at the minimum level prescribed.

In Sheffield we took a different approach, choosing a range of services where it was deemed that there were opportunities to improve value and outcomes by planning and managing services in a more joined up way. In the first year, the value of the budgets in scope was £282m (compared to the minimum requirement of circa £30m).

This gave a strong signal of our aspiration to examine a wide range of areas to support integration across our Place and underpin our alliance arrangements for personalised, enabling, out-of-hospital services. Over the past 7 years the themes and joint funding have evolved as integrated working has progressed.

A revision to the budgets included in the s75 agreement were approved at Cooperative Executive on 16th March 2022 – Working with NHS Report.

The decision on 16th March enabled a revision to the s75 agreement which is explained in the diagram below. Following on from that approval and in particular increase in joint activity and joint working with NHS to achieve better outcomes for people. This supported and set a foundation for the Better Care Fund 2022 – 2023 plan.

Appendix A

Proposed Revised Budgets for inclusion within the s75 Agreement

	Current s75		
	CCG	SCC	Total
JCC Priority Area	£'m	£'m	£'m
Children and Young People			
Ageing Well	49.7	14.4	64.1
All Age Mental Health	106.3	10.7	117.0
All Age Learning Difficulties	15.4	44.9	60.3
On-Going Care	35.5	65.9	101.4
Collaborative Working	0.0	0.0	0.0
Urgent and Emergency Care	69.9	0.0	69.9
Disability Facilities Grant		5.7	5.7
Total	276.8	141.6	418.3

	Proposed s75 21/22		
	CCG	SCC	Total
JCC Priority Area	£'m	£'m	£'m
Children and Young People	**62.9**	**73.6**	136.5
Ageing Well	**77.5**	**18.4**	95.9
All Age Mental Health	**137.9**	**19.2**	157.2
All Age Learning Difficulties	**21.4**	44.9	66.4
On-Going Care	**38.1**	**71.0**	109.0
Collaborative Working	**1.0**	**2.1**	3.1
Urgent and Emergency Care	**180.2**	**0.1**	180.3
Disability Facilities Grant		5.7	5.7
Total	519.1	234.9	**754.0**

Appendix 1: Overview and Benefits of the Better Care Fund

2 The Benefits to Sheffield

From the outset the focus has been the maximisation of benefits to citizens in Sheffield, with decisions around any requirements for health and social care taken once and in collaboration to maximise outcomes delivered for the available resources.

However, in 2018 CQC undertook a local area review of the Sheffield System and found that too much of the care and support provided to Sheffield citizens was delivered away from their home environment, that services were fragmented and hard to navigate, there was insufficient focus upon preventative pathways and that financial pressures could be increasingly risk managed in collaboration.

This led to the creation of a revised governance framework and the creation of Joint Commissioning structures as part of the Sheffield Better Care Fund. Within the first year from the inspections Sheffield had:

- Established Joint Commissioning arrangements for new community care services
- Provided additional investment to support neighbourhood development - to embed neighbourhoods working collaboratively at increased pace
- Developed a collaborative working framework in a number of areas to address system pressures resulting in reduced delays in acute settings and improvement in flow and improved patient experience
- Developed a co-produced Dementia strategy, through employing a cross organisational approach
- Continued engagement into communities and general practices to listen to the problems and issues that patients experience in urgent care and stakeholders across the city.
- Establishment of Joint Commissioning Committee to provide single commissioner approach
- Delivered £3.8m efficiency savings from the changes above and clarified risk sharing arrangements.

This meant the City was aligned, had open transparent relationships in place across key partners and was functioning well so at the start of the Covid-19 pandemic the existing Better Care Fund governance structure was mobilised as part of the Command-and-Control Structure in Sheffield.

The strong relationships and mutual trust allowed decisions to be taken at pace to ensure the response for the City was timely and appropriate, adhering to the underlying principles of supporting those citizens who experience health inequalities as a key part of all changes.

The clearly defined Section 75 agreement was utilised where national funding was allocated with a specific element added to clarify how funding could reach the right organisations quickly while still having sufficient scrutiny and oversight as public funding.

During 2021/22 an additional £34m was received and managed through this process, with £13m of one – off funding allocated from the NHS to SCC set out below:

- £2.8m one – off funding to assist social care providers with early adoption of the National Living Wage increase and schemes designed to enhance recruitment and retention in the sector.
- £0.5m of one-off funding was focused upon staffing to reduce the backlog in equipment assessments and home adaptations to enable people in their own homes to remain safe and well with reduced need for core services.
- £10m of social care support to Hospital Discharge Funding was received by SCC to acknowledge the pressures and instability in the system and to support keeping safe in the most appropriate location outside of hospital.
- Local funding was also agreed to support people shielding at home, ensuring a single access point was created for all contacts from food parcels being required to support with loneliness and mental health or bereavement.

The structure is not only instrumental to effective working during times of need and crisis, without the Better Care Fund structure being in place and gaining national approval, the four funding streams attached to the requirement would not be received into the City.

By working in collaboration, with oversight of the whole Health and Social Care system, we can identify inefficiency, blocks to the system flow and ineffective use of resources. This approach is being taken across all areas of spend within the ICB and SCC to derive joint efficiency and savings plans.

While the financial challenges being faced by all sectors of Health and Social Care is large, by breaking down the requirements and savings targets to service level they become achievable through on-going transformation. Through a collaborative approach it means we can move the Sheffield resources to the most effective place, regardless of the origins of the allocated funding.

3 The Future of The Better Care Fund

The future ambition for the Sheffield Better Care Fund is to promote further collaborative and integrated working focused around better outcomes for people and communities.

While the national Better Care Fund programme is focused upon Adult services, our local ambition reported to the Health and Wellbeing Board is to ensure provision is not dependent upon the age of a person and that the transition between the four “well” stages of the Health and Wellbeing Board Strategy and Shaping Sheffield Plan can be delivered without individuals seeing the steps and joins in provision.

Appendix 1: Overview and Benefits of the Better Care Fund

The four stages have had key milestones identified through engagement with citizens and key partner organisations:

Starting Well:

- Every child achieves a level of development in their early years for the best start in life
- Every child is included in their education and can access their local school
- Every child and young person has a successful transition to independence

Living Well:

- Everyone has access to a home that supports their health and social care needs
- Everyone has a fulfilling occupation and the resources to support their needs
- Everyone can safely walk or cycle in their local area regardless of age or ability

Ageing Well:

- Everyone has equitable access to care and support shaped around them, personalised to their needs
- Everyone has the level of meaningful social contact that they want

Dying Well:

- Everyone has the right to dignity in death
- Everyone lives the end of their life in the place of their choice
- Everyone is supported in their grieving and bereavement process, from the point of diagnosis of an advanced, progressive, incurable illness to support for carers after death

The expansion of the Section 75 agreement to include additional services, such as Children's Commissioning and communities-based services, is designed to enable wider integration and continue to remove some of the transitions and barriers faced by individuals and our workforce who are required to navigate the complex health and care system.

By working across the city, we can streamline conversations, make decisions that support true integration of staff, resources, and provision to allow delivery of services which are co-designed with all stakeholders and have the user at the heart, all supported and underpinned by the legal framework of the Section 75 agreement and embedded within the effective Better Care Fund principles and governance structure.

Classification: Official

Publication approval reference: PAR1296

Better Care Fund planning requirements 2022-23

19 July 2022

Contents

Introduction

1. The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2022-23. The framework forms part of the NHS mandate for 2022-23.

2. The use of BCF mandatory funding streams (NHS minimum contribution, Improved Better Care Fund grant (iBCF) and Disabled Facilities Grant (DFG) must be jointly agreed by integrated care boards (ICBs) and local authorities to reflect local health and care priorities, with plans signed off by health and wellbeing boards (HWBs). BCF plans should include stretching ambitions for improving outcomes against the national metrics for the fund. No new metrics have been introduced for 2022-23.

3. One of the findings from the 2018 BCF review was to provide clearer and more focused objectives for the BCF that address wider system and prevention outcomes through co-ordination of services. The two objectives for 2022-23 BCF are:

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

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

4. National condition four of the BCF has been amended to reflect these two objectives and now requires HWB areas (referred to as areas in this document) to agree an approach within their BCF plan to make progress against these objectives in 2022-23.

5. BCF plans must be submitted by 26 September 2022. Draft plans can be submitted to Better Care Managers (BCMs) by 19 August for feedback, and areas are strongly encouraged to do this. Assurance will be carried out on final plans.

6. As in previous years, this guidance forms part of the core NHS Operational Planning and Contracting Guidance. ICBs are required to have regard to this guidance, which is issued using NHS England's powers under the NHS Act 2006.

   These planning requirements are being published jointly with the Local Government Association and will be disseminated directly to local government.

7. The iBCF and DFG continue to be paid to local authorities with a condition that they are pooled locally into the BCF and spent on specific purposes set out in the grant determinations and conditions.

8. For 2022-23, BCF plans will consist of:

- a completed narrative template
- a completed BCF planning template, including:
  - planned expenditure from BCF sources
  - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
  - ambitions and plans for performance against BCF national metrics
  - any additional contributions to BCF section 75 agreements.
- A completed intermediate care capacity and demand plan submitted alongside the BCF plan. (These will not be subject to assurance.)

Legal framework

9. The government's mandate to the NHS for 2022-23, issued under section 13A of the NHS Act 2006, sets an objective for NHS England to ringfence funding to form the NHS contribution to the BCF. The Policy Framework confirms that this ringfence is £4.504 billion in 2022-23.

10. These planning requirements set allocations (published on the NHS website) from this ringfence to ICBs, and in turn from ICBs to their HWB areas, and apply conditions and requirements to their use.

11. BCF plans and their delivery should comply with these conditions as part of the delivery of ICB duties relating to the promotion of integration, acting effectively and efficiently, the improvement of the quality of services and the reduction of health inequalities under the NHS Act 2006.

Mandatory funding sources

12. The following minimum funding must be pooled into the BCF in 2022-23.

Source	2021/22 (£m)	2022-23 (£m)	Percentage change
NHS contribution	4,263	4,504	5.66%
Improved Better Care Fund	2,077	2,140	3%
Disabled Facilities Grant	573	573	0

National conditions

13. The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved. These are:

    1. **A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.**
    2. **NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.**
    3. **Invest in NHS commissioned out-of-hospital services.**
    4. **Implementing the BCF policy objectives.**

14. Compliance with the national conditions will be confirmed through the planning template and narrative plans. Spend applicable to these national conditions will be calculated in the planning template based on scheme-level expenditure data.

National condition 1: Plans to be jointly agreed

15. National condition 1 requires that a plan for spending all funding elements is jointly agreed by the relevant local authority and ICB(s) and placed into a pooled fund, governed by an agreement under section 75 of the NHS Act 2006. Plans will need

to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and these planning requirements.

16. Plans must be agreed by the ICB (in accordance with ICB governance rules) and the local authority chief executive, prior to being signed off by the HWB.

17. Areas can agree to pool additional funds into their BCF plan and associated section 75 agreement(s). These additional contributions are not subject to the conditions of the BCF but should be recorded in the planning template.

18. Systems should review the assessment of health inequalities and equality for people with protected characteristics under the Equality Act 2020 from their 2021-22 plans and update these, where appropriate. Narrative plans should briefly set out any changes to local priorities in terms of health inequality or equality for people with protected characteristics, and how BCF funded services are being delivered to address these, including data where this is appropriate. Where data is available, local areas should also consider any differential outcomes for people from groups with protected characteristics and other vulnerable groups in relation to the metrics of the BCF and how actions in their plan can contribute to reducing these.

19. Data on avoidable admissions and on discharge to be used in the BCF for 2022-23 will be made available on the Better Care Exchange. This will include ethnicity and age information to support analysis as well as links to guidance and documents on equality. ICBs will need to have regard to the NHS Operational Planning and Contracting Guidance regarding the reduction of health inequalities. This guidance emphasises the importance of partnership working for effective use of the available resources to ensure that reducing inequalities in access is embedded in the NHS's approach. While local authorities will have their own priorities under the Equality Act, BCF plans will need to reflect what NHS bodies are doing to address inequalities under Core20PLUS5, which focuses on the most deprived 20% of a population, the ICS-identified groups in each area that experience poorer than average access and five additional areas of focus.

Mandatory components of the Better Care Fund

NHS minimum contribution to the Better Care Fund

20. NHS England has published allocations from the national ringfenced NHS contribution for each ICB and HWB area for 2022-23 on its website. The minimum

NHS contribution to each HWB area is the 'NHS minimum contribution' or the 'NHS minimum'. The allocations for all mandatory funding sources are pre-populated in the BCF planning template at HWB level.

21. For 2022-23, the allocations of the NHS contribution to the BCF have been increased by 5.66% for each HWB area. The contribution for each HWB area continues to include funding to support local authority delivery of reablement (£300 million), carers' breaks (£130 million) and implementation of duties to fund carer support under the Care Act 2014 (£161.62 million). Local allocations of these elements of the NHS minimum contribution are not set for each area, and it is for local government and ICBs to agree the funding to allocate to these services as part of their local BCF plans. BCF plans should reflect clearly how this funding has been identified.

22. With particular reference to funding to support carers' breaks and carer support under the Care Act 2014, the narrative section of BCF plans should also include a brief overview of how BCF funding available in their locality is being used to support unpaid carers. This supports the government's recent commitments on empowering unpaid carers, as set out in the adult social care reform white paper: People at the Heart of Care.

23. When agreeing plans for use of BCF funding to support reablement, areas should consider how this expenditure and the approach to commissioning these services aligns to wider plans. Plans should set out how reablement (and rehabilitation) services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care, and how BCF funding is supporting capacity for these services, along with NHS and local authority funding (see national condition 4). For the BCF in 2022-23, systems are required to agree high level capacity and demand plans for intermediate care services, covering both BCF and non-BCF funded services (see paragraphs 45–52 and Appendix 4).

24. National conditions 2 and 3 apply only to spend from the NHS minimum contribution and are set out below.

National condition 2: NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution

25. National condition 2 requires that, in each HWB area, the contribution to social care spending from the NHS minimum contribution is maintained in line with the percentage uplift in the NHS minimum contribution to the BCF in that HWB area.

The NHS minimum contribution for each HWB area has been uplifted by 5.66%, and this uplift must be applied to the minimum expectation for social care spend in 2021-22 plans for the HWB.

26. The purpose of this condition is to ensure that support from the NHS for social care services with a health benefit is maintained in line with the overall growth in the NHS minimum contribution to the BCF.

27. As in previous years, the minimum expectations in each HWB area will be confirmed in the BCF planning template. Any schemes where the spend type is 'social care' and the funding source is the NHS minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum. ICBs and councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

Revisions to baselines for social care maintenance

28. Baselines for social care contributions are based on local agreements for maintaining the financial contribution from the NHS to social care (baselined from 2016-17).

29. Areas were able to query the baselines in 2017 to 2019. However, if since then, an area has identified that the baseline used for calculating the minimum contribution is wrong, they can request that the figure is reviewed. This can only be done, by exception, in cases where activity has been miscoded and the request must be made by the HWB. Further details are set out in Appendix 2.

National condition 3: Agreement to invest in NHS commissioned out-of-hospital services

30. A minimum of £1.28 billion of the NHS contribution to the BCF in 2022-23 is ringfenced to deliver investment in out-of-hospital services commissioned by ICBs, while supporting local integration aims. Each HWB area's share of this funding is set out in the BCF planning template and will need to be spent as set out in national condition 3. This condition will be assured through the planning template, based on spend allocated to primary, community, social care or mental health care, that is commissioned by ICBs from the NHS minimum contribution.

Grant funding to local government

Improved Better Care Fund (iBCF)

31. The grant determination for the iBCF was issued on 22 April 2022. Since 2020-21, funding that was previously paid as a separate grant for managing winter pressures has been included as part of the iBCF grant but is not ringfenced for use in winter.

32. The grant conditions remain broadly the same as in 2021-22.

33. The funding may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

34. iBCF funding can be allocated across any or all of the four purposes of the grant in a way that local authorities, working with ICB(s), determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the purposes.

35. The grant conditions for the iBCF also require that the local authority pools the grant funding into the local BCF and reports as required through BCF reporting. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care (national condition 2).

Disabled Facilities Grant

36. Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local authorities. The statutory duty to provide DFGs to those who qualify for them is placed on local housing authorities. Therefore, each area must ensure that sufficient funding is allocated from the DFG monies to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of eligible people of all ages.

37. In two-tier areas, decisions around the use of DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government must be passed down to the relevant housing authorities (in full, unless jointly agreed to do otherwise) to

enable them to continue to meet their statutory duty to provide adaptations and in line with these plans.

38. The DFG is pooled into the BCF to promote joined-up approaches to meeting people's needs to support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care, and strategic use of the DFG can support this.

39. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

- the funding is included in one of the pooled funds as part of the BCF
- as DFG funding is capital funding, the funding can only be used for capital purposes
- the funding supports a strategic approach to housing and adaptations that supports the aims of the BCF
- the use of the funding in this way has been developed and agreed with relevant housing authorities.

40. The scope for how DFG funding can be used includes to support any local authority expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables local government to use specific DFG funding more flexibly. There are numerous case studies of innovative use of DFG funding on the Better Care Exchange[1] and Foundations websites.

41. This discretionary use of the funding can help improve delivery and reduce the bureaucracy involved in the DFG application process, helping to speed up the process. The Care Act 2014 also requires local authorities to establish and maintain an information and advice service in their area. The BCF plan should consider the contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

[1] An account is needed to access the Better Care Exchange, if you do not have one and would like to set one up, please email england.bettercarefundteam@nhs.net

42. The Government published updated guidance for local authorities on 28 March 2022 that sets out how they can effectively and efficiently deliver DFG funded adaptations to best serve the needs of local older and disabled people.

National condition 4: implementing the BCF policy objectives

43. National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:

i. **Enable people to stay well, safe and independent at home for longer.**

ii. **Provide the right care in the right place at the right time.**

44. For both objectives, areas should describe:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.
- How BCF funded services will support delivery of the objective.

45. In addition to this, areas are asked to develop plans that outline expected capacity and demand for intermediate care services in the area, covering demand for both services to support people to stay at home (including admissions avoidance) and hospital discharge pathways 0–3 inclusive, or equivalent, for quarters 3 and 4 of 2022-23 across health and social care. This should cover both:

- BCF funded activity
- non BCF funded activity.

46. The NICE guidance on intermediate care defines it as “a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care”.

47. A system-wide understanding of demand and capacity across intermediate care is critical to enabling areas to maximise both people’s health, wellbeing and

independence, and utilisation of system resources. It enables areas to understand trends and variation, and so agree joint actions to anticipate demand more accurately across health and care in the medium and long term, and respond more effectively to shorter term or unpredicted demand or challenges.

48. While councils retain their Care Act 2014 duties in terms of market management, a joint approach to planning intermediate care enables areas to more effectively and holistically shape local health and care provision to develop the necessary capacity to meet anticipated demand. The Local Government Association (LGA) and partners' High Impact Change Model for managing transfers of care provides advice on developing effective capacity and demand systems.

49. As a first step, areas are asked to jointly develop a single picture of intermediate care needs and resources across health and social care funded by the BCF and other sources for quarters 3 and 4 of 2022-23. There is no expectation that the BCF should be used to fund all services within this capacity and demand plan.

50. Areas should work closely across all partners to produce the plan and utilise data submitted by NHS organisations on hospital discharge pathway activity as well as local authority service data as part of operational plans. NHS trusts should be involved in, and contribute to, the development of these plans. Further guidance is available in Appendix 4, and bespoke support will be available through the BCF external support programme delivered by the LGA.

51. When estimating capacity and demand at local authority level, ICBs should make use of the discharge pathways model that is available on NHS Foundry and the projected activity levels submitted as part of NHS planning. Plans should also take account of planning carried out in preparation for the winter.

52. These capacity and demand plans will need to be submitted with main BCF plans, but the content will not form part of the overall BCF assurance process.

Objective 1: Enabling people to stay well, safe and independent at home for longer

53. This objective seeks to improve how health, social care and housing adaptations are delivered to promote independence and address health, social care and housing needs of people who are at risk of reduced independence, including admission to residential care or hospital. This might include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

54. The LGA published a High Impact Change Model for reducing preventable admissions to hospital and long-term care in 2021. The document sets out five actions for systems that areas should consider:

- population health management
- target and tailor interventions for those most at risk
- effective multidisciplinary working
- educate and empower people to manage their own health and wellbeing
- provide a co-ordinated and rapid response to crises in the community.

55. BCF plans for 2022-23 should set out how BCF funding (including any voluntarily pooled funding) aligns in support of this objective. This should include:

- providing details in the BCF planning template of planned spend on prevention-related activity
- how joint health and social care activity will contribute to the improvements agreed against BCF national metrics, including prevention (unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)).

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

56. BCF plans should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this. Systems should have regard to the guidance on collaborative commissioning

published by the LGA, in partnership with the BCF Programme, and guidance produced following the evaluation of the Hospital Discharge Policy and Discharge to Assess.

57. The High Impact Change Model for managing transfers of care was refreshed in 2019 and has been further updated in 2020 to reflect changes to discharge introduced to support the response to COVID-19. Continued implementation of the model is integral to delivery of this objective and the requirements of the BCF. As part of developing their BCF plan, areas should review and self-assess their implementation of the model. Narrative plans should include confirmation of this review and the planned actions arising from this.

58. The national Hospital Discharge Fund came to an end on 31 March 2022.[2] NHS England wrote to systems in March to encourage them to continue to make best use of existing resources to support safe and effective discharges within local priorities. BCF plans for 2022-23 should set out how BCF funding (including any voluntarily pooled funding) aligns in support of this objective. This should include:

- providing details in the BCF planning template of planned spend on discharge-related activity
- how joint health and social care activity will contribute to the improvements agreed against BCF national metrics for discharge (increasing the proportion of people discharged from hospital to their normal place of residence).

59. Local authorities and ICBs are expected to continue to pool pre-existing expenditure on discharge. Where this expenditure is from BCF sources, this should be indicated in the BCF planning template by selecting the appropriate scheme type and subtype in the expenditure worksheet.

Agreement of local plans

60. Areas will need to agree a narrative plan and confirm agreed expenditure and compliance with the requirements of the fund in the BCF planning template. Local

[2] https://www.england.nhs.uk/coronavirus/publication/funding-of-discharge-services-from-acute-care-in-2022-23/

NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans.

61. Final narrative plans, completed planning templates, and intermediate care capacity and demand plans should be submitted by 26 September. Areas are strongly encouraged to submit draft plans (including capacity and demand plans) to BCMs (copied to the BCF team) by 18 August for review and feedback.

62. Narrative plans should reflect how commissioners will work together in 2022-23 to:

- continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally
- set out how the area will make progress against the two objectives set out in national condition 4
- an overview of how BCF funding is supporting unpaid carers (with particular reference to how funding in the NHS minimum contribution to fund carer's breaks and local authority duties to support carers under the Care Act 2014 is being used)
- priorities for promoting equality and reducing health inequalities.

63. Narrative plans will be collected separately to the main BCF planning template. A narrative template has been made available on the Better Care Exchange site, but areas can use their own formats.

64. Intermediate care capacity and demand plans need to be submitted alongside main BCF plans but will not be subject to BCF assurance.

BCF planning template

65. The planning template will continue to be used to collect expenditure details, confirmed funding contributions and confirmation that planning requirements are met. This will include information on discharge and non-discharge spend, as in previous years.

66. The template will be pre-populated with:

- minimum funding contributions from all mandatory funding sources for each area
- minimum ringfenced amounts from the NHS minimum for:

- the contribution to social care (national condition 2)
- spend on NHS commissioned out-of-hospital services (national condition 3) for each area.

67. The template will calculate spend applicable to each of these national conditions automatically.

68. Areas will need to confirm:

    a. That all mandatory funds have been pooled and agreed.

    b. Scheme level spend by:

        - funding source
        - scheme type and subtype
        - brief scheme description
        - amount of spend in 2022-23
        - area of spend (that is, social care, community health, continuing care, primary care, mental health, acute care)
        - commissioner type
        - provider type.

    c. Performance ambitions for metrics and how BCF activity will contribute to making progress against these metrics.

69. A separate confirmation sheet will collect yes/no confirmation that the following requirements are met:

    - In two-tier local government areas, that DFG funding has either been passed to district/borough councils, or that there is agreement with district/borough councils on the use of any retained grant.
    - Funding for reablement, Care Act 2014 duties and carers breaks has been identified in spending plans and the BCF narrative plan sets out the approach to supporting unpaid carers through the BCF (see paragraph 62).

70. The specific scheme types and subtypes were updated in 2021 to collect better information on how BCF funding streams support discharge. This information will support future policy development and areas should aim to record these scheme types as accurately as possible in their spending plans.

71. When completing the BCF planning template, areas should, as far as possible, avoid classifying scheme types as ‘other’ where a specific scheme category can be used. The clarity of this information is important in being able to account properly for the effective use of the funding pooled into the BCF. Areas may be asked for further information on spend classed as 'other’ through the assurance process.

Metrics

72. The BCF Policy Framework sets national metrics that must be included in BCF plans in 2022-23. The metrics for the BCF in 2022-23 are:

- proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)
- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes)
- unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)
- improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence).

Please see Appendix 3 for further detail.

73. Ambitions should be agreed between the local authority and ICB(s) and signed off by the HWB. The BCF planning process will also collect rationales for the ambitions set for each metric, plans for achieving these ambitions and how BCF funded services will support this.

74. The metrics tab in the BCF planning template has been updated to include two narrative sections; ‘rationale for ambition’ and ‘local plan to meet ambition’. The first of these should be used to detail how the target has been arrived at (including analysis of historical data) and expected impact of planned funding (including the impact of previous investment). The second should outline the local plan for improving performance against each metric, including changes to commissioned services, joint working and how BCF funding will support this.

75. Baseline data on discharge and unplanned admissions for ambulatory care sensitive conditions will be made available on the Better Care Exchange. Hospital trusts, local authorities and ICBs should work together to continue to improve the use of situation reporting and other data to understand flow.

76. Ambitions for 2022-23 as a whole should be set based on:

- current performance (from locally derived and published data)
- local priorities, including COVID-19 recovery
- expected demand
- planned (particularly BCF funded) services and changes to locally delivered services based on performance to date.

Discharge metrics

77. Local systems should agree a plan to improve outcomes across the HWB area for the proportion of people discharged home using data on discharge to their usual place of residence.

78. The ambition should be developed with NHS trusts and foundation trusts. The ambition should be stretching and should build on performance from 2021-22.

79. From April 2022, the discharge ready date filed in hospital patient administration systems has become a required field and will be used to collect the date a person no longer meets any of the criteria to reside. From 2023, this data will be used as a basis for a metric linked to delayed discharge, as long as the data is robust and can be published. During 2022-23, systems should work together to improve data collection rates and quality with a view to being able to agree plans for performance on delayed discharge from April 2023. The measure of the percentage of acute hospital stays that are 14 days, or 21 days or over has been removed as a core metric for 2022-23, although length of stay remains a priority. Therefore, data on length of stay will continue to be made available on the Better Care Exchange for local areas and will continue to be monitored regionally and nationally with BCF support provided for areas facing the greatest challenges.

Assurance

80. Assurance processes will confirm that national conditions and planning requirements are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed.

81. Assurance of final plans will be led by Better Care Managers (BCMs) with input from NHS England and local government representatives. It will be a single stage exercise based on a set of key lines of enquiry (KLoEs).

82. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region. The purpose of the cross-regional calibration session is to:

- share the position on BCF plan assurance status across each of the seven regions
- provide confidence that the scrutiny during plan assurance has been consistent
- identify any variations between regions and discuss the approach taken to preserve consistency
- identify concerns that require clarity from outside the attendee group and determine next steps.

83. Following the calibration meeting, recommendation for approval will be made by NHS England regional directors – this will include confirmation that local government representatives were involved in assurance and agree the recommendations. NHS England will approve BCF plans in consultation with DHSC and DLUHC. NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released.

Table 1: BCF assurance categories

Category	Description
Approved	• Plan agreed by HWB • Plan meets all national conditions and planning requirements (including but not limited to the requirement to submit an intermediate care capacity and demand plan)

	• Agreed ambitions for BCF metrics are sufficiently stretching • Agreement on use of local authority grants (DFG and iBCF) • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions • Area has submitted an intermediate care capacity and demand plan
Not approved	• One or more of the following apply: – plan is not agreed – one or more national conditions are not met, taking into account the associated planning requirements – no local agreement on use of local authority grants (DFG and iBCF). – no intermediate care capacity and demand plan submitted

84. Where plans are not initially approved, the BCF team may implement a programme of support, with partners, to help areas achieve approval as soon as possible or consider placing the area into formal escalation.

85. Escalation will be considered in the event that:

- the ICB and the local authority are not able to agree and submit a plan to their HWB; or
- the HWB does not approve the final plan; or
- the NHS England regional director does not recommend a plan for approval.

86. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. This will initially be a regional process, facilitated by the BCF programme and team. If regional escalation is not able to address the outstanding planning requirements, senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to a national escalation panel meeting to discuss concerns and identify a way forward.

87. In instances where an area is unable to agree a compliant plan following a national escalation panel with support from BCMs and external advisors commissioned by the BCF team, NHS England, in consultation with departments, will consider enforcement action, including directing the use of the NHS funds under the NHS Act 2006.

Monitoring and continued compliance

Updating BCF plans in year

88. It is recognised that areas may wish to amend plans in-year, following sign off and assurance, to:

- modify or decommission schemes
- increase investment or include new schemes.

89. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the local authority and ICBs and continue to meet the conditions and requirements of the BCF.

90. In both cases, revisions to plans should be approved by the HWB and confirmed in the end-of-year reporting template with an accompanying rationale. If the need arises to amend BCF plans in-year, please contact the relevant BCM in the first instance.

Monitoring compliance with BCF plans

91. BCMs and the wider BCF team will monitor continued compliance against the national conditions through their wider interactions with local areas.

92. Where an area is not compliant with one or more conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan and risk the national conditions being unmet, then the BCF team, in consultation with national partners, may make a recommendation to initiate an escalation process. Any intervention will be proportionate to the risk or issue identified.

93. The intervention and escalation process could lead to NHS England exercising its powers of intervention, in consultation with DHSC and DLUHC, as the last resort.

Reporting in 2022-23

94. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy-making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

95. These reports are discussed and signed off by HWBs as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into section 75 agreements. Monitoring will include confirmation that the section 75 agreement is in place.

96. Reporting will recommence in 2022-23 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the national conditions of the fund. Timely submission of reports is a requirement for the BCF, including as a condition of the iBCF. Therefore, areas that do not comply with the reporting timescales and detail may be subject to the procedures set out in Appendix 1 on support, escalation and intervention.

Timetable

The timescales for agreeing BCF Plans and assurance are set out below:

BCF planning requirements published	19/07/2022
Optional draft BCF planning submission (including capacity and demand plan) submitted to BCM and copied to the BCF team (england.bettercarefundteam@nhs.net)	18/08/2022
BCF planning submission from local HWB areas (agreed by ICBs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercarefundteam@nhs.net	26/09/2022
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	26/09/2022 - 24/10/2022
Regionally moderated assurance outcomes sent to BCF team	24/10/2022
Cross-regional calibration	01/11/2022
Approval letters issued giving formal permission to spend (NHS minimum)	30/11/2022
All section 75 agreements to be signed and in place	31/12/2022

Appendix 1: Support, escalation and intervention

1. Where performance issues or concerns over compliance with the requirements of the BCF are identified, the BCF team and BCM will take steps to return the area to compliance. Broadly this will involve the following steps:

1. **Trigger:** a. Concern during planning process that a compliant plan will not be agreed b. BCF plan not submitted c. BCF plan submitted does not meet one or more planning requirement (eg requirement to submit an intermediate care capacity and demand plan) d. Area is no longer compliant with their approved plan (in year)	The BCM and regional partners in consultation with the BCF team will consider whether to recommend specific support or if the area should be recommended for escalation. Initially support may be appropriate or a defined timescale set for the issue to be rectified.
2. Informal support	If appropriate, the BCM will work with the area to advise on the issue and consider, with local leaders, what further support may be provided. This may include support through regional NHS or local government structures. Alternatively, it may be decided that it is appropriate to move straight to formal support or a formal regional meeting.
3. Formal support	The BCM will work with the BCF team to agree provision of support.
4. Formal regional meeting	Areas will be invited to a formal meeting with regional NHS and local government representatives and the BCF team to discuss the concerns, plans to address these and a timescale for addressing the issues identified.

5. **Commencing escalation** as part of non-compliance	If, following the regional meeting, a solution is not found or issues are not addressed in the timescale agreed, escalation to national partners will be considered. If escalation is recommended, BCF national partners will be consulted on next steps. To commence escalation, a formal letter will be sent, setting out the reasons for escalation, consequences of non-compliance and informing the parties of next steps, including date and time of the escalation panel.
6. **Escalation panel**	The escalation panel will be jointly chaired by DLUHC and DHSC senior officials, supported by the BCF team, with representation from: • NHS England (as the accountable body for NHS spend and for plan approval) • The LGA, in its role as a national partner for the BCF. Representation from the local area needs to include the: • health and wellbeing board chair • accountable officers from the relevant ICB(s) • chief executive from the local authority.
7. **Formal letter and clarification** of agreed actions	The local area representatives will be issued with a letter summarising the escalation panel meeting and clarifying the next steps and timescales for submitting a compliant plan. If support was requested by local partners or recommended by the escalation panel, an update on what support will be made available will be included.
8. **Confirmation** of agreed actions	The BCM will track progress against the actions agreed and ensure that the issues are addressed within the agreed timescale. Any changes to the timescale must be formally agreed with the BCF team.
9. Consideration of **further action**	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious, then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: • agreement that the escalation panel will work with the local parties to agree a plan

	• appointment of an independent expert to make recommendations on specific issues and support the development of a plan to address the issues – this might be used if the local parties cannot reach an agreement on elements of the plan • appointment of an advisor to develop a compliant plan, where the escalation panel does not have confidence that the area can deliver a compliant plan • directing the ICB, eg regarding its use of resources. The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.

2. If an area fails to develop a plan that can be approved by NHS England, or if a local plan cannot be agreed, any proposal to issue directions will be subject to consultation with DHSC and DLUHC ministers. The final decision will then be taken by NHS England.

3. The escalation panel may make recommendations that an area should amend plans that relate to spending of the DFG or iBCF. This money is not subject to NHS England powers to direct. However, a BCF plan will not be approved if there is no agreement between health and local government partners on the use of these grants (a requirement of national condition one). Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue not to be met.

Appendix 2: Querying baseline for social care maintenance contributions

1. Required contributions to social care from NHS minimum contributions at HWB level have been calculated from locally agreed figures assured in 2016/17 BCF plans, uprated in line with growth in that area's ICB contribution in each subsequent year.

2. In 2022-23, if local areas believe that this baseline is not correct, they will be able to request that it be reviewed. A review can only be requested where the baseline is not correct because historical schemes have been incorrectly coded. A review can be requested because the current baseline overstates or understates social care spend.

Process

3. Areas should inform their better care manager (BCM) if they believe that the baseline for maintaining social care spend is incorrect, setting out their reasoning, confirming the miscoded schemes and any supporting documents. Areas must confirm that both the relevant ICB(s) and local authority(ies) agree that the baseline is not correct, and the HWB supports the request..

4. The query and supporting evidence will be reviewed by the BCF team with the BCM. Recommendations for amending a baseline will be made to the BCF Programme Board. If the BCF Programme Board agrees to amend a baseline, areas will be notified as soon as possible.

Appendix 3: Detailed definitions of BCF metrics

Metric 1: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Overarching measure: delaying and reducing the need for care and support.
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups admission to residential or nursing care homes can improve their situation.
Definition	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital. **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework NHS Digital (SALT) Population statistics (ONS)
Reporting schedule for data source	Collection frequency: annual (collected April to March) Timing of availability: data typically available 6 months after year end.
Historical	Data first collected 2014-15 following a change to the data source.

Metric 2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

Outcome sought	Delaying and reducing the need for care and support. When people develop care needs, the support they receive is provided in the most appropriate setting and enables them to regain their independence.
Rationale	There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, to minimise their need for ongoing support and dependence on public services. This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from SALT collected by NHS Digital. **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).

	The collection of the denominator will be between 1 October and 31 December. This data is taken from SALT collected by NHS Digital Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework
Reporting schedule for data source	Collection frequency: annual (although based on 2 x 3 months of data – see definition above) Timing of availability: data typically available 6 months after year end.
Historical	Data first collected 2011-12 (currently five years' final data available: 2011-12, 2012-13, 2013-14, 2014-15 and 2015-16).

Metric 3 Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Outcome sought	Improved health status for people with chronic ambulatory care sensitive conditions
Rationale	This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. The numerator is given by the number of finished and unfinished admission episodes, excluding transfers, for patients of all ages with an emergency method of admission and with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema. Because the denominator for the official published measure (mid-year population estimates for England published by the Office for National Statistics (ONS) are only available in June following the end of year in question, baseline data provided in the BCF template shows uses mid-year estimates for 2020-21 as a denominator).
Definition	**Numerator: Unplanned admissions by quarter for ambulatory care sensitive conditions.** Hospital Episode Statistics (HES) admitted patient care (APC). A fuller code and historical data is provided on the Better Care Exchange.
Source	NHS Outcomes Framework

Reporting schedule for data source	Data will be extracted monthly by the BCF team
Historical	Quarterly and annual data from 2003-04 Q1 for all breakdowns

Metric 4 Discharge to usual place of residence

Outcome sought	Improving the proportion of people discharged from hospital to their own home using data on discharge to their usual place of residence.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Maximising the proportion of people who return to their usual place of residence at the point of discharge enables more people to live independently at home. This indicator measures the percentage of discharges that are to a person's usual place of residence.
Definition	**Numerator:** The number of discharges of people over the age of 18, following an inpatient stay, that are recorded as being to a person's usual place of residence. **Denominator:** All completed hospital spells recorded in SUS for people over the age of 18 – calculation on monthly total.
Source	NHS Secondary Uses Service (SUS)
Reporting schedule for data source	Monthly. Data is extracted by the BCF team and updated monthly on the Better Care Exchange. SQL codes are available for systems on the Better Care Exchange.
Historical	Monthly data from 2018-19 Q1 for all breakdowns.

Appendix 4: Capacity and demand planning

Introduction

1. All systems must submit a high-level overview of expected demand for intermediate care and planned capacity to meet this demand alongside their BCF plans. The content of capacity and demand plans will not be assured in 2022-23 but their completion is a condition of BCF plan approval.

2. For capacity and demand planning to work well in an integrated context, there needs to be a joint understanding of the demand for health and social care and a comprehensive picture of capacity.

3. This is the first time that capacity and demand plans have been required through BCF. As far as possible, areas should aim to use their existing data and plans to ensure alignment. For example, using ICS level projections for expected discharges per month and by discharge pathway. Areas can also make use of the Discharge Pathways Model Analytical Tool, available on the NHS Futures site. In both cases, these will need to be mapped to local authority footprints and agreed locally, making use of local management information data.

4. Plans should be agreed between local authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23. Service capacity should cover health, social care and jointly commissioned services. Plans should also consider the full spectrum of care supporting recovery, reablement and rehabilitation, such as from the voluntary and community sector.

5. A template is provided for areas to complete with this information, and guidance for filling this in is provided separately.

Services to be included in plans

6. All local authority and health commissioned intermediate care services, not just those funded by the BCF, should be included in capacity and demand plans.

7. The NICE guidance on intermediate care defines it as "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care". The capacity and demand plans should cover:

   - reablement/short-term domiciliary care to support someone to remain at home following a deterioration, fall, or following a spell in hospital
   - home-based intermediate care, provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists
   - bed-based intermediate care involving therapy, either to recover function and avoid admission to hospital/residential care, or to return home following a spell in hospital
   - crisis response (two-hour response/short term) to prevent hospital admissions.

8. Where the source of demand is to support hospital discharge; this should be broken down by discharge pathway, as defined in the Hospital discharge guidance (2022).

Why capacity and demand?

9. Demand for services changes across a year, but comparing demand data against available resources, allows systems to model future demand and anticipate pressures before they arise. Capacity and demand modelling can help visualise performance and increase the likelihood that demand will be met, through service redesign and efficient use of resources, and help reduce the need for costly measures such as using agency staff and spot purchased provision.

10. The aims of requesting these plans are to:

    - ensure that an integrated approach to capacity and demand planning is happening across health and social care

- improve understanding (locally, regionally and nationally) in systems of how capacity is used and inform commissioning decisions – with a view to increasing use of support in a person's own home where appropriate
- inform nationally commissioned support (particularly BCF support) and policy
- provide insights regarding the potential to improve the impact and outcomes for people who use intermediate care.

Content of BCF capacity and demand plans

11. To develop capacity and demand plans, ICBs and local authorities will need to collaborate with input from providers (NHS trusts and social care providers) to review existing data, including NHS planning returns (this should include estimated discharge activity for 2022-23 and anticipated levels of urgent community response referrals). This should involve the following steps.

12. **Estimated current demand** – as a first step, expected levels of demand for intermediate care from a range of services will need to be reviewed and agreed. There is scope for areas to identify their own referral sources, but this section will likely include:

    - expected episodes of short-term care following community referrals for assessment (eg single points of access, 111, primary care, social workers)
    - current and expected demand for supported discharge by source (ie trust/site); these should draw on ICB-level data on expected discharge activity developed for NHS plans
    - referrals for rapid crisis response, again from data developed for NHS plans.

13. Expected demand levels should be projected on a month-by-month basis. Systems should review historical and current demand to identify the level of demand they will be expecting over this time period. We recommend that systems follow the guidance on the discharge pathways model. This involves:

    – Reviewing referrals that lead to short-term care (demand) by day across a period and ordering these in terms of increasing numbers of referrals.

    – Agreeing a level of demand that should be assumed to happen on a daily basis such that, if capacity were to meet this, it would enable people to commence their care package within the expected timeframe. The discharge pathways model recommends that assumed demand should be the 95th

centile (eg if looked at across 100 days, the 95th centile would be the sixth busiest). Depending on the source of demand, a different threshold may be set.

  - Repeat this for different sources of referral.

14. **Current commissioned capacity** – across health and social care. This will include:

    - service type (eg bed-based/home-based, reablement/rehabilitation)
    - where applicable, discharge pathway. Show pathway 0 discharges with no further support needs as a single service
    - capacity: this should show the number of new referrals the service could normally accept each month
    - for services that accept community and hospital referrals – expected split between discharge and community referrals.

15. **Estimated spend** – the template does not collect detailed spending on intermediate care at a service level, but areas are asked to estimate the total annual spend on intermediate care in the area from:

    - BCF sources – including additional voluntary contributions
    - other funding.

16. This information is being collected to improve understanding of current investment in intermediate care and to support policy development. As with the capacity and demand plans in general, this information will not be subject to assurance or used for performance management.

Narrative

17. Systems will be expected to include a narrative explanation of any assumptions they have made in their plans – for example:

    - changes in demand over winter
    - assumptions about services in scope
    - mapping figures from an ICS onto a local authority footprint
    - data gaps

- support needed, eg to help improve demand modelling or to agree action to reduce capacity gaps.

18. It is expected that, especially this first year, many systems could encounter some difficulty with projecting expected demand because of, for example, masked unmet needs and the impact of COVID-19. This narrative section should be useful for summarising data gaps, limitations and assumptions systems have had to make to complete their plans.

19. The narrative section should also include an overview of expected demand and planned services, likely gaps in provision and any changes as a result of the planning process.

Other sources of guidance

20. Further guidance and advice on capacity and demand planning is available.

- Report for the LGA on developing a capacity and demand model for out-of-hospital care by Professor John Bolton, based on work with seven systems.
- NHS England guidance on capacity and demand modelling for health.
- The Better Care Exchange, where some additional supporting documents including an FAQ will be published.

Contact us:

If you have any queries about this document, please contact the BCF team at: england.bettercarefundteam@nhs.net

For further information on the Better Care Fund, please go to: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/

For more information and regular updates on the Better Care Fund, sign up to our fortnightly bulletin and the Better Care Exchange by emailing england.bettercarefundexchange@nhs.net

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This publication can be made available in a number of other formats on request.

 Publication approval reference: PAR1296

Sheffield Better Care Fund Plan 2022/ 2023

Introduction

Prior to the Covid-19 pandemic the population of Sheffield experienced high levels of complex health and social care needs disproportionately across the city. Many individuals were struggling with poor health and wellbeing and the concerns of day-to-day life did not enable an environment that promoted prevention. The impact of the Covid-19 pandemic has exacerbated this situation and placed pressure on services and resources within the system to deliver in increasingly challenging conditions.

Sheffield City has a strong history of partnership working to meet these challenges and the existing links between partners were further developed across the city with strong relationships being required to deliver strong health and social care services to keep the population safe. In 2019 Sheffield developed a partnership of organisations, the Accountable Care Partnership, now Health and Care Partnership to develop a Sheffield Partnership Plan to ensure a dynamic approach to meeting the needs of the population were achieved. Building in the needs and learning from the pandemic a recent iteration has been undertaken which allows commissioning organisations to feed the additional information found through the engagement with services and the public into their commissioning intentions.

At each stage all the Sheffield Partners, including voluntary and community organisations and public service users, have been involved in formulation of the overall delivery Plan for Sheffield – Shaping Sheffield. The documentation and an overview of the process undertaken can be found at the following link Our plan for 'Shaping Sheffield' - Sheffield Health and Care Partnership (sheffieldhcp.org.uk).

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

In writing this narrative to the underlying plan contributions have been made by the following services and teams:

Health and Care Partnership Organisations:

ICB Sheffield Place: Commissioners for Community Services, Acute Services, Mental Health Services, CHC and On-Going Care support, Discharge and Primary Care Services.

Sheffield City Council:

Adult Social Care, Housing Services, Adaptations, Housing and Health Team, Equipment Commissioners, Care and Support Services, Reablement Services, Advocacy Commissioners, Vulnerable People’s Services, People Keeping Well/Resilient Communities Team.

Voluntary, community and social enterprises (VCSE) Partners:
Voluntary Action Sheffield, Healthwatch, Sheffield Churches Council for Community Care (SCCCC) and Sheffield Carers.

Business Intelligence and Data:
ICB Sheffield Place, Sheffield City Council and Sheffield Teaching Hospitals NHS Foundation Trust (STHFT).

The Health and Care Partnership has undertaken the role to support system wide engagement in the development and delivery of our plan, in particular reinforcing the role of our VCSE and non-statutory partners. (Public Pack)Agenda Document for Sheffield Health and Wellbeing Board, 23/06/2022 14:00 – from page 115.

Executive Summary
2022-23 has been a transitional year for the Sheffield system with the ending of Covid restrictions leaving a legacy of an increase in health inequalities and poverty within the city, driving growing needs for health and social care provision. Nationally the focus has shifted to increasing access to primary care services and volumes of elective care delivery to reduce the backlog in health referrals. While rising to these challenges Sheffield has worked hard to build sustainable and cost-effective services. These services are transforming to meet the increase in need, within a reducing financial envelope and challenges with recruitment and retention within the workforce. Whilst system flow and the need for timely discharge remain a priority in the Sheffield system, more emphasis is being placed upon joined up pathways and shared accountability for the population health outcomes. It is acknowledged at all levels that services must work together, be person-centred and be able to be tailored to meet both health and social care needs to deliver the best outcomes for the population.

The transformation work has been set within the changing political landscape and while structures within the two commissioning organisations were taking place, CCG to ICB and LA Cabinet to a Committee structure. As part of this process the system is taking the opportunity to reviewing the direction of Health and Social Care and the overall vision for Sheffield, captured within the Shaping Sheffield Plan, has been refreshed to reflect the evolving position of the city.

Alongside the Better Care Fund and Joint Commissioning environment the Health and Care Partnership was developed to bring together the key system partners into one collaboration working together to ensure the best possible outcomes for the citizens of Sheffield.

The Better Care Fund programmes are aligned to delivering the Sheffield System priorities which for 2022-23 have been agreed as:

- respond to the COVID-19 pandemic and the subsequent unmet demand within the system.
- reduce health and social care inequalities across Sheffield.
- focus on improving access to and availability of health and care services.
- ensure all children across Sheffield have the best possible start in life.
- improve the support and treatment for your mental health and wellbeing.

- ensure that health and social care support is personalised to needs.

Since the submission of the 2021-22 Better Care Fund plan the key focus of the Sheffield system has been reshaping services, pathways and provision to remove blockers to delivery. Services are being reviewed to align with the locality and primary care network footprint to ensure they are proactive to the specific needs of the users and adaptable to the demand in each part of the city. This is being done as a collaboration with system partners, including service users and other stakeholders, both internal and external to statutory organisations. A number of the stakeholders have been instrumental in the formulation of this narrative update and are acknowledged in the above section.

The change in organisational structures has allowed a reassessment of the process of joint commissioning intentions to make them more ambitious and allow them to be fully embedded in every decision made by the partners. This has then fed into the Sheffield Outcomes Framework, which at each stage is being co-produced with system partners and is the basis of all contracting decisions and the measure of successful services. It aims to be a framework which can be managed at a service level but also tailored to allow patient centred care to be delivered.

Adopting a personalised outcomes approach to commissioning allows the identification of the assets within the city and how best to utilise them to support people, services, and providers. The learning from the Covid-19 pandemic around the importance of wrap around care and support networks has been embedded within the recent review of carer support, highlighting the importance of the wellbeing outcomes for those who look after and advocate for our population as well as the statutory service users themselves.

The short-term commissioning service reviews have focused upon how best to support the most vulnerable within the city, preventing health deterioration where there were pre-existing conditions, enabling self-care to delay health and social care requirements with wrap around support that can be tailored to an individual, and overall maximising the outcomes achieved by the system resources.

Governance
The Governance Structure across Sheffield is overseen by the Sheffield Health and Wellbeing Board. They delegate oversight to the Executive Management Group who in turn task Executive Management Group Working Party with delivery and co-ordination of the Better Care Fund Programmes.

Executive Management Group (EMG) membership is derived from the two Sheffield Commissioner organisations, ICB Sheffield Place and Sheffield City Council. EMG is responsible for the development of commissioning strategies within the overall direction set by the Health and Wellbeing Board. It is also responsible for the implementation of agreed commissioning strategies, oversight of service. The functions of the Group are undertaken in the context of increasing quality, efficiency, productivity and value for money and removing administrative barriers. A number of the responsibilities of the Group are to satisfy requirements within the Section 75 Agreement. Each member of the EMG shall be an officer or Member of one of the Partners and will have been appointed by the relevant Partner to carry out its role and responsibilities.

Executive Management Group Working Party (EMG WP) shall ensure that it progresses the functions delegated to it from EMG. It provide assurance to Executive Management Group (EMG) on all the responsibilities delegated to it and updates/reports and recommends specific actions, ie; proposed business cases for areas of service integration and transformation; on-going review of performance; review budget variations to ensure proposals do not destabilise the health and social care system; oversee delivery of the details programme of work to achieve the aims of the Pooled Fund and identify areas where performance is off-track; interdependencies between workstreams where delivery of one scheme is affecting another and suggest actions to correct performance; prepare reports for partner organisations including Health and Wellbeing Board (HWBB); review the adequacy of non-financial contributions to each individual scheme; provide detailed scrutiny of the financial and operational performance of the Pooled Fund; complete quarterly and annual returns in accordance with BCF planning requirements. Members are officers from South Yorkshire ICB Sheffield Place (SYICB) and Sheffield City Council (SCC) and are appointed by the relevant partners to carry out its roles and responsibilities.

The terms of reference for each group are included within the following files:

EMG WP Terms of Reference Review Sep

EMG Terms of Reference Nov 2021.p

Approach to Integration

Sheffield's commitment to co-production and collaborative working has been further cemented by the agreement of Joint Commissioning Intentions, ensuring sustainable service delivery, transformation and improvements to continue to be implemented against a backdrop of continued cases of Covid-19, implementation of the elective recovery plan and structural changes with the local council and NHS organisation.

The overarching principle is that everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are and - when they need it - they receive care and support that prioritises independence, choice, and recovery.

The high-level priorities identified for 2022-23 can be found within the following document which was reported at the CCG Governing Body in May 2022.

22 23 joint Commissioning Plan (

Joint Priorities in 2022-23:

- respond to the COVID-19 pandemic and the subsequent unmet demand within the system.
- reduce health and social care inequalities across Sheffield.
- focus on improving access to and availability of health and care services.
- ensure all children across Sheffield have the best possible start in life.

- improve the support and treatment for your mental health and wellbeing.
- ensure that health and social care support is personalised to needs.

To deliver the Sheffield Joint Commissioning Intentions a Joint Commissioning Committee and Development Group were established:

Joint Commissioning Committee (JCC) the purpose of the Committee is to bring a single commissioning voice to ensure new models of care deliver the outcomes required for the city. The Committee will support SCC and SCCG to deliver national requirements, including but not limited to the NHS Long Term Plan, Social Care Green Paper and Spending Review. The Committee will ensure, in the first instance, delivery of outcomes in the three priority areas of focus; Frailty, Send and Mental Health. The JCC is a meeting of the Council Cabinet and ICB Sheffield Place's Governing Body representatives with the purpose of agreeing joint health and social care commissioning plans for the City. In discharging this, the Committee does not have any direct decision-making powers delegated to it: all decisions will still be ratified separately in accordance with statutory requirements; however, by meeting jointly the joint decision making will be simplified. Any future delegations would have to be agreed by SCC and ICB Sheffield Place. The Committee is also authorised to create working groups to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group. The existing Executive Management Group officers will report to and support the Joint Commissioning Committee. The Committee shall strengthen the way that we commission health and social care together. In particular, the Committee shall focus on; i) giving a single commissioning voice; ii) Single commissioner plan; iii) ensure new models of care deliver the outcomes required by the city; iv) building on Better Care Fund and Section 75, driving forward change.

The Terms of Reference for the JCC and the Development Group are included within the following file:

JCC ToR June 2021.pdf

Paper B - Joint Commissioning Devel

During 2022/23 Sheffield City Council has transitioned from a cabinet to a committee structure and NHS Sheffield CCG has become ICB Sheffield Place as part of South Yorkshire ICB. This has presented an opportunity to take stock of the joint commissioning arrangements embedded to date, in particular:

- Ensure we keep the good joint working, learning and progressed made to date but that we are jointly facing challenges such as financial risk and work force pressures.
- Ensure that we understand the distinction between JCC and HCP arrangements in the new context and look where links can be strengthened, and potential duplication removed.
- Consider how we continue to align the commissioning tole the council still has alongside NHS new focus on strategic planning

The following documents set out the terms for the ACP, now titled HCP, Executive Delivery Group and Accountable Care Partnership Board. The meetings were changed during the Covid-19 pandemic to reflect the city's command and control response and are being updated as described above.

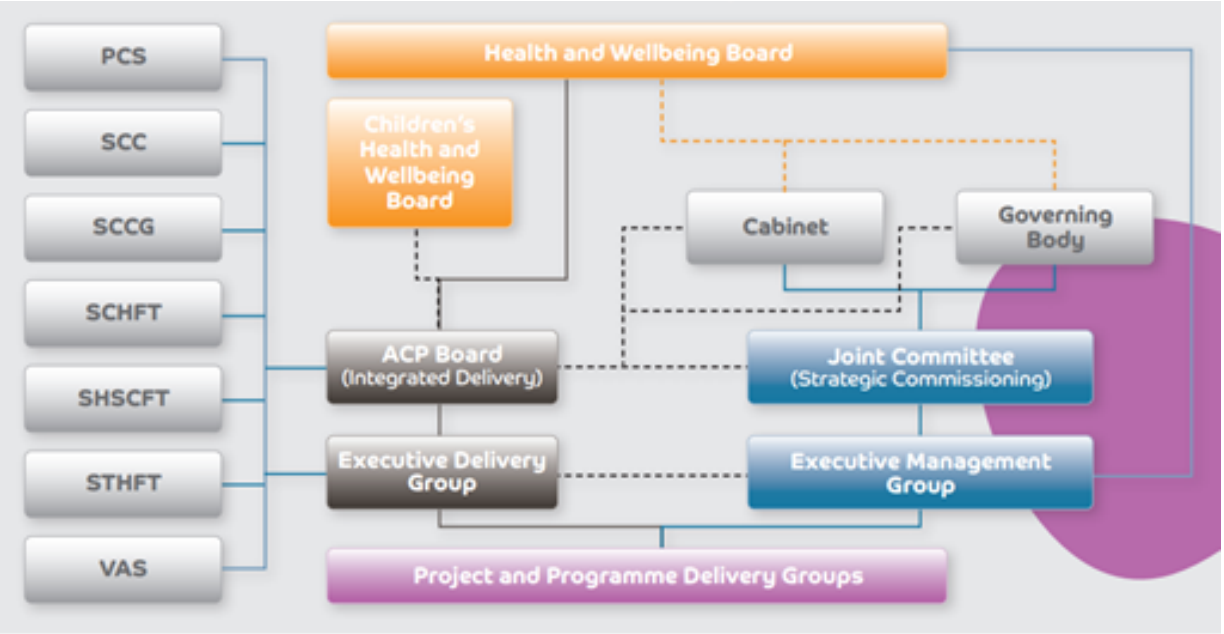
ACP Board T of R FINAL.pdf

Update to Terms of reference ACP.pdf

Terms of Reference ACP EDG .pdf

The aim of this city partnership is to ensure all services are targeted to need, responsive, transformational and co-produced with all stakeholders. This means involving all parties at the outset to identify and understand the needs of the Sheffield citizens and look at the most effective way to meet that need.

Therefore, in parallel to the joint commissioning work streams, the Health and Care Partnership structure looks at delivery of longer-term transformational plans which require all system partners working together to deliver. The governance structure of the Partnership is captured within the following diagram alongside the BCF structure.



Our planning and delivery plans also take into account that non-statutory partners, VCSE and citizens remain at the forefront of delivery of safe and high targeted quality services, with recognition that partner organisations and Providers are facing the same challenges in terms of financial resilience, capacity within services, workforce shortages and fatigue alongside increasingly complex care requirements. Voluntary Action Sheffield represent these organisations as part of the Health and Care Partnership.

The key changes in 2022-23 have focused upon moving away from the reactive command and control commissioning which was necessary during the height of the Covid-19 pandemic to sustainable commissioning which aims to make services more streamlined for users, removing duplication of contacts, improving reporting and reducing blocks to the system.

Sheffield's Better Care Fund goes beyond the minimum required contributions to include services where there is benefit from a joint commissioning focus and application of the Better Care Fund principles will drive sustainable services and efficient use of the limited system resources. Work is underway and reassess the themes and pathways within the programme to ensure with the aim of expansion of the current fund and risk sharing arrangements.

The Joint Commissioning Office team has also been expanded in year to recognise the broadening of the joint ambitions and scope of the workload. The team now includes additional dedicated programme management support, a role focused upon the development and monitoring of the outcomes framework and a medicine's management role to offer pharmaceutical advice and support to community staff and carers, where skills in this area were identified as a reason for low retention rates within these staff groups.

The development of the outcomes framework has been a great success in year. More information around the development of the outcomes framework is described in the file embedded within page 5 of this narrative. The Outcomes Framework Steering Group has been established to ensure co-production and delivery of the outcomes. The terms of reference and membership can be found in the following file:

Final TOR Sheffield Health and Wellbeing

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

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

The principles from the Sheffield Adult Social Care Strategy being applied at each step of this redesign process are:

- Support people to live a fulfilling life at home, connected to the community and resources around them, and provide care and support where needed.
- Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis.
- Provide care and support with accommodation where this is needed in a safe and supportive environment that can be called home.
- Make sure support is led by 'what matters to you,' with helpful information and easier to understand steps.
- Recognise and value unpaid carers and the social care workforce, and the contribution they make to our city.
- Make sure there is a good choice of affordable care and support available, with a focus on people's experiences and improving quality.

To avoid duplication within this narrative the Sheffield approach to personalised care is included within the update of meeting national condition four and the links with housing services is included within the update of the delivery of the DFG.

Personalised Care

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

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

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

The Principles that Underpin 'Person Centredness

Asset based: knowing that people and communities are resourceful. Building on what skills are already there. Focusing effort on searching out and developing strengths. An example of this is capture within the embedded document which shows the City's approach to building, supporting and maintaining resilient communities.

Resilient
Communities Overvie

Population Health Information contributions to the design of services to meet the current needs of the demographic as well as to extrapolate expected future need requirements and to ascertain if any impact is being evidenced of preventative work already in place.

Enabling and Engaging: making it easier for people do for themselves, or 'work with'. Avoiding 'doing to' unless absolutely essential (we recognise that there are situations where 'doing to' is most appropriate). The ethos of "What matters to you" is embedded across our health and social care partners with the lead for the city being a GP who also holds a role within our main provider FT. This has allowed the message to be a key part of the PCN and locality development with ARRS social prescribing and our People Keeping Well services applying the principle.

Personalised: any support is tailored to the person's context to help build capabilities. This means we must be able to understand people's strengths and where they need additional support and a personalised response. The Sheffield Team Around the Person Service is multi-organisational, multidisciplinary and makes use of public health data to identify measures which can be put in place to prevent likely outcomes. This is also linked to the Ageing Well workstreams, enhanced care in care home, the falls prevention service, community AHP services and EOLC support where appropriate.

System Focused: we look at the whole picture as a city, for example strategy development, policy choices, service redesign, recruitment procedures; and use coproduction, connections, and community knowledge and expertise to improve quality of life and wellbeing for everyone. The aim is for one consistent message is shared across all our meetings, partners and staff groups to ensure the culture in Sheffield is reflective of the overall strategic vision and system

priorities. Alongside the core BCF and HCP structures sub-groups with representation from across the partners are held to support this aim. For example, the Workforce, Culture and Leadership and Community of Interest Group, NEY Personalised Care Board has representation behalf of SY ICB and Sheffield Compassionate City Board.

The benefits of being person centred in Sheffield

- **To People**: Stronger consideration of each person's unique set of strengths and needs. Feels better and helps them to maximise their potential. Great sense of being in control, guiding own destiny.

- **To Professionals**: Better job satisfaction (feeling of doing the right thing), 'joy at work'. For example, co-design of long covid service with experts by experience.

- **To Systems**: Achieves best value from limited resources. Builds trust. Over time can reduce waste. 'Teach a person to fish' approach is more sustainable in medium to long term.

- **To City**: Better quality of life, reduced inequalities, stronger economy (healthier workforce), more sustainable services, positive reputation.

The focus for personalised care over next 12-18 months includes:

Delivery of the national person-centred strategic priorities:

- Embedding a Personalised Care Ethos
- Reducing health inequalities
- Enriching Personalised Care approaches across health and care (SDM, Choice, PCSP, PHBs)
- Workforce Development

Delivery of the 6 key components of Personalised Care:

- Shared decision making
- Personalised care and support planning
- Enabling choice
- Social Prescribing and community-based support
- Supported self-management
- Personal Health budgets

Delivery of the Long-Term Plan Personalised Care Metrics:

- No. of Social Prescribing Link Workers
- No. of Social Prescribing referrals
- No. of Personal Health budgets
- No. of Personalised Care and Support Plans
- No. of workforce that have undertaken personalised care training (including eLearning and accredited training which can be accessed through the Personalised Care Institute)

Other work underway to enable national requirements:

- Strategic co-production: Recruit peer leaders and work collaboratively with them
- Workforce: Support Personalised Care ARRS roles, for example, SPLWs, Care Coordinators and Health and Wellbeing Coaches
- Personalised care is included in digital strategies
- Strengthening Finance contracting and commissioning for Personalised Care

Personalised Care Examples

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

Personalised Care Future Focus

From a health perspective we are above trajectory for all long terms plan metrics in Sheffield however SY MoU includes some challenging stretch targets for all elements and a particular focus is required to achieve for PHB and workforce training.

From a Planned Care perspective inclusion / continuation of personalised approaches in planning and delivery of areas such as virtual ward, hospital discharge pathways, Ageing Well and links with intermediate care, community equipment and adaptations.

Focus on personalised care as an enabler for reducing health inequality and improving population health.

Continue to develop expertise in co-design, co-production in the promotion of building skills, confidence, and expertise within our population with one or more long term conditions to enable greater self-care / self-management as part of our strategic approach to frailty prevention / greater focus on proactive care and prevention

Risks to achieving Personalised Care:

- Lack of maturity in ICB in terms of relationships between commissioners in different places hinders ability to use funding differently.
- Reduced ability to release workforce for training and development due to service pressures and continued higher sickness rates.
- System under pressure puts personalised approaches at risk as takes time to have What Matters to You? conversation, develop care plans with people / families in a truly multidisciplinary and co-produced way.
- Temporary nature of some funding streams means the financial support isn't always available until completion of the work programmes.
- Pace of change required may reduce ability to co-produce / co-design and hinder the ability to involve all partners to an optimum level.

- Limited digital integration is still incomplete across the system. The digital roadmap for Sheffield has been designed but is still in early stages of implementation.

The Active Support and Recovery Better Care Fund Theme also focuses upon services to enable flow and avoiding inpatient admissions. Work programmes include Urgent Community Response, Enhanced Health in Care Homes and Anticipatory Care as part of the wider Ageing Well system offer. More detail of the current position can be found within the following document:

Ageing Well collaborative Group U

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

Discharge Planning

Place system partners work together to ensure plans are developed and implemented to support discharge and care capacity to enable flow. Discharge plans have been developed and aligned to the national hospital discharge and community support guidance operating model and to established elements of the discharge pathways.
Since the pandemic the focus has been to respond to the unprecedented demand on services that provide health and social care for people, to enable a safe and timely return home or move on to another temporary care setting where home is not possible in the short term. This includes:

- **Increased capacity in reablement and intermediate care support**, building on work already underway with partners including trusted assessment.
- **Increased capacity in Independent Sector Support** (home care) including additional capacity for night care and improved processes in the review of patients
- **Increased capacity in Fast Track and provision for End of Life –** including capacity for hospice care and bereavement support
- **Increased capacity in Voluntary Sector Discharge Support** – a wide range of practical support for individuals and support for family cares to ensure people have support on the day they leave hospital and for the days following discharge
  A key partner has been SCCCC who are integrated within the discharge hub and community services delivered by statutory partners. More of the work can be found on their website www.scccc.co.uk and within the following embedded files:

SCCCC presentation at GP PLI Event.pptx

BCF Policy and Planning Q_A webinar

- **Temporary Increases in Bedded Capacity** in care homes to improve flow where home is not a short-term option. The system is undertaking a collaborative review of this service with the aim to re-procurement a new model of support-to-support discharge from September
- **Improvement and Ongoing Development of Arrangements**: Work on processes to reduce delays and improved partnership working around discharge. This is an iterative

process to unblock areas of the system and embed the learning from the Covid-19 pandemic.

Discharge Governance

The governance for the discharge process sits with the system wide group, System Leadership and Partnership working - Sheffield System Discharge Implementation Group (SSIDG)

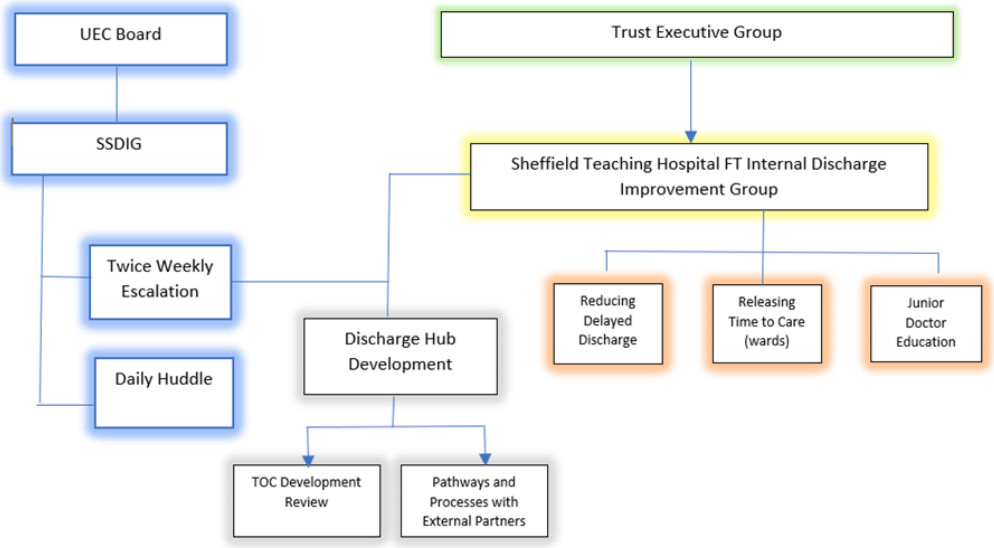
Utilising existing partnership relationship SSDIG was initially set up during the pandemic to streamline the discharge process and ensure delivery and implementation against the new national discharge operating model. As part of the command and control structure the group provide the system with assurance that services were delivered and implemented in line with the agreed city principles and priorities. Following the secession of command and control to deal with the pandemic the group has continued to operate to have oversight of join initiatives and planning and system management of projects that ensure a system wide response to discharge pressures. It has also been responsible for the review of plans and the impact of the additional funding.

The group is represented by statutory commissioning and provider organisations who work closely with Voluntary Sector Partners and includes representation from NHSE. The group report progress and escalations to the System UEC flow board. The relationship can be seen on page 4 of the UEC terms of reference:

DRAFT Terms of Reference Sheffield U

Following changes to the reporting, governance and programme structures during 2022/23 the model will be revisited in detail and updated and expanded as required.

The following diagram gives an overview of the discharge governance in place across the Sheffield system:



Current priorities also include the implementation of the work directed by NHSE:

- The 100-day Acute Discharge Challenge and the work supported by ECIST

- The System Bid (Sheffield's Bid against £250m – work is underway to implement the plans set out in the bids which will include, additional home care capacity and increase temporary care home beds which will reduce a specified number to demonstrate direct reduction in acute beds and any capacity in home care or additional care home beds will be above current baseline. System leads are now developing plans, trajectories, metrics and confirmation of the governance and procurement activity requirements ready for an autumn implementation. This is a key priority for SSDIG partners who will ensure monitoring, oversight and report progress, risks, and assurance back to the UEC Flow Board
- Hospital Discharge Hub Development – ongoing development of the discharge hub and progress of our system and partner work moving forward.
- Current operational Challenges (identified through the Twice Weekly Escalation Meeting 'TWEM'). Work continues around the daily operational challenges and system wide work focussing on the need to increase and maintain capacity across all pathways.
- Complex Needs, work around complex patient pathways is underway linked closely to Mental Health community provision.

Each of the programmes adheres to the principles of the HICM. The following document contains a summary of the position consolidated from updates from the various programmes.

High Impact Change Model Action planning

Supporting Unpaid Carers

Within Sheffield the Carers services are commissioned by Sheffield City Council as part of their lead role for contracting prevention, support and people keeping well services, many of which are with the voluntary and charity sector.

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

The main offer to Carers' is commissioned with the Sheffield Carers Centre as a familiar face in the city. Individuals in need of support do not always feel able to be open with a statutory organisation until the point of crisis. They undertake the Carer Assessment, a requirement of the Care Act 2014, which is designed to understand the role of the carer and signpost to resources tailored to the individual's circumstances. More detail can be found at the following link Carer's Assessment | Sheffield Carers Centre. While the Covid-19 pandemic has made contact with individuals more complex it has proven to be more vital than ever, as many other support networks, such as friends, family, clubs or social events were cancelled. For those able to access online services this offer has been enhanced to maximise contact with those who require support. The Sheffield Carers Centre offer a range of services alongside those commissioned by the council to fully support the needs of Adult Carers. These include:

- **Carers Advice Line:** for 1:1 personalised expert information, advice and support on anything related to your caring role. One of the Carer Advisors is an Urdu/Punjabi speaker, and the service use an interpretation service for other languages.
- **Carer Card:** that gives discounted activities, services and products and space to write two emergency contact numbers.
- **Group activities and workshops:** that meet carers' support needs and provide opportunities for carers to meet each other.
- **Community Connect:** 1:1 telephone support for carers who are isolated.
- **Carers Café:** for social contact with other carers.
- **Carers support groups:** up to date information about all the groups in Sheffield.
- **Carers Enews! for regular up to date information:** Carers who do not have email receive an annual update letter.
- **Information and resources:** can be found on the website of Sheffield Carers Centre.
- **Emergency Planning:** Information and guidance around making preparations to ensure that the person/s you care for are looked after in an emergency.
- **Time for a Break grants:** Small grants to help you in taking a break. As part of a Carers Assessment, the service assesses if this is something you're eligible for.
- **Digital Resource for Carers:** providing information, eLearning, resources, and the Jointly app.
- **Legal Advice Clinic:** Free 30-minute individual legal advice sessions with a legal expert, offering advice around things such as wills, estate planning and power of attorney.

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

As part of the BCF Theme 4 – Mental Health - a carers wellbeing course is also commissioned from Sheffield Health and Social Care FT. This course aims to provide support to family and friends who are adult carers and want to learn ways of managing their own mental and physical wellbeing. The short course helps Carers learn and develop new skills which help build resilience to cope with the demands of a caring role as well as meet a network of people with similar life experiences to draw upon at the end of the sessions.

Alongside the specific services there are other ways in which carers are supported by the city. For example, funded within our BCF PKW Theme programmes, attendance at community groups such as coffee mornings or craft clubs can offer breaks in the day or week to allow carers to undertake normal activities away from their caring responsibilities. Dementia cafes can allow carers to leave their loved ones in a safe space while they go shopping or focus time on themselves. The BCF On-Going Care Theme specifically commissioned packages of respite care can allow a long duration vital break from responsibilities that carers need to avoid deterioration in their own health and wellbeing. Those packages are funded by the local authority IBCF funding except for respite packages for clients with learning disabilities which are commissioned by ICB Sheffield Place.

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

Disabled Facilities Grant (DFG) and Wider Services

The Sheffield Joint Health and Wellbeing Strategy lays the critical foundation for a strong connection with housing, with a priority that:

'Everyone has access to a home that supports their needs'.

The Sheffield Housing Strategy and Homelessness Prevention Strategy are both due to be renewed. They recognise the importance of health and wellbeing in their plans, as well as the relationships needed between the City Council and their local health partners to deliver them.

Leaders within the Health and Wellbeing Board, and their partners in the Sheffield Health and Care Partnership, recognised that further action was needed to integrate housing within the health and wellbeing agendas across the City. They wanted to explore with their local stakeholders how a more central role for housing could be built and delivered in their future plans. A Sheffield Housing, Health and Wellbeing Summit was established to bring these senior stakeholders together to begin exploring areas for shared opportunity and action in September 2022.

In 2019/20 Sheffield amended their local policy around the use of DFG, adaptations and housing to bring the services closer together and streamline the conversation required to effect change. This led to the creation of the Sheffield Adaptations, Housing and Health Service bringing together a team from social care and housing into one team, and the Housing, Health and Care Reference Group who work with colleagues from health services to assess peoples' living environment to ensure they promote safety, independence and enablement. The team will review appropriate use of the DFG for adaptation and equipment where a person isn't a resident in a council property using their four objectives:

- Reduced hospital admissions.
- Earlier hospital discharges.
- Less demand for formal care services.
- Increased independence and wellbeing – discharging the terms of the DFG legislation to help people remain safe and well in their own homes.

The core team within the SAHH are drawn from social care, contracting and AHP backgrounds including specialist OTs, one of whom is embedded within the discharge team at the foundation trust. One of the key changes brought about by policy was for the team to train their own apprentice OTs to ensure continuity of service as the skills are in high demand across the country and have historically proven difficult to recruit and retain. Over the last 12 months the OTs have also worked with health and social care colleagues undertaking reviews of high value intensive packages of home care. These packages were initiated at pace during the pandemic to enable safe discharges and support flow. Working with CHC nurses and social workers the aim is to understand if the clients' needs could be more effectively met by equipment, adaptations, or assistive technologies such as telecare sensors, which would in

turn reduce the requirement for statutory care hours and ease the intense pressure felt by the home care providers.

Spending in this area has increased significantly over the last two years with an overspend on the DFG allocation, in part by the widening of scope of equipment and adaptation available and offered by the service, where evidence could be given that the intervention would be more effective than on going care provision. The cost pressure also recognises the underlying market costs have increased, in some cases double the pre-pandemic levels, necessitating investment by SCC to continue to meet the demand in a timely manner. The reduction in demand has not yet abated as expected following the pandemic backlog being completed. Work is underway to understand changes in practice against the changes in underlying need in the population.

The equipment contracting team, alongside our equipment provider Medequip and VCSE partner SCCCC, have created training for equipment champions who are embedded within enablement, discharge and reablement teams across the city to promote adaptations and equipment before use of care packages or to minimise additional care requirements.
Where homes cannot be adapted or are not suitable to house the equipment required by the individual the wider housing team based at the council will work to identify alternative accommodation to enable rehousing. The team make use of extra care accommodation while rehoming takes place to ensure safety and ensure discharges are not delayed for those in a hospital setting.

The current standard waiting time for assessment by an OT are around 6 months although our target is to carry out an initial assessment within 3 months of receiving the referral and we have plans in place to meet this target.

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

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

All 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.

The following documents are examples of the reviews undertaken by our PKW commissioners of our 17 community partners as part of the assessment of the sector.


PKW Next Steps - DWB response FINAL


PKW next steps questions M&C FINAL


PKW next steps questions SOAR Com

Using local evidence alongside national data the system has been able to identify the following priority areas where health inequalities are more profoundly felt. The key areas are BAME communities; areas of high deprivation and poverty; people experiencing homelessness; people who are experiencing mental health issues; and people who have a learning disability and / or physical disability and impairment.

The common theme which emerges when reviewing these communities is a high level of poverty, which has been exasperated by the Covid-19 pandemic. These groups of the populations are also prone to digital exclusion with high levels of digital illiteracy. The ICB Sheffield Place are leading on a Digital Roadmap which explicitly addresses digital inclusion, digital literacy and digital poverty. One of our outcome measures is that more Sheffield people will be able to use digital and online pathways to meet their health and social care needs.

Alongside this, we are ensuring providers offer face to face care to patients who cannot use remote services; and ensure more complete data collection, to identify who is accessing face to face/telephone/video consultations is broken down by patient age, ethnicity, IMD, disability status etc.

Using the network of organisations within the Health and Care Partnership and the governance structure of the JCC and BCF there are plans for the primary care estate in Sheffield to recognise and support digital inclusion in some of our most excluded communities. The primary care hubs projects being developed as part of the ICS Wave 4B Capital Programme in three primary care networks, City Centre, and SAPA5 and Foundry in the north of the City, will include facilities to enable digital access to health and other services for the local population. A similar approach is being taken in our plans to re-develop void space in LIFT and NHS Property Services premises within the City.

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

(reducing medication errors) and improving access and experience e.g. for people with dementia, physical disabilities. This project was deigned to address feedback from vulnerable people and their carers.

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

The following document gives an example of the types of services under review:

Decision Report
Older People Preventi

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

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

As part of the Better Care Fund On-Going Care Theme are programmes which commission services for our older citizens who live in care homes, who are some of the city's most vulnerable people with complex health and care needs, often with multiple frailty, and including people nearing the end of life. We have used our Better Care Fund in 2022/23 to provide enhanced support to improve the health status of people in care homes, for example dietetics and speech and language therapy to address swallowing issues and improve nutritional status, as well as work on falls prevention (upskilling care home workers).

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

To support our Mental Health Better Care Fund Theme we have developed Local Care Coordination Centres across the City based on the Team Around the Person (TAP) process. The TAP process supports the integration of health (physical and mental) and social care, reduces demand on the acute/statutory services and supports individuals to build their capabilities and resilience. The process focuses on preventing wellbeing problems from becoming more serious, promotes independence and reduces the need for acute hospital and

residential care services. TAP was designed to support the integration of health (physical and mental) and social care and to help co-ordinate personalised support for individuals, who are involved with multiple services, and their needs are at risk of escalating. It is closely linked to our mental health transformation work streams.

To date TAPs have been successful in pilot areas, over 350 referrals have been received and over 40 services/organisations have been involved. Some of the initial key findings are that TAP:

- creates a more accurate assessment of risk and need,
- improves identification of risk, thereby allowing for earlier intervention,
- uncovers multiple previously unmet needs.
- enables a more thorough and driven management of cases and have avoided cases getting ‘lost’ in the system.
- improves standards of care and support and greater scrutiny between professional organisations.
- achieves greater efficiencies in process and resources due to avoiding duplication of services.

In 2022/23 investment has been made for evidence-based changes in the care offered by general practices and networks working within our most deprived populations. This includes extended appointments for patients with the most complex needs to enable a holistic approach to care, and co-location of other groups in PCNs who are able to provide advice and support, such as Citizens Advice within practices.

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Working with you to make Sheffield HEALTHIER

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

Better Care Fund 2021-22 Annual Report

23 June 2022

The Better Care Fund

Working with you to make Sheffield HEALTHIER

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

Better Care Fund

What is the Better Care Fund?

- The better care fund is a national programme that requires Local Authorities and CCGs to pool defined budgets through a section 75 arrangement to support the integration of care.

- In Sheffield our Better Care Fund goes beyond the minimum contributions and our programmes extend to include many other areas of work that benefit from joint decision making and are commissioned through integrated and pooled budgets.

Working with you to make Sheffield HEALTHIER

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

Sheffield Better Care Fund Plan

The Sheffield Better Care Fund Narrative Plan, described how Sheffield commissioners work towards a single budget for health and social care.

Ambitions of the Sheffield Better Care Fund

- Ensure service users have a seamless, integrated experience of care, recognising that separate commissioning can be a block to providers establishing integrated services;
  Achieve greater efficiency in the delivery of care by removing duplication in current services;
  Be able to redesign the health and social care system, reducing reliance on hospital and long-term care so that we can continue to provide the support people need within a reducing total budget for health and social care.

Next steps

- Building on the 2017-2019 narrative plan, the Joint Commissioning Committee will continue to drive forward the development and delivery of the Joint Commissioning plan and Joint Commissioning Intentions.
- Update the governance arrangements and TOR to account for the change to committee structure at SCC and the ending of the CCG and the implementation of the ICB Sheffield Place.
- Strengthen the BCF programmes and realign for post Covid-19 health and social care priorities.
- Recruit to the vacancies within the Joint Commissioning Office to strengthen the support to the Joint Commissioning Committee Executive Management Group, Executive Management Group Working Party and the BCF Programmes.
- Understand the requirements of the BCF guidance when released by NHSE.

Working with you to make Sheffield HEALTHIER

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

What we achieved in 2021-22

- Continued to support our statutory, voluntary sector and independent sector providers through the COVID-19 pandemic, with particular emphasis upon prevention of admission and timely discharge.
- Supported the delivery of the changing infection control, discharge and Covid-19 guidance, enabled prevention of inappropriate admissions to hospital, ensured people remained at home 91 days after discharge and minimised the number of people admitted permanently into residential care.
- Worked together to improve our community equipment and adaptations service, to ensure more people receive equipment they need in a timely manner to remain as independent as possible in their usual residence. In year adaptations, funded via the DFG, exceeded the planned volume as the backlog created by social distancing and shielding was targeted.
- Worked with partner organisations to deliver joined up services for people with Mental Health needs, including crisis cafes and alternatives to A&E for 16–17-year-olds in crisis.
- Increased Mental Health services supporting Minority Ethnic Groups and those experiencing health inequalities across the city, achieving higher than target levels of integration between primary and community services.
- Streamlined our joint assessment and review process to ensure those with ongoing care needs have their needs met and are then reviewed in a timely manner. This has been challenging due to the backlog created during the Covid-19 pandemic, but plans are now in place to ensure all outstanding reviews are completed.
- Worked with partners and Provider organisations to develop recruitment and retention plans designed to stabilise the workforce challenges within the sector.
- Maintained people in a safe location during unprecedented times.

Working with you to make Sheffield HEALTHIER

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

2021/2022 Outturn

NHS Sheffield Clinical Commisisoning Group/Sheffield City Council Finance Report 2021/22- Financial Position for Period Ending 31st March 2022				
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	7,820	7,055	(766)	(9.8%)
Active Support & Recovery	54,383	54,383	0	0.0%
Independent Living Solutions	5,297	5,429	132	2.5%
Ongoing Care	177,383	182,846	5,464	3.1%
Emergency Medical Admissions - STH	70,927	70,927	0	0.0%
Mental Health	121,268	129,495	8,228	6.8%
Capital Grants	5,853	6,451	598	10.2%
TOTAL EXPENDITURE	**442,929**	**456,585**	**13,656**	**3.1%**

The current agreed risk share arrangements state that each organisation is responsible for any financial variances on their individual budget areas. The final year end position shows a £13.656m overspend (CCG £2.476m, SCC £11.180m).

Costs within this report have been adjusted to take into account the spend and funding related to the Hospital Discharge Fund during the Covid-19 pandemic where the costs incurred fall within the scope of the Better Care Fund.

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Sheffield City Council

NHS Sheffield Clinical Commissioning Group

Performance Measures

Metric	Definition	Target		Outturn
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,052.3		764.7
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	**14 days or more (Q4)**	**21 days or more (Q4)**	14 days = 13.6% 21 days = 8.21%
		13.9%	7.6%	
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	96.6%		97.6%
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)	767.6		661.0
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	80.0%		80.5%

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Sheffield City Council

NHS Sheffield Clinical Commissioning Group

Summary of 2021/22 BCF Plan

- 2021/22 continued to be challenging with the ongoing Covid-19 pandemic requirements and the restarting of elective and preventative services.

- The S75 mechanism was used as a way of ensuring cross system working and best use of the resources to maximise outcomes, including from any non-recurrent Covid-19 support funding.

- The finance minimum NHS contribution to community services and social care was retained as requirement and for Sheffield this equated to £45 million of the total Better Care Fund of £443 million closing budget.

- The BCF KPIs were met apart from the 21 days in hospital target that was missed during the 2nd half of March 2022.

- The submission was approved by Dr Terry Hudsen, CCG Governing Body Chair, on behalf the H&WB Board, on 24 May 2022.

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Sheffield City Council

NHS Sheffield Clinical Commissioning Group

2022/23 Financial Planning

- Better Care Fund Planning guidance to be expected in Summer 2022 to clarify scope of the Programme and associated KPIs.
- Reporting focus anticipated to be the reduction of health inequalities across the system.
- NHS funding is being allocated in Q1 to the CCG and Q2 onwards to the Sheffield Place as part of the ICB.
- Minimum funding has been confirmed as: £81.082m
  - NHS Minimum Contribution £47.545m
  - IBCF £28.429m
  - DFG £5.108m
- Additional contributions to the Sheffield BCF: £373.813m.
  - Additional SCC: £114.277m
  - Additional NHS: £259.536m
- **Total Sheffield BCF for 2022/23: £454.895m**

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Sheffield City Council

NHS Sheffield Clinical Commissioning Group

Joint Commissioning Update

- A set of joint commissioning intentions has been finalised and is being developed into an overall strategy plan and delivery programmes.

- Work is underway to co-produce the outcomes framework that will underpin the programme of delivery.

- The S75 agreement is being updated to expand to include the services within the scope of the joint commissioning intentions. For example, inclusion of children's and community services to allow pathways to be redesigned to be all age and multi-organisational.

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Local Government Association

High impact change model

Managing transfers of care between hospital and home

Draft updated for 2020/21

A self-assessment tool for local health and care systems

Contents

1. Introduction

This model was developed in 2015 by strategic system partners, and was then refreshed in 2019 with input from a range of partners including the Local Government Association, the Association of Directors of Adult Social Services, NHS England and Improvement, the Department of Health and Social Care, the Ministry of Housing, Communities and Local Government and Think Local Act Personal Partnership. It has now been updated in July 2020 to integrate emerging learning from responding to the COVID-19 pandemic.

It builds on lessons learnt from best practice and promotes a new approach to system resilience, moving away from a focus solely on winter pressures to a year-round approach to support timely hospital discharge resulting in quality outcomes for people. While acknowledging that there is no simple solution to creating an effective and efficient care and health system, this model signals a commitment to work together to identify what can be done to improve current ways of working. Throughout implementation of the model, achieving the right outcomes for people is key, enabling them, with the right information and advice to make the best decisions about their ongoing care. The model is endorsed by government through its inclusion in the Integration and Better Care Fund (BCF) policy guidance.

The refreshed model

The 2019 review broadly endorsed the High Impact Change Model (HICM) as a positive tool to support the continued reduction of delays in transferring people home from hospital. Respondents asked for more clarity, a strengthening of focus on the person, and greater emphasis on the key Home First and discharge to assess policies. The resulting refresh therefore consists of a number of additional components including:

1. I and We statements: these expand on the impact of the changes from the perspective of the person or worker supporting them; these were chosen from Think Local Act Personal's Making it Real framework, and their usage is supported by the National Coproduction Advisory Group.
2. Tips for success: in addition to the outcomes in the maturity matrix and are often key principles.
3. The maturity levels are more focused on outcomes for both the system and people: these will not all match every system, but are intended to reflect what the changes should feel like.
4. Expanded links to supporting materials, including up-to-date case studies and fuller papers on certain changes.
5. The whole-system response needs to support a hospital 'place-based approach', enabling local systems to develop creative solutions which meet local demand and capacity. A shared understanding of performance underpinned by an agreed set of metrics to create a single version of the truth will help to achieve this.

2019 REVIEW OF THE HICM

As the model has been in use for several years, it was felt a refresh of its effectiveness was appropriate. This included a review of a wide range of materials, as well as consultation events to invite views from those using the tool. The evidence gathered included:

- Feedback from nine consultation events in each local government region, gathering reflections of over 550 colleagues from across health and local government.
- Online questionnaire asking for reflections on the model, completed by 44 respondents.
- Performance and reporting data, such as on implementation of the tool from BCF quarterly reports.
- Work of partner organisations and various regional projects underway to develop HICM support and collate good practice at a more local level.
- New sector research, quick guides and guidance (links to some of these materials are at the end of the introduction).

2. Purpose of the model

This HICM aims to focus support on helping local system partners to improve health and wellbeing, minimise unnecessary hospital stays and encourage them to consider new interventions.

It offers a practical approach to supporting local health and care systems to manage the individual's journey and discharge. It can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to improve flow throughout the year.

The original model identified eight changes which will have a significant impact on effective transfers of care; we added an additional change in the refresh; these are:

- early discharge planning
- monitoring and responding to system demand and capacity
- multi-disciplinary working
- home first
- flexible working patterns
- trusted assessment
- engagement and choice
- improved discharge to care homes
- housing and related services (added in 2019)

The new change was created in response to feedback about the importance of home-based support in facilitating discharge, and includes the use of effective housing, home adaptations and assistive technology services. The change is focused on what is needed in terms of the 'living environment' in order to enable a safe and effective discharge.

Respondents to the review also asked for the model to extend to cover admissions avoidance and other preventative actions. This is being developed by national partners as a separate good practice tool. This new tool will seek to identify actions which delay, divert or prevent the need for acute hospital and statutory care, and instead increase focus on maximising people's independence and helping to keep them well in their usual place of residence.

3. Principles

This model is not designed to be a performance management tool. Instead, it takes as its starting point a recognition that even the best-performing systems can experience challenges in relation to hospital discharge. Its inclusion as a national condition in the BCF is intended to support implementation of good practice, rather than to performance manage local systems.

The model is underpinned by a sector-led improvement approach which emphasises the importance of triangulating both hard and soft types of data and insight to tease out local stories within a culture of openness and trust. It reinforces the values set out in The Ethical Framework for Adult Social Care, written in response to COVID-19. This model supports genuine, honest reflection and discussion between trusted colleagues within local health and care systems and includes a suggested action plan so that decisions arising from conversations using the model can be implemented.

There are a number of overarching principles that underpin the model:

Home First is an approach which expects people to return home as the preferred option, rather than end up by default in bed-based care. Discharge to Assess (D2A) enables this approach through a single point of access building on the successful joint working developed during the COVID period.

- A hospital is not the right environment for people to make long-term decisions about their ongoing care and support needs. Home First and Discharge to Assess enable assessments to be completed at home with families, carers or advocates, after reablement or rehabilitation if required
- It is important for the system to follow best practice in safeguarding, giving due consideration to deprivation of liberty, Mental Capacity Act (2005), and any other concerns that have been identified.
- An asset or strength-based approach to assessment and planning, as set out in the Care Act as part of a personalised health and social care approach, is essential.
- The whole-system response needs to support a hospital ‘place-based approach’, enabling local systems to develop creative solutions which meet local demand and capacity.
- Systems are encouraged to share and learn from practice emerging from the COVID experience
- The changes apply to all discharges although systems may want to focus on specific groups, such as around health inequalities or risk groups needing targeted support post-COVID infection.
- The changes are inter-linked and interdependent, are also solutions to problems, and may not be needed in their own right. So, set out to improve outcomes for people not tick a performance tool.
- Although there is no specific reference to overarching enablers of the good practice highlighted in the tool, these – including workforce, communication, culture, governance among others – are crucial and should be considered in any local conversation.

4. 'Making it Real' Framework

Providing personalised care and support is central to improving better outcomes for people transferring from hospital to an appropriate setting. Consequently in this updated HICM there is a greater prominence to this, linking the High-Impact changes to a person-centred approach. This model borrows from Think Local Act Personal's 'Making it Real' framework, which is a set of "I" and "We" statements that describes what good care and support looks like from a person's perspective and encourages organisations to work together to achieve good outcomes for people. TLAP's National Coproduction Advisory Group, made up of people with lived experience of accessing care and health, including family carers, were engaged to help decide how best to incorporate a more person-centred approach through inclusion of the Making it Real framework. These principles support a Home First D2A approach which measures success by achieving the best outcome for people after treatment in hospital, avoiding their readmission and maximising independence through timely provision of reablement where needed with due consideration being given to any safeguarding concerns, for a safe and timely discharge.

The framework is based on the following principles and values of personalisation and community-based support:

- People are citizens first and foremost.
- A sense of belonging, positive relationships and contributing to community life are important to people's health and wellbeing.
- Conversations with people are based on what matters most to them. Support is built around people's strengths, their own networks of support, and resources (assets) that can be mobilised from the local community.
- People are at the centre. Support is available to enable people to have as much choice and control over their care and support as they wish.
- Co-production is key. People are involved as equal partners in designing their own care and support.
- People are treated equally and fairly, and the diversity of individuals and their communities should be recognised and viewed as a strength.
- Feedback from people on their experience and outcomes is routinely sought and used to bring

Through engagement with TLAP's National Co-Production Advisory Group and the Making It Real framework, the refreshed HICM ensures that the tool reflects the voices of people and enables a focus on what matters to people when transferring in, out and through hospital. For more information, visit https://www.thinklocalactpersonal.org.uk/_assets/MakingItReal/TLAP-Making-it-Real-report.pdf

5. How to use the HICM

The self-assessment matrix forms part of the model, and the intention is for the matrix levels to describe the journey to what good looks like. This should enable a system to see where they might benchmark their current performance and thus inform their development plans. The wording of the matrix has been purposely chosen to provide systems with the flexibility to make a judgement call on where they would self-assess to be against a level. For example, instead of specifying exact timings or figures, the matrix uses words like 'many', 'often', and 'early'. While it is important to make an accurate assessment of your system, it is also important to ensure there is consensus across partners.

This tool is about supporting improvement, so once a level is agreed, the crucial point is that partners come together to create an improvement plan. The outcomes in the matrix are not set in stone. As a result, a system may feel it is performing well in any area but not always delivering as the matrix suggests. Given the flexibility of the model this is entirely possible. Systems can go back to the problem the change is designed to address and show how they have achieved success.

Self-assessment matrix levels:

Not yet established	Plans in place	Established	Mature	Exemplary
Processes are typically undocumented and driven in an ad hoc reactive manner.	Developed a strategy and starting to implement, however processes are inconsistent.	Defined and standard processes in place, repeatedly used, subject to improvement over time.	Processes have been tested across variable conditions over a period of time, evidence of impact beginning to show.	Fully embedded within the system and outcomes for people reflect this, continual improvement driven by incremental and innovative changes.

Emerging and Developing Practice

This refresh has incorporated the Emerging and Developing Practice resource, providing examples of work being undertaken across the country for each of the nine system changes. These reference a range of initiatives where there is already evidence of impact, and point to examples of emerging practice that are starting to make a difference. The examples are designed to be used alongside the HICM to provide a sense of what 'good' looks like when self-assessing, but also provide inspiration to support the development of joint improvement plans. The LGA/ADASS summary of Care Home Support Plans describes recent COVID good practice examples.

Measuring and Monitoring Success

As part of the refreshed model, one of the key challenges identified by many systems was how hard it could be to monitor and measure progress against each change. While systems implement the changes and make improvements to patient flow, it can be hard to show the impact or to maximise how well a change is working.

There are a number of support options available to systems if they require further help in implementing a change or the overall model. For more information, speak to your Better Care Manager or LGA Care and Health Improvement Adviser, or visit our website

Supporting Materials

Throughout the tool, there are links to further information, case studies and guidance. There are a range of materials which apply across more than one change [links to come]:

- NHS good practice guides: focus on improving patient flow; reducing long length of stay
- Why not home? Why not today? — (Newton, 2017)
- People first, manage what matters — (Newton, 2019)
- Reducing delays in hospital transfers of care for older people — (Institute of Public Care)
- London's mental health discharge top tips — (ADASS, 2017)
- Factsheet: hospital discharge — (Age UK, 2019)
- NICE guideline – NG 27
- NHSE/I hospital to home activities
- Rapid improvement guide to: red and green bed days — (NHS)
- NHS benchmarking report – (NHS)
- LGA and ADASS National Overview of Care Home Support Plans

Change 1

Early discharge planning In elective care, planning for discharge should begin before admission. In emergency/unscheduled care, a joint crisis response for people living at home and in care settings can prevent unnecessary admission. However once admitted, an expected date of discharge should be set as soon as possible,

Change 2

Monitoring and responding to system demand and capacity Develop systems using real-time data about demand and capacity taking a joint approach to shaping the price, flow, quality and shape of the market. While councils remain the lead commissioners and retain their Care Act duties, a joint approach is key to developing step-down facilities, integrated health and social care support and work with the voluntary sector.

Change 3

Multi-disciplinary working (MDTs) COVID has underlined the importance of MDTs, including the voluntary, community and social enterprise sector (VCSE), working together to deliver a Home First D2A approach. Effective discharge and positive outcomes for people are achieved through discharge planning based on joint assessment processes and protocols, shared and agreed responsibilities, and good conversations with, and information for, people and families. Working together with the individual at the centre results in a more timely, safer discharge to the right place for them.

Change 4

Home First D2A This means people going home as soon as possible after acute treatment. It means always prioritising and, if at all possible, supporting someone to return to their usual place of residence before considering other options, because home is best. COVID has shown success of a single point of access operated by an MDT.

Change 5

Flexible working patterns COVID is showing that seven-day working, weekend working and extended hours for services across health and social care can deliver improved flow of people through the system. This is successful, however, only if it is applied to all services including clinical decision-making and practical support services, including innovative use of virtual delivery.

Change 6

Trusted assessment Using trusted assessment to carry out a holistic strengths-based assessment avoids duplication and speeds up response times so that people can be discharged in a safe and timely way. During COVID, it has worked well and should be sustained among professional groups and between care settings.

Change 7

Engagement and choice Early engagement with people, their families and carers is vital so they are empowered to make informed decisions about their future care. A robust choice protocol, underpinned by a fair and transparent escalation process, is essential so that when people have capacity they can understand and consider their options.

Change 8

Improved discharge to care homes The NHS Enhanced Health in Care Homes framework supports ways to join up and coordinate health and care services to support care home residents. COVID is strengthening these healthcare links, ensuring safe transfer from hospital to home, and making greater use of solutions including digital technology.

Change 9

Housing and related services Effective referral processes and good services which maximise independence are in place to support people to go home. The need for housing and homelessness services, home adaptations and equipment are addressed early in discharge planning and readily available when needed. COVID has highlighted that people who are homeless are at greater risk from the disease, and that support should now to focus on their increased vulnerability.

Change 1: Early discharge planning

I In elective care, planning for discharge should begin before admission. In emergency/unscheduled care, a joint crisis response for people living at home and in care settings can prevent unnecessary admission. However once admitted, an expected date of discharge should be set as soon as possible

'Making it Real'- I/We statement

When **I** move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place before change happens.

We support people to plan for important life changes, so they can have enough time to make informed decisions about their future.

Tips for success:

- Ensure the MDT sets a proposed date of discharge prior to admission for elective admissions and within two days of an emergency admission.
- Ensure the individual and their family and carers are involved and central in discussions about discharge and that this occurs as early as possible. Encourage and support them to take responsibility in discharge planning.
- Draw up a simple but practical discharge plan and ensure practical considerations are accounted for (e.g. keys, clothes, heating). Identify potential barriers to discharge and review these on a daily basis (e.g. the individual is homeless or their home will be unsuitable to return to meaning they need a move to more suitable short-stay or permanent accommodation, or aids and adaptations to their home).
- Ensure there is clear ownership of actions and all agencies required for resolution are involved. Staff should have a strong understanding of procedures and escalation processes.
- Ensure all staff are aware they all have a role in discharge planning.
- Early identification of people who will need support on discharge assists clinicians in enabling community health and social care staff to identify the appropriate pathway and achieve a same day discharge.
- This is important where there are concerns about mental capacity, safeguarding or other complexities where the right pathway needs to be chosen in a safe and timely way.

Supporting Materials

- NHS guidance on hospital discharge planning
- NHS explainer for health and social care staff on early discharge planning:
- A review of discharge planning from the Nursing Times
- British Red Cross research and recommendations for getting discharge right
- NHS quick guide explaining how the red bag scheme works and how it supports discharge planning

Examples of emerging and developing practice:

- **Newcastle Gateshead: Bringing care homes from the periphery** - Introduction of a 'transfer of care bag', helping to improve communication between hospital and care home teams when residents moved between both settings, and raising the profile of older people living with frailty and very complex needs in care homes.

	Not yet established	Plans in place	Established	Mature	Exemplary
Planned	Discharge is not discussed when planning an admission or at the referral stage in the community.	There is an active plan led by senior staff to instigate early discharge planning for all planned admissions.	Joint pre-admission discharge planning is in place in primary care. A discharge plan, including an estimated discharge date (EDD), is started for all planned admissions.	GPs and district nurses, often within a MDT, lead the discussions about early discharge planning for elective admissions. Discharge planning is business as usual for all staff involved in referrals including community staff such as GPs and district nurses. People know what is going to happen to them and when they will be going home.	Early discharge planning occurs for all planned admissions by a rapid response community MDT with the person and their carers as well as other relevant agencies e.g. housing. People have a clear understanding of when their treatment is going to happen, what it will achieve and when they will go home.
Emergency	Discharge planning does not start in A&E (if an admission has been agreed).	There is an active plan led by senior staff to instigate early discharge planning for all emergency admissions.	Emergency admissions have a provisional discharge date set within 48 hours and planning to support discharge begins as early as possible.	Health and social care work with individuals and their families and carers to plan for and deliver EDDs. People at a high risk of admission already have plans in place. People know what is going to happen to them and when they will be going home, and discharge is on the same day as the decision that the individual need no longer reside in hospital.	All patients go home on date agreed on or near admission, and discharge is on the same day as the decision that the individual need no longer reside in hospital.
Red Bag Scheme	The red bag scheme (or appropriate substitute) is not being used.	There is agreement across partners to implement the red bag scheme and a project plan in place.	The red bag scheme is being piloted on at least one ward.	The red bag is business as usual across the system.	Staff understand the red bag scheme well and use it confidently, leading to smoother discharges.

Change 2: Monitoring and responding to system demand and capacity

Develop systems using real-time data about demand and capacity taking a joint approach to shaping the price, flow, quality and shape of the market. While councils remain the lead commissioners and retain their Care Act duties, a joint approach is key to developing step-down facilities, integrated health and social care support and work with the voluntary sector.

'Making it Real'- I/We statement

I have care and support that is coordinated and everyone works well together and with me.

We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services.

Tips for success:

- Establish a digital platform to provide real-time information about people and capacity across the system. You might develop a bespoke platform for your area or adopt an existing system.
- Use data analysis to understand system trends, to lead medium and long-term strategy, and to anticipate service demand across health and social care.
- Create plans to manage variance in system demand on a seasonal, weekly and daily basis, and to respond to unanticipated demand. This may not mean increasing capacity, but instead arranging staff rotas etc. to put resources in the best place/time.
- While councils remain the lead commissioners and retain their Care Act duties in relation to assessment and care planning, safeguarding and market management, a joint approach is key to developing post-COVID step-down facilities, integrated community and primary health and social care support and work with the VCSE sector.
- Daily ward and board rounds – virtual or face to face are key to managing flow to ensure people are on track to go home in a safe and timely way.
- Identify key system blockages and take action to resolve them. This may involve other high impact changes, such as Home First D2A, depending on your system's needs.
- Utilise 'Red and Green Bed Days' system help understand flow through the hospital by identifying wasted time in a person's journey in both acute and community ward settings.
- Give frontline staff the information they need to understand service capacity and to make the best decisions for individuals.
- Make plans for sharing relevant information easily and in a timely manner among partners. This will require an understanding of what information is useful to which system partners, and consideration of data governance.

Supporting Materials

- NHS guide to demand and capacity management
- NHS resources for demand and capacity management
- NHS Digital guidance on data sharing
- Nuffield Trust guide on understanding flow in hospitals
- Safer, faster, better: good practice in delivering urgent and emergency care
- Health Foundation/AQA guide on understanding whole system flow
- NHS presentation on modelling to identify system bottlenecks
- NHS 'Guide to reducing long hospital stays'
- NHS 'Rapid improvement guide to: red and green bed days'

Examples of emerging and developing practice:

- **Kent: Use of SHREWD** - Use of a daily reporting system to view capacity and flow within Home First/ Discharge to Assess pathway.
- **Central Bedfordshire: Hospital Discharge Service- Person Tracker** **-** To support the working of the co-located discharge teams, a 'person tracker' was developed, which has enabled the council to provide a single point of monitoring for its residents' admission, hospital stay and discharge data.
- **Southampton: Hospital flow and bed management** **-** Implemented an electronic system as a more effective way of managing complex discharges, which includes a user dashboard designed to provide "at a glance" status reports.

	Not yet established	Plans in place	Established	Mature	Exemplary
Responsive capacity	There is no understanding of system demand or its variations.	Analysis is underway to develop understanding of system demand and its variations.	Analysis has created an understanding of system demand and its variations, and practice changes are being implemented to better match demand and capacity.	Capacity usually matches demand and responds to variations. Understanding of system demand informs decision making.	Capacity matches demand and responds in real-time to variations. A sophisticated understanding of system demand informs decision making at all levels.
Improving how the system flows	There is no understanding of how the system flows or its blockages.	Analysis is underway to develop understanding of how the system flows and its blockages.	Analysis has created an understanding of how the system flows and its blockages, and practice changes are being implemented to improve performance.	There are no major blockages and ongoing action is taken to monitor and respond to issues with how the system flows.	Flow across the system is smooth, timely, safe and effective. Outcome destinations reflect a Home First D2A approach.
Effective information sharing	Information about how the system flows and demand is not shared with partners.	Conversations are taking place to develop information sharing infrastructure between system partners.	System partners share data about how the system flows and demand effectively and quickly.	Partners share an understanding of how the system flows.	Partners use data to examine flow and have a shared understanding of the cause of poor outcomes of patients or reduced capacity in the system.

Change 3: Multi-disciplinary working (MDTs)

COVID has underlined the importance of MDTs, including the voluntary, community and social enterprise sector (VCSE), working together to deliver a Home First D2A approach according to the criteria to reside. Effective discharge and positive outcomes for people are achieved through discharge planning based on joint assessment processes and protocols, shared and agreed responsibilities, and good conversations with, and information for, people and families. Working together with the individual at the centre results in a more timely, safer discharge to the right place for them.

'Making it Real'- I/We statement

I have care and support that is coordinated and everyone works well together and with me.

We work with people as equal partners and combine our respective knowledge and experience to support joint decision-making.

Tips for success:

- Work out who to involve in your MDT. Independent and VCSE organisations are important, particularly for supporting people who are funding their own care. Members of your MDT could include doctors, nurses, therapists, mental health practitioners, pharmacists, carers, dietitians, social workers, housing representatives (such as housing or homelessness officers or home improvement agency staff), and any other specialists who may bring expertise and coordination.
- Foster a collaborative, integrated working culture in the MDT, for example through joint training and co-location. COVID has underlined the importance of MDTs and joint work with the VCSE
- Working together with the individual at the centre results in a more timely, safer discharge to the right place. Consideration of people's mental capacity, their rights to continuing healthcare and their ongoing Care Act support needs are all better discussed outside hospital in a setting which maximises their opportunity for independence and reablement.
- Ensure social care and representatives of other discharge support services are involved in board rounds.
- Ensure the individual is treated as an equal partner in the co-planning of care. Provide accurate information and advice to them and their families and carers about their options and the risks involved, dispelling fears and working together to achieve the right outcome.
- Train your MDT to take a strengths-based, person-centric approach to coordinate care and support around the individual. Use continuous feedback and evaluation to improve the experience for staff and people accessing care.
- Make sure people have a named point of contact within the team and know who to talk to about planning their discharge.

Supporting Materials

- NHS guide for MDT development
- Social Care Institute for Excellent resource for MDT working
- National Institute for Health and Care Excellence guidelines on transfers of care, including how the multi-disciplinary team should work
- Health Education England framework for care navigation

- Tackle barriers to smooth and effective MDT working; ensure processes are clear and well-understood, and take measures to reduce funding disputes or confusion about responsibilities.
- Communicate clearly with staff so they understand who should be referred to the MDT. Overcome potential bottlenecks by not sending simple discharges to the MDT. The Single Points of Access / Discharge Hubs have worked well in COVID as a way of pulling people out of hospital to home and ensuring that people are not assessed in an acute setting and not making long-term care decisions when they are at their most vulnerable.

Examples of emerging and developing practice:

- **Durham: Multi-disciplinary discharge teams** - Teams Around Patients (TAPs) is a virtual model of integrated care delivery, which uses a multi-disciplinary working platform involving social workers, nursing and allied health professionals.
- **Lincolnshire: Hospital avoidance response team** - A service delivered by members of the Lincolnshire Independent Living Partnership, which takes referrals from secondary care discharge hubs, A&E in-reach teams, the ambulance service, primary care and community health providers, to help either prevent an avoidable A&E attendance or admission, or speed up discharge from secondary care.
- **Luton and Dunstable: Integrated discharge hub** - Co-location of the team which has regular multi-disciplinary sessions to track and discuss complex patients and their length of stay.

	Not yet established	Plans in place	Established	Mature	Exemplary
MDT working	No daily multi-disciplinary team meeting in place. Health and adult social care work in silos.	Plans developed to introduce MDTs on all wards, involving adult social care, community health and VCSE.	MDTs established on all wards, and work underway to foster collaborative working. Daily MDT meetings attended by adult social care, community health and VCSE.	MDT members work together well, leading to more effective discharge and better outcomes for people.	Single points of access run by MDTs operating a Home First D2A approach to discharge are working in the community to pull individuals out of hospital and assess them at home or in a step-down facility.
Discharge planning and assessment	Separate discharge planning processes in place.	Discussion underway to integrate health and social care assessment and discharge processes.	Practice changes to integrate health and social care assessment and discharge processes, through the MDT.	MDT staff trust each others' assessments and discharge plans.	MDTs maximise people's independence enabling them to live at home using trusted assessment and a reablement approach working together with primary care.

Change 4: Home First Discharge to Assess

This means people going home as soon as possible after acute treatment. It means always prioritising and, if at all possible, supporting someone to return to their usual place of residence before considering other options, because home is best. COVID has shown success of a single point of access operated by an MDT.

'Making it Real'- I/We statement

I can live the life I want and do the things that are important to me as independently as possible.

We talk with people to find out what matters most to them, their strengths and what they want to achieve and build these into their personalised care and support plans.

Tips for success:

- Establish system-wide principles between partners and develop a single narrative across the system about supporting people home as a default option. Concentrate on costs to the system, not provider versus commissioner or health versus social care costs.
- Simplify pathways for hospital discharge, and ensure discharge pathways are set up so home first is the favoured option.
- A home first approach and understanding that home is best also involves system-wide work to support people to remain at home: consider how multi-disciplinary teams and community/home care services can be developed to prevent escalation of need and avoid unnecessary hospital admissions or readmissions.
- Start with domiciliary support (rather than bed-based options) both in terms of service development and choice. COVID has shown the real benefit of caring for people in their own homes with domiciliary care support or PAs arranged via a personal budget.
- Remember there is strong evidence that therapy-led services achieve the best results. Consider merging reablement and rehabilitation services with voluntary sector support.
- Regularly review and evaluate intermediary care to ensure 'temporary' beds are not becoming permanent. Take measures to ensure the focus here is on reablement and recovery, not on getting people out of acute hospital beds.
- Ensure Continuing Health Care (CHC) and other assessments of long-term need are made after a period of reablement and recovery, during which a person's support requirements may change.

Home First D2A

Return people home as soon as possible after their treatment and within one day of being no longer considered having a reason to reside in hospital (MFFD). A single point of access operated by an MDT has proved a successful model in Covid and ensures there are no gaps in the care pathways and specialist support is mobilised. Locally developed models based on good system relationships are key supported by united senior leadership, especially when demand begins to exceed capacity.

- Consider using trusted assessment to provide speedy access for discharge to assess pathways or other discharge support services.
- To have a good home first support service you need it to be fully integrated i.e. NHS, the local authority, and VCSE and independent sector as well as having support structures of families, carers or advocates.
- Make sure these services will work for everyone: have a single point of access, including for people who fund their own care, people who need only low-level support, people who appear to meet the Care Act eligibility threshold and people who don't, and people with ongoing care needs.
- Track people to see where they are six months after discharge to monitor progress and impact of home first initiatives. You should expect to see a reduction in support for those with ongoing support needs. Monitor services as to their quality and effectiveness in terms of reablement and do not use services that will not provide that information or whose results are poor.
- Consider joint commissioning and strong market management interventions where they are needed. i.e. it is not helpful to have an excellent intermediate service if there is a lack of capacity to provide ongoing support.
- Work with consultants and therapists to build confidence and overcome risk aversion to discharge, using positive stories to achieve a hearts-and-minds culture change.
- The decision about future care should not be made in an acute hospital in the persons own home after a period of reablement and be the persons own decision, wherever possible, not the decision of family, clinicians or other professionals – people need to be informed and empowered to choose, whatever their age, disability or circumstance.

Supporting Materials

- ADASS partnership quick guide on discharge to assess
- NHS guide on home first for health and social care staff
- Blog post about the importance of a home first mindset, and how to develop it
- ECIP presentation explaining discharge to assess, with practical tips for implementation
- Sample discharge to assess model, used in Staffordshire and Stoke on Trent partnership NHS trust
- Sample public-facing page providing information about home first, developed by Suffolk County Council
- Royal College of Occupational Therapists guide on embracing risk and enabling choice

Examples of emerging and developing practice:

- **North Staffordshire: Track and triage** - Replacing the assessment functions on the acute site, it tracks patients from entry-to-end of D2A, with a 'pull' function once the patient is judged medically fit for discharge.
- **Bath: Home first/D2A** - A step down service (which uses apartments), and can be commissioned by any hospital clinician or health care professional involved in the discharge process.
- **Tower Hamlets: Admission avoidance and discharge service** - Consists of: rapid response in the community; an admission avoidance team; in-reach nurses and admission avoidance and discharge service (AADS) screeners; and an intermediate care team using a D2A model and offering up to six weeks intensive rehabilitation in the community.
- **Medway: Home First** - An approach and ethos which has sought to achieve Medway Health and Social Care Partners' pledge to: minimise patients' acute hospital length of stay; maximise independence through enablement; support care at home or closer to home; and make no decision about long term care in an acute setting.

	Not yet established	Plans in place	Established	Mature	Exemplary
Discharge to assess	People are usually assessed for care on an acute hospital ward.	Plans have been drawn up for a discharge to assess pathway, and nursing capacity in the community is being created to do complex assessments outside of acute hospital wards.	Discharge to assess pathway implemented, and practice changes in place to increase the number of complex assessments in the community.	Whenever possible, people are supported to be assessed in their usual place of residence.	Assessments under the Care Act, continuing health care, and mental health capacity take place in people's own homes unless a short period of step down reablement is needed. Investment in joint community-based reablement delivers increased independence and increased flow through hospital.
Reablement and pathways	Long-term care decisions are routinely made in an acute hospital ward. People are entering residential/nursing care too early.	Existing pathways have been evaluated and solutions developed for shifting the focus to reablement and recovery. Capacity is being created for reablement and intermediate care.	Practice changes in place to make reablement and recovery the norm.	Decisions about long-term care are not made in acute hospital wards, but instead after people have accessed reablement/intermediary care services. Whenever possible, people return home with reablement/intermediate support.	Investment in joint community based reablement delivers increased independence and increased flow through hospital. Single points of access ensure clarity of pathways and equality of access.
Embedding and home first mentality	Home first D2A is not well understood.	Home first is being debated as an overarching principle to inform other developments. It is raised in business as usual meetings.	Training material and workshops provide home first evidence and guidance. Staff know what home first means as concept as well as a service and own this way of working.	Staff expect to steer people into a home first pathway; it is their default position.	Home First D2A is the destination of choice for all – individuals, families and carers, clinicians and other professionals involved in the person's care. It is seen to be a safe and timely alternative to bedded care.

Change 5: Flexible working patterns

COVID is showing that seven-day working, weekend working and extended hours for services across health and social care can deliver improved flow of people through the system. This is successful, however, only if it is applied to all services including clinical decision-making and practical support services, including innovative use of virtual delivery.

'Making it Real'- I/We statement

I can choose who supports me, and how, when and where my care and support is provided.

We make sure that people can rely on and build relationships with the people who work with them and get consistent support at times that make sense for them.

Tips for success:

- Consider your system's demand, capacity and bottlenecks (see change 2) and identify where extended hours or weekend working could have the biggest impact. Local systems tell us that seven-day working does not need to be in place across the whole system for benefits to be seen. Be prepared to start somewhere even if corresponding services are not in place.
- Take a pragmatic approach to responding to your system's need: this does not need to be 24/7 working across all services; instead it is about placing staff well to ensure consistent flow throughout the week. Practical alternatives to seven-day services may work better for parts of your system, such as having a bigger volume of staff on Mondays to handle a weekend backlog.
- Think broadly about your whole system: identify where seven-day working could be helpful across health and social care, including pharmacy, transport and housing services. Talk to all partners, including care providers and work out cost implications. COVID has highlighted how integrated community health and social care teams supported by virtual or digital solutions can reduce the pressure on local services to provide this cover.
- Developing trusted assessment (change 6) can help to enable individuals to be assessed throughout the week or at the weekend in the community setting.
- Engage with practitioners to understand how increased seven-day working would affect them personally and what you can do to help. Don't assume staff won't work weekends – talk to them about how it could work.
- This change is undoubtedly challenging, so work gradually and draw on shared best practice and resources.

Supporting Materials

- NHS resources on achieving seven-day working, including clinical standards and case studies
- NHS resources for seven-day working
- NHS Digital data and indicators on seven-day working
- NHS resource on costing seven-day services
- King's Fund vision for seven-day working

Examples of emerging and developing practice:

- **Hertfordshire: Seven-day working** - Seven-day working strategy with the aim of improving the flow from acute to community settings, ensuring discharges were not put back over the weekend while people waited for a package of care due to processes outside of the Monday to Friday norm.
- **Hackney: "A continuous cycle of improvement in patient flow"** - Development of weekend working in strategically important service areas to help improve patient flow.
- **Milton Keynes: Getting people home** - Seven-day working through home first reablement supporting discharges every day of the week as part of wider strategy to "get people home".

	Not yet established	Plans in place	Established	Mature	Exemplary
Assessment and decision making	Patient flow is poor as a result of limited timings of assessment and decision making.	Plan being drawn up to move to seven-day assessment and decision making.	Practice changes in place in some areas of system to move towards seven-day assessment and decision making.	Increased seven-day working improves outcomes due to timely assessment and decision making with better opportunity to involve carers. Work underway to further extend seven-day working.	Assessments and decisions about long-term care take when the individual is ready, regardless of the time or day of the week, and in an individual's own home or in a reablement step-down facility.
Discharge services	Services to support discharge (e.g. transport, pharmacy, housing) only available Monday to Friday.	Service areas which could benefit from extended hours/weekend working identified and plans being drawn up for change.	Practice changes in place to extend service provision to facilitate timely discharges.	Increased seven-day service provision creates improved system flow. Work underway to further extend services according to system need.	Services are in place (e.g. transport, pharmacy, housing) to support smooth discharges when the individual is ready, regardless of the time or day of the week.
Care packages	Care providers only accept new referrals and restart packages of care Monday to Friday.	Discussions underway about how care providers can move to seven-day working.	Some care providers have moved towards seven-day working.	Most care providers accept new referrals and restart packages of care when the individual is ready, regardless of the time or the day of the week.	Council-led joint system commissioning of the care provision supports providers to work 7 days a week, understanding the pressures of COVID and the impact on care provision if discharges are not properly managed.

Change 6: Trusted assessment

Using trusted assessment to carry out a holistic strengths-based assessment avoids duplication and speeds up response times so that people can be discharged in a safe and timely way. During COVID, it has worked well and should be sustained among professional groups and between care settings.

'Making it Real'- I/We statement

I am supported by people who listen carefully so they know what matters to me and how to support me to live the life I want.

We know how to have conversations with people that explore what matters most to them – how they can achieve their goals, where and how they live, how they can manage their health, keep safe and be part of the local community.

Tips for success:

- Start by agreeing what the problem you are trying to solve is.
- Remember a trusted assessment can be either:
  - An assessment completed earlier in the persons' pathway being used, with agreement, for a second purpose and thus avoiding a delay
  - An assessment carried out by a third party on behalf of another organisation

  Think about using trusted assessment wherever there is a delay caused by an assessor not being able to do their assessment when needed – this includes access to home care.
- Remember trusted assessment can be used in a variety of settings, such as:
  - to agree restarts and ensure the person gets home more quickly
  - to support hospital discharge to a residential or a community service, in place of the provider carrying out their own assessment
  - to move between services
  - to make a local authority eligibility determination.
- Consider how trusted assessment interlinks with home first and discharge to assess – think holistically about your approach to the changes.
- Without trust between partners, trusted assessment will not work. Think about how to achieve and build trust to avoid poor outcomes for people. Trusted assessments can only be used with the agreement of all parties, so a co-design approach is essential. This involves engagement with care providers too. Trusted assessment has worked well during the COVID pandemic, with trust built up across health and care. This needs to be sustained, but care providers remain concerned about the COVID risk they are asked to carry.
- People should be informed that it is not necessary to make decisions about a permanent move when they are in hospital.

Supporting Materials

- A guide to trusted assessors and trusted assessments, co-authored by The Care Provider Alliance, NHS England and Improvement, Local Government Association and Association of Directors of Adult Social Services
- An example of a successful trusted assessor scheme in Lincolnshire
- Better Care Exchange section on trusted assessment, including shared resources
- NHS FAQ page developed from a series of trusted assessment webinars
- CQC guidance on trusted assessment
- Rapid improvement guide: trusted assessors

Examples of emerging and developing practice:

- **Newcastle Gateshead: Trusted assessment**
- **North Yorkshire: Trusted assessment** - Implementation of integrated discharge pathways and to use trusted assessment to facilitate discharge to assess.
- **Lincolnshire: Care home trusted assessor** - Creation of a trusted assessor role to improve the trust between acute sector assessment team and care home managers.
- **Blackburn and Darwen: Home first with trusted assessment** - Focus on people waiting for packages of care. Led by a home first approach in which ward staff undertake a partial assessment before the person is discharged to their home, with wraparound care offered until a full assessment is completed.

	Not yet established	Plans in place	Established	Mature	Exemplary
Independent care sector assessments	Care providers insist on assessing for the service or home regardless of their capacity to do so in a timely manner.	Care providers engaged in discussions about whether existing assessments completed in the hospital can be made to meet their needs / agreement to appoint a trusted assessor.	An existing assessment has been adapted to serve the needs of a pre-admission assessment or a worker has begun to carry out assessments on behalf of at least one provider.	An existing assessment has been adapted to serve the needs of a pre-admission assessment and is being used with several providers or a worker(s) is carrying out assessments on behalf of several providers.	Systems have understood the challenges in accepting patients post-COVID and support care providers with clinical support and specialist equipment to care for people safely.
Within hospital (acute or community)	Each profession insists on doing its own assessment, taking longer to determine the person's pathway.	Professionals are engaged in discussions as to when a shared or joint assessment might be possible.	Existing assessments are used for more than one purpose for at least one pathway.	Existing assessments are used for more than one purpose for several pathways.	Assessments are carried out in people's own homes or in step-down facilities – initial screening ensures this is safe to do so drawing on expert advice as needed.
Adult social care (hospital and community)	People have to wait a long time to have an eligibility determination.	Exploration is under way to determine why this is and to address it.	A third party has been trained and authorised to carry out eligibility determinations.	Eligibility determinations are routinely carried out by a third party when the local authority is unable to do so on time.	People have safe and timely assessments in the right setting.

Change 7: Engagement and choice

Early engagement with people, their families and carers is vital so they are empowered to make informed decisions about their future care. A robust choice protocol, underpinned by a fair and transparent escalation process, is essential so that when people have capacity they can understand and consider their options.

'Making it Real'- I/We statement

I can get information and advice that helps me think about and plan my life.

We provide information to make sure people know how to navigate the local health, care and housing system, including how to get more information or advice if needed.

Tips for success:

- Talk to people (including family and friends) on or, where possible, before admission about their likely discharge route (see change 1).
- Provide information in community settings and on wards about discharge routes.
- Be creative to deliver the message in the best way for people e.g. use videos in waiting rooms, or leaflets in mailings. Take a co-design approach and involve patient groups and other organisations in developing the message.
- Get the whole team involved, it's everyone's business.
- Don't be afraid to be clear – waiting in hospital is not an option, but people must know what their options are.
- Utilise key messages and communications support issued as part of initiatives to reduce length of stay in hospital – these should focus on information around harm and deconditioning as the key drivers to people and their families and carers to seek earlier discharge.
- Work with colleagues across the health and social care system to manage people's expectations of the care they will require after discharge, and to avoid unrealistic claims about the support people will receive. Managing expectations requires giving people the right information and advice throughout so they are fully informed.
- Remember long-term decisions should not be made in acute hospital. D2A and other intermediate care are not subject to a choice protocol but should be seen as the next stage in the treatment programme.
- Remember the Care Act 2014 guidance on choice of accommodation is that while any choice should be real they should also be within the personal budget and practicable.
- Do involve the voluntary sector to support discharge.
- People who fund their own support are often forgotten, it is important to engage with everyone to provide appropriate information and support so that everyone can make informed decisions. This is particularly important given the desire many will have to arrange care at home post COVID.

Supporting Materials

- NHS quick guide, describing the choice protocol and providing sample template policy and template patient letters
- The Care Act: see 30, cases where adult expresses preference for particular accommodation and Annex A of 2014 Statutory Guidance
- Care Navigation: A Competency Framework

- Do carry out a demand, capacity and quality audit of your independent care market, as a system.
- Try to avoid the need for choice letters, but when necessary don't be afraid to issue them, as they are in the person's best interest.
- Ensure the choice protocol is part of team induction training.

Examples of emerging and developing practice:

- **Isle of Wight: Care navigators** - The service was developed as a different way of working with and utilising the VCSE sectors, to build capacity in stretched services and support the island's new model of care and system redesign.

	Not yet established	Plans in place	Established	Mature	Exemplary
Information and support to decide care	No advice or information about discharge options available at admission.	Co-designed information packs are being prepared with patients and their families to ensure that they are helpful resources.	Admission advice and information leaflets in place and being used in different formats to engage with people, regardless of how they fund their care.	People and their family and carers are aware of the value of making timely decisions about discharge.	People and their family and carers, regardless of how they fund their care, are engaged and supported to go home or to a step-down facility to enable them to make a considered choice about future care and support needs.
Choice protocol	No choice protocol in place.	Choice protocol being written or updated to reduce long length of stay.	New choice protocol implemented and understood by staff.	Choice protocol used proactively to challenge people as necessary.	All staff understand choice and can discuss discharge proactively, and there is good consideration of safeguarding concerns. People feel empowered to manage their own discharge.
VCSE provision	No provision in place to support people to make decisions about their care, regardless of how they fund it.	Health and social care commissioners co-designing contracts with VCSE or other support.	VCSE support in place, providing advice and information.	VCSE or other provision integrated in discharge teams to support people, regardless of how they fund their care, home from hospital.	Everyone is supported through the discharge process, from admission. People are provided with good information in good time to make decisions about their future care.

Change 8: Improved discharge to care homes

The NHS Enhanced Health in Care Homes framework supports ways to join up and coordinate health and care services to support care home residents. COVID is strengthening these healthcare links, ensuring safe transfer from hospital to home, and making greater use of solutions including digital technology.

'Making it Real'- I/We statement

I have a place I can call home, not just a 'bed' or somewhere that provides me with care

We have a 'can do' approach which focuses on what matters to people and we think and act creatively to make things happen for them.

Tips for success:

- A person should not be making long-term decisions about their care from a hospital setting. See change 4, for further support and guidance on how people can be supported to move to a suitable environment from where they can make decisions.
- Join your local care forum to hear what providers find unhelpful about admission from hospital.
- Refer to best practice in discharge planning as can be found in other high impact changes, particularly change 1 and the supporting material. Involve care homes in the discharge planning process, and provide them with the information they need in good time. This is particularly important when supporting individuals who are or may be COVID-positive.
- Ensure each care home is linked to a consistent, named GP and wider primary care service, particularly in relation to management of residents during the COVID pandemic.
- Provide access to out-of-hours/urgent care to prevent unnecessary hospital admissions and to support care home staff. Areas have taken an innovative approach to this – for instance Airedale's telehealth hub connects local care homes directly with the MDT.
- Develop channels for sharing information with care homes – such as NHSmail accounts.
- Ensure COVID care plans are provided, detailing test status, protective equipment and clinical support requirements. Step-down facilities must be available for those unable to return to their care setting because of infection in the care home. Digital solutions are vital to maintain support.
- Involve your ambulance service in planning. It will have valuable information on care homes in need of support and can help develop solutions. Include care homes in system conversations.
- Link work on Enhancing Health in Care Homes with other high impact changes.
- Consider how your system can provide enhanced services to better support vulnerable people in community settings, such as through rapid response.
- Build on the existing learning and training opportunities to ensure that staff who are employed by social care providers receive a wide range of training and development opportunities.

Supporting Materials

- NHS overview of the enhancing health in care homes project
- NHS enhancing health in care home framework
- Health Foundation article about the importance of good relationships
- King's Fund review of learning about enhancing health in care homes
- NHS quick guides for supporting care homes
- NHS quick guide: Improving Hospital Discharge into the Care Sector

- See the NHS guidance on Enhanced Health in Care Homes for additional components of this work which can support your system. Evidence shows certain relatively small investments can yield significant results both for people and the system.

Examples of emerging and developing practice:

- **Wirral: Care home teletriage service** - Care homes have been provided with HD iPads and secure nhs.net email addresses to access a triage service, and staff have been trained to take basic observations and equipped with blood pressure monitors, thermometers, urine dip sticks and pulse oximeters.
- **Surrey: East Surrey care home multi-disciplinary project** - Aim of the project was to enhance the level of care to all residents of care homes by increasing GP time to support care homes; care coordinated approach; and improved medicine management support and training.

	Not yet established	Plans in place	Established	Mature	Exemplary
Discharge support	Best practice in discharge planning is not established and there is little trust between care homes and hospitals.	Systems are reaching out to care homes to find out where the systems need to change.	Systems have a regular dialogue with care homes (ideally through the care forum) and discharge is a regular agenda item.	Care homes and systems work in tandem to facilitate discharges seven days a week including evenings.	Care homes report few poor discharges or failed discharges as a result of system failure.
Enhanced primary care	Care homes are not linked with local community and primary care.	Scoping is underway to understand care home need. Plans have been made to establish clear links with primary and community care.	Community and primary care support provided to care homes on request. All care homes have access to a consistent, named GP.	People with increased acuity are well-managed in care homes due to a strong support network with primary and community care.	Care homes are supported by their named clinical lead and have access to primary care support. They are able to access support and advice on managing COVID and supported to make the right decision for their provision.
Access to out-of-hours/urgent care	High numbers of referrals to A&E from care homes, especially in the evenings and at weekends.	Specific high-referring care homes identified, and plans developed to provide better support.	Dedicated intensive support provided to high-referring care homes.	Improvement seen in unnecessary admissions from care homes, particularly on evenings and at weekends.	Across the system, care homes are well supported by access to out-of-hours/urgent care with appropriate COVID support where needed.

Change 9: Housing and related services

Effective referral processes and good services which maximise independence are in place to support people to go home. The need for housing and homelessness services, home adaptations and equipment are addressed early in discharge planning and readily available when needed. COVID has highlighted that people who are homeless are at greater risk from the disease, and that support should now to focus on their increased vulnerability.

'Making it Real'- I/We statement

I live in a home which is safe, accessible and suitable so that I can be as independent as possible.

We have conversations with people to discover what they want from life and the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments.

Tips for success:

- As part of early discharge planning talk to the person and their family or carers about their current housing/home situation to understand if a person's home is going to be safe and suitable for them to return to if there may be any issues that could affect discharge.
    - Take action as early as possible – a person's housing status should be known as soon as possible after admission.
    - Are there specific issues with their home which may affect its suitability, for example, is it accessible to the person given any changed mobility or health needs; or is there a problem with heating or damp?
    - Don't wait until the individual is ready to leave hospital to refer. Talk to any relatives, particularly if the person does not have a normal place of residence, as this may mean they don't have somewhere they can be discharged to.
- Include housing/housing service provider(s) as real or virtual member(s) of your discharge planning team.
- Take a holistic, person-centred approach to understand what matters to the people in your care, taking a positive attitude to risk and how you can best help them to be as independent as possible in their home. People who are homeless are at greater risk from COVID and support needs now to focus on their increased vulnerability.
- Consider how your VCSE sectors can help people to get home and access community support.
- Ensure staff know what housing options and support services are available and understand how to make referrals to them. There should be well-developed links between the discharge planning team and these services. Consider creating a single-point of contact to help guide staff through the various housing options available. Staff should understand their statutory duties with regard to housing, as well as how to access specialist housing (such as extra care

Supporting Materials

- NHS quick guide to health and housing
- NHS quick guide to better use of care at home
- NICE guidelines on home care
- National Housing Federation resources on housing, care and health
- Skills for Care the role of housing in effective hospital discharge
- Care and Repair England/Centre for Ageing Better: Adapting for ageing: Good practice and innovation in home adaptations
- Housing LIN health and housing resources
- Foundations/Housing LIN best practice map
- Royal College of Occupational Therapists Adaptations without delay
- The Regulatory Reform Order
- Online directory of home improvement agencies
- SCIE Moving between hospital and home, including care homes

or supported housing). For example, there is a new statutory duty to refer people who are homeless or at risk of homelessness to the housing authority.

- Educate staff about the housing support needs of different groups. These go beyond aids or adaptations for older people, and include, for example, support for people who are homeless or who may have mental ill-health, substance misuse needs, a learning disability or dementia.
- Minor repairs and small home adaptations can make a real difference to the speed and ease of discharge when they are readily available and delivered quickly. Identify needs as early as possible, not just what will help people get home, but what will aid independence and help avoid hospital readmission or future health or care needs.
- Housing-based short-term accommodation such as step-down or intermediate care can be appropriate for people who are medically optimised but waiting for a new home or adaptations. This is not a substitute, however, for late assessment of need or a lack of capacity for a more appropriate service.
- Understand the demand for, and capacity of housing and related support services across your system, and ensure this analysis informs commissioning intentions. Work with partners to identify and prioritise addressing the most challenging areas for your system. Approaches to this change will vary greatly in different systems, and may involve developing better processes, improving services or investing in extra capacity whether to meet any planned care needs or help facilitate self-care.
- Be creative in considering how technology and innovation can improve the way you support people to live at home; for instance telecare and assistive technologies can be very useful. Everyone involved in discharge should know what is on offer and how to access it locally.
- Homelessness should not be a reason for staying in hospital –
    - NHS trusts have a statutory duty under the Homelessness Reduction Act (2017) to refer people who are homeless or at risk of homelessness to a local housing authority.
    - Referrals should be made at the earliest opportunity as soon as it has been identified that a person may be homeless on discharge as this provides more time for the housing authority and other support services to respond. The person must give consent, and can choose which authority to be referred to.
    - Persons who have no recourse to public funds are not eligible for homelessness assistance, but are entitled to receive housing advice. It is not the responsibility of NHS trust staff to assess whether a person is eligible for such support; this is determined by the housing authority.
    - The Local Housing Authority should incorporate the duty to refer into their homelessness strategy and establish effective partnerships and working arrangements with agencies to facilitate appropriate referrals.

Examples of emerging and developing practice:

- **West of England - Reducing DTOC through housing interventions**
- **Leicester: Lightbulb** - The scheme involves housing enabler posts, their role involves aiming to assess patients as early as possible, and offer patients options to resolve housing issues.
- **Cambridgeshire: Technology Enabled Discharge (TED)** - To help people overcome the complications of referral and installation, Cambridgeshire Technology Enabled Care offers a custom telecare discharge package, which includes installation and rental of the lifeline, alongside other pieces of appropriate equipment such as smoke alarms, temperature sensors and fall detectors.
- **Kirklees Council: Home from Home initiative - T**he service provides seven accessible flats as temporary accommodation for people awaiting adaptations in their own home or changes in accommodation.

	Not yet established	Plans in place	Established	Mature	Exemplary
Systematic response, and demand/capacity	Housing and homelessness issues are not considered as part of a discharge support strategy.	Responses to housing issues and homelessness are usually discussed during ward rounds.	Staff have clear guidance which they routinely use to inform referrals and advise people and their families.	The impact of housing and homelessness issues on discharge and people's outcomes is understood and used to improve them.	System planners use demand, capacity and impact data to improve support to people who have housing needs or are homeless.
Early needs assessment and response	Housing status and support needs are not part of the admission checklist.	Amendments to the checklist are proposed/being considered.	A person's housing status and support needs are routinely noted on admission and where needed acted on during their hospital stay.	A person's housing status and support needs are part of a wider housing needs assessment on admission, with support put in place, including temporary accommodation if necessary, by expected discharge date.	Discharge is timely because staff know a person's housing status and act on their support needs. Particular attention is given to their health needs in relation to vulnerability to COVID infection.
Integration/joint working	Service response is slow, disjointed or unavailable.	Links between housing and discharge teams are being planned.	Discharge services have a named housing link, and there is regular contact between services/staff.	Housing staff are part of discharge support services, and there are good working relationships across the system.	Joined-up services deliver timely, person-centred support which maximises recovery and independence.
Home adaptations, equipment, telecare and health	Staff are not aware of available services.	A stock take of available support is being undertaken.	Discharge services know what is available and routinely access in good time.	Support is quick and easy to access, and is delivered promptly.	Support is integrated with related services, delivered 24/7, and takes account of any COVID-related needs such as special equipment, rehabilitation etc.

Action planning template

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning				
Change 2: Monitoring and responding to system demand and capacity				
Change 3: Multi-disciplinary working				
Change 4: Home first				
Change 5: Flexible working patterns				
Change 6: Trusted assessment				
Change 7: Engagement and choice				
Change 8: Improved discharge to care homes				
Change 9: Housing and related services				

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We consider requests on an individual basis.

REF 25.1

Report to Policy Committee

Author/Lead Officer of Report
Liam Duggan, Assistant Director Governance and Financial Inclusion

Tel: 07791119860

Report of:	Director of Adult Health & Social Care
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	16th November 2022
Subject:	Adult Health and Social Care: Effective Use of Resources and Financial Recovery Plan Update

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	x	No	
If YES, what EIA reference number has it been given? **1128**				
Has appropriate consultation taken place?	Yes	x	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	x
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 information about our use of resources, an update on progress with our 2022/23 financial recovery plan, an update on improvements made in relation to our financial governance and to the Adult Social Care Effective Use of Resources Delivery Plan.

Recommendations:

It is recommended that the Adult Health and Social Care Policy Committee:

1. Note the update to the financial forecast for the delivery of savings in 2022/23
2. Note actions taken to achieve savings or mitigation of pressures.
3. Note the updates to the Financial and Resource Management Delivery Plan – highlighted
4. Note the budget analysis provided in the Use of Resources Report in Appendix 2
5. Request updates on progress with implementation through our Budget Delivery Reports to future Committees.

Background Papers:

None

Appendices:

Appendix 1 – Financial and Resource Management Delivery Plan
Appendix 2 – Use of Adult Social Care Resources Report

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. *Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.*	Finance: Liz Gough, Ann Hardy Legal: Patrick Chisholm Equalities & Consultation: Ed Sexton Climate: Jessica Rick
2	**SLB member who approved submission:**	Alexis Chappell
3	**Committee Chair consulted:**	Councillor George Lindars-Hammond and 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:

Liam Duggan

Job Title:
Assistant Director Governance and Financial Inclusion

Date: 7th November 2022

1.0 PROPOSAL

1.1 This report delivers on our commitment to transparent and accountable financial reporting.

1.2 Quarterly reports to the Adult Health and Social Care Policy Committee will update on:

- Income and Expenditure: use of resources
- Financial recovery and forecast
- Financial risks and issues
- Implementation of the financial governance framework
- Implementation of the AHSC Delivery Plan

2.0 BACKGROUND

2.1 Our vision is that everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are – and, when they need it, they receive care and support that prioritises independence, choice, and recovery.

2.2 A priority under this strategy is for Adult Health and Social Care to demonstrate effective use of resources and effective governance to improve experiences, outcomes, and quality of care across the City. A *Care Governance Strategy and Framework* was approved on 15th June 2022 which supported implementation of this priority.

2.3 Our *Financial and Resource Management Delivery Plan* consolidates the actions underway to manage our resources effectively, providing an evidence base for decisions on continuous improvement and where to prioritise the further efficiencies required to alleviate budget pressures. It also provides an assurance that Adult Social Care is using resources effectively to improve outcomes for the people of Sheffield in the context of financial pressures and historical overspend.

2.4 The reporting milestones on use of Adult Health and Social Care Policy Committee resources for agreement by the Committee are:

- November 2022 – Better Care Fund & S75 Agreement, Grants and Other Income, use of Disability Facilities Grant and assurance regarding Adult Health and Social Care income and expenditure.

- December 2022 – Integrated Commissioning Budget Overview and Expenditure, Covid Grants, Establishment Controls and Contract Management Controls.

- March 2023 – Use of Resources Delivery Plan, Establishment and Contract Management 6 Monthly Progress Update.

3.0 ADULT SOCIAL CARE FINANCIAL RECOVERY AND SUSTAINABILITY PROGRESS

3.1 Forecast Delivery of 2022/23 Savings

3.1.1 A summary of the **£43.2m** pressures on Adult Health and Social Care Budget for 2022/23 is set out in Table A below. The delivery of planned savings is critical to the financial sustainability of Adult Health and Social Care, bringing expenditure down to within available resources and supporting the Council to set a balanced budget.

Table A: Adult Health and Social Care Pressure Mitigations Agreed at Cooperative Executive 16th February 2022	**Value (£000s)**	**Forecast (£000s)**	**Forecast %**
Social Care Precept	£3.3m	£3.3m	100%
Increased Grant / Swap Cash Limit for Grant income	£8.5m	£8.5m	100%
Funding from Council Reserves	£6.2m	£6.2m	100%
Savings / mitigations	£25.2m	£15.6m	62%
Total Pressures	**£43.2m**	**£35.1m**	**81.2%**

3.1.2 Since the update report to Committee 21st September 2022, the forecast for delivery of £25.2m planned savings has decreased from £17.1m (68%) to £15.6m (62%).

The main reasons for the decrease in the forecast are:

1. An increase in the average cost of **new** home care packages for people **over** 65. From May to July the average cost had reduced to under £300 per week, compared to a peak average of £380 per week in 2021. However, average new costs for the year to-date have since risen to £314 per week.

2. An increase in the cost of **existing** support packages for people **under** 65. Increases to existing support costs are expected and budgeted for, however a planned saving to mitigate this year's increase from £2.1m to £1m is not currently forecast to be delivered. Increases are currently forecast at £2.6m (£500k in excess of the original forecast).

3.1.3 Table B shows a breakdown of the forecast by savings type and the movement in the forecast:

Table B – Recovery Activity and Progress Against Savings Approved on 16th February 2022.

Saving Category by Service	**Savings Value** (£000s)	**Forecast June 22**	**Forecast Sept 22**	**Forecast Nov 22**	**Forecast %**
Change and Strategy Delivery	**1,803**	1,803	1,803	1,803	100%
Living and Ageing Well	**10,888**	6,980	7,154	6,423	59%
Adults with Disabilities	**9,506**	4,797	5,650	4,360	46%
Mental Health and Wellbeing	**1,650**	1,275	1,150	1,210	73%
Care Governance and Inclusion	**1,254**	1,254	1,254	1,683	134%
Commissioning and Partnerships	**100**	100	100	100	100%
Chief Social Work Officer	**0**	-	-	-	-
Total	**25,201**	**16,609**	**17,111**	**15,579**	**62%**

3.1.4 To date, Adult Health and Social Care have **delivered £9.15m** in savings through staffing budget adjustments, recommissioning programmes, reviewing excess costs and other projects – **an increase of £1.7m from September's update report**.

3.1.5 As a context to these savings and the risks and challenges associated with achieving the level of savings required in one year, our work to review adult social care budget indicates that **Adult Health and Social Care has delivered £48m in savings over the past five years**. The proportion of the total budget made up of cash limit has reduced by 14% from 62% in 2017/18 to 48% today.

3.1.6 As Tables A and B show, current forecasts do not anticipate full delivery of the £25m budgeted savings plan at Quarter 2 within one year and its likely that these level of savings will now be achieved over a 2 year period mainly due to the time to complete reviews set against the staff availability to complete alongside delivering core services.

3.1.7 Following on from the decision of the Cooperative Executive[1] on 16th February 2022, the Adult Health and Social Care Policy Committee is required to mitigate this forecast overspend by 31st March 2023.

3.1.8 To mitigate the risk of overspend, the service is undertaking the following actions, and this is reflected in our forecast for 22/23 and in our budget plans

[1] Budget Report 2022/ 2023 – 16th February 2022 - Draft Protocol for Cabinet Reports (sheffield.gov.uk)

for 23/24. In total his mitigates **£2,429m within 2022/ 2023** and **£5.7m of predicted overspend pressure going into 2023/ 2024**.

- **Reviews** of high-cost support arrangements by in-house teams and agency staff. This has delivered a **£4.2m** saving so far, with a total of **£5m forecast in-year** and **a further £4m** forecast during 2023/24, making a total of **£8.2m savings over an 18 month year period.**

- **Reviews** of Mental Health support and funding, in partnership with health colleagues. This will ensure appropriate arrangements are in place and it is anticipated that this will save at least **£300k** during 22/23 and **£700k** during 23/24.

- **Direct Awards** (the use of non-framework providers at a higher cost) are now under stricter regulation. Direct Awards have been required to facilitate timely discharge from hospital, but this is now agreed on a temporary basis only following introduction of new procedures. 200 people currently receiving a Direct Award are under review and it is anticipated that the majority will transfer to a framework provider, saving **£500k** during 22/23 and **£500k** during 23/24.

- **Voids and Vacancies costs** have reduced compared to 21/22 and it is anticipated this will save **£1.2m** during 22/23 and **£500k** during 23/24.

- **An additional £429k income** from a larger than forecast increase to state benefits, showing as a 34% over achievement against Care Governance and Inclusion, will mitigate the final overspend position.

- **Homecare** reviews are also expected to release 4,500 homecare hours per week, aligned to the capacity requirements for the new well-being homecare contract.

3.1.9 To further mitigate current and future risks in relation to the Adult Social Care financial pressures, the following practice development and governance activities are underway:

- **Care Package Approvals** will come under systematic controls as part of embedding ongoing governance improvements across the service. Its aimed to complete this at same time as move towards new model of operating aligned to the Target Operating Model discussed today.

- **Double Handed Care Assessment** - An assessment of new homecare packages that require high volumes of hours, night-time care and/or double handed care is underway. This will help to ensure the most appropriate decision was taken and support learning for the service.

- **Adaptations Housing & Health** are managing 450 new assessments per month, reducing waiting times to 6 months, down from 20 months in

2021, and reducing the backlog of referrals in order to reach a sustainable level of demand in 2023. A report is set for Committee today providing an update.

- **Staffing budget** overspends are being addressed through the new Operating Model – now progressing to implementation after agreement with Trade Unions – and VER/VS schemes in selected areas of the service. An update in relation to staffing establishment governance processes is planned for December Committee as part of the budget update.

- **Review of Increasing Costs** – An investigation into the increasing costs for new care packages led by the Chief Social Work Officer. The outcomes and an action plan will build upon our practice development plan and be reported to December Committee as part of our budget update reporting;

- **Criteria for Adult Social Care** - Development of a criterion for accessing adult social care services for approval at December Committee;

- **Practice Guidance and Case File Audits** - Development of practice guidance which supports a consistent approach to strength-based practice and conversations across Adult Social Care as we move into a new model and way of working. This is noted in the Care Governance report to Committee today;

- **Early Help** - Development of an early help model which focuses on independence and support at an early stage in line with Care Act statutory guidance. A committee briefing is planned for December and with a model proposed for February Committee aligned our Target Operating Model;

- **Continuing Health Care** - Verification of financial data related to Continuing Health Care and Joint Packages of Care with NHS partners and recording onto our electronic recording systems. The outcomes and an action plan will build upon our practice development plan and be reported to December Committee as part of our budget update reporting

3.1.10 It is planned that these actions will support and enable prevention of need for care and support in line with the Care Act 2014 requirements as well as enable a greater and consistent focus on wellbeing outcomes and independence across Adult Social Care.

3.1.11 These developments also continue to deliver on our ambitions set out on 15th June 2022 to improve our homecare offer and to deliver on our service priority to reduce waiting lists to acceptable risk levels. It also supports and enables

Adult Health and Social Care to become financially sustainable in both our staffing and purchasing of care spend.

3.1.12 Despite these actions, it remains a risk that the £25m saving required for delivery by Adult Social Care within one year was always going to be a significant challenge, especially when set against the following context:

- Ongoing response to the pandemic and its long term impacts;
- Wider legal duties relating to the Care Act, Mental Capacity Act and in particular duties relating to safeguarding;
- Maintaining stability of the social care market;
- Introduction of a CQC Assurance Framework, Workforce Reporting, Fair Cost of Care and Social Care Charging Reforms under Health and Care Act 2022;
- National challenges in recruiting social work and social care staff;
- Increased inflationary costs, cost of living and energy crisis impacting all residents and care providers in the city.

3.2 Additional Actions to Increase Confidence in Delivery of £25m Savings in 22/23.

3.2.1 On 15 June the Committee agreed the Adult Health and Social Care financial update report[2] setting out a range of additional actions to increase confidence in the delivery of 2022/23 savings.

3.2.2 Since the September Committee, the following has been completed: -

- Provision of use of resources and benchmarking information. This is described in section 4.1 and Appendix 3 of the September report.
- Local Government Association (LGA) feedback of adult health and social care budget. This is described in section 4.2 of the September report and actions included in the use of resources action plan presented today.
- A joint NHS and LA funding bid to provide additional social care capacity to enable people to be discharged from hospital on a timely basis, which resulted in Adult Health and Social Care receiving £2.427m until March 2023. This was agreed at Finance Sub Committee on 6th September 2022[3] and a report on our Discharge Improvement Programme will accompany this report to the December Committee.

3.2.3 To support additional and increased confidence in the service focus on delivery of best value and good financial governance over finances, the service is progressing:

- An arrangement for LGA to undertake a follow up visit to determine progress in implementing recommendations noted to Committee in September 2022;
- Costs of a dedicated external focused review of Adult Social Care finances, expenditures, and governance to inform any further activities

[2] Adult Social Care Financial Update Report – 15th June 2022 - Draft Protocol for Cabinet Reports (sheffield.gov.uk)

[3] (Public Pack)Item 16 - Additional Social Care Hours Report Agenda Supplement for Finance Sub-Committee, 06/09/2022 14:00 (sheffield.gov.uk)

which the service can undertake to become financially sustainable and at the same time improve outcomes for Adults across the City.

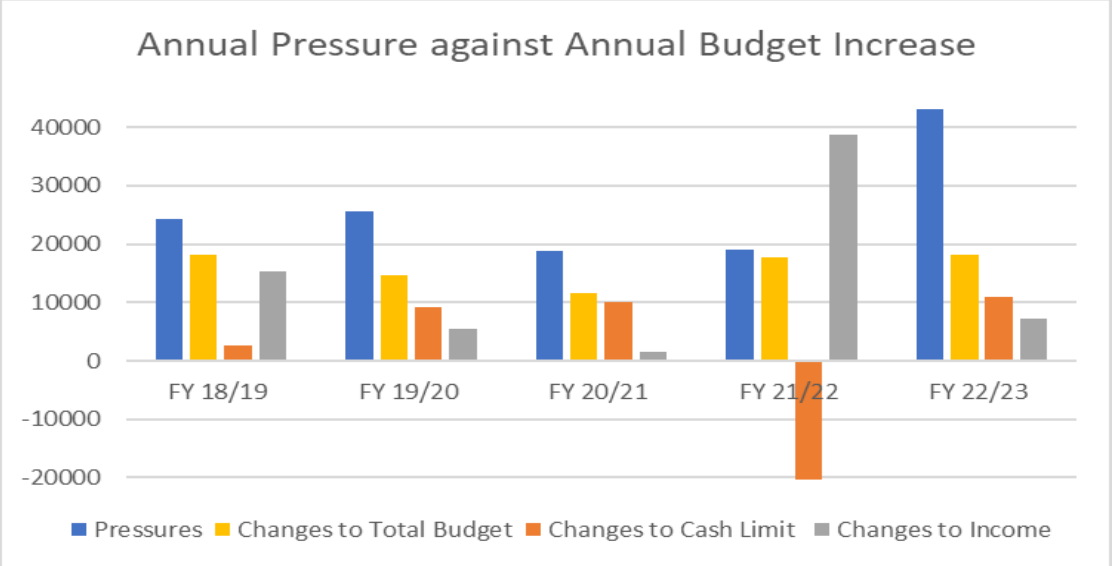
- A business case for an additional one off spend on agency staff to escalate pace of reviews.
- A business case for support to implement automation and digital technologies across Adult Social Care to escalate pace of delivering efficiencies in system processes and in doing so release time to care.

3.2.4 The outcomes of these additional actions will be reported to next Committee.

4 EFFECTIVE USE OF RESOURCES

4.1 Appendix 2 of this report provides a detailed analysis of the changes to the Adult Health and Social Care budget over the last six years.

4.2 The analysis shows that, despite annual increases to the total budget, cost pressures are in excess of the council's ability to increase funding on a year by year basis.



4.3 The analysis provides a narrative of a changing profile in the allocated budget, with the proportion of cash limit reducing over time. The overall budget is increasingly reliant on grant funding and other income.

4.4 The erosion by government of the Revenue Support Grant and the increased reliance on specific grants and other income presents a structural risk, because it means the Council has less control over funding levels than if the service were funded more from its own resources. The key risks are: -

- Individual contributions are levied and collected by the Council, but the ability to pay is subject to wider economic factors, such as the cost of living crisis and energy crisis.

- Grant payments are determined nationally and passed to Adult Health and Social Care via Health, Public Health or through Corporate Finance. Amounts received are therefore subject to national policy decisions.
- Allocation of funding to Adult Social Care Policy Committee after corporate recharges are applied.

4.5 Appendix 2 makes the following recommendations to the Committee:

- Note the diminishing proportion of cash limit in the Adult Health and Social Care budget and increased proportion of external income, especially grant funding. This reflects the transfer of funding by central government, away from Revenue Support Grant to specific Adult Social Care grants.
- Note the analysis of cost pressures for the last five years, that shows the cost of increasing demand is in excess of local resources. In addition to which must be considered cost pressures from inflation, staff pay and loss of external funding.
- Adult Health and Social Care directorate has delivered over £48m savings over the last five years and is forecast to deliver a further £15.6m in 2022/23 – a total of £63.8m.

5 Better Care Fund

5.1 Alongside this report to the November Adult Health and Social Care Policy Committee will be a full report on the Better Care Fund agreement between Sheffield City Council and the NHS Integrated Commissioning Board.

5.2 Governance of the Better Care Fund forms part of our ongoing review to realise the benefits of integrated working, improve outcomes for the people of Sheffield, and deliver efficiencies in the Adult Health and Social Care system.

5.3 Relevant to this financial update is the report's reference to:

- Targets for **national** metrics set for measuring effectiveness of the Better Care Fund, predicated on reablement following discharge from hospital, admission to residential care, avoidable hospital admissions, and whether people were discharged from hospital to their own home.

- Outcomes under the **local** Better Care Themes relating to well-being, prevention, recovery, independence, autonomy, community, and better communication.

- Alignment with our strategic intentions for the delivery of savings:
  - Improved Information, Guidance and Advice
  - Greater use of and access to equipment, technology, and other independent living solutions

- Alignment of Adult Social Care systems to Primary Care Networks
- Multi-Disciplinary Team working
- Risk stratification linked to prevention approaches

6 HOW DOES THIS DECISION CONTRIBUTE?

6.1 Good governance in relation to resource management and financial decision making supports the delivery of the adult social care vision and strategy

6.2 Our long-term strategy for Adult Health and Social Care, sets out the outcomes we are driving for as a service, and the commitments we will follow to deliver those outcomes:

- Support people to live a fulfilling life at home, connected to the community and resources around them, and provide care and support where needed.
- Provide temporary assistance to help people regain some stability and control in their life following ill health or crisis.
- Provide care and support with accommodation were this is needed in a safe and supportive environment that can be called home.
- Make sure support is led by 'what matters to you,' with helpful information and easier to understand steps.
- Recognise and value unpaid carers and the social care workforce and the contribution they make to our city.
- Make sure there is a good choice of affordable care and support available, with a focus on people's experiences and improving quality.

7 HAS THERE BEEN ANY CONSULTATION?

7.1 The purpose of this report is provided background to the funding of Adult Social Care, an update to the forecast spend position for 2022/23 and progress with the delivery of savings. No consultation has been undertaken on these aspects.

7.2 Consultation is undertaken during the development of proposals for the budget and implementation of proposals for the budget as appropriate.

8 RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

8.1 Equality of Opportunity Implications

8.1.1 As part of the annual budget setting process, an overarching EIA assesses the cumulative impact of budget proposals (EIA 1128), as well as individual EIAs for each proposal that are monitored and maintained as an ongoing process.

The Savings Plan referred to in summary was agreed by the Council as part of the 22/23 Budget and the EIAs for each element remain live.

8.2 Financial and Commercial Implications

8.2.1 Our long-term financial strategy to support the implementation of the adult health and social care strategy consists of three elements:

- Supporting people to be independent
- Secure income and funding streams
- Good governance

8.2.2 This report is part of an improved financial governance framework that aims to improve understanding and provide transparency on the use of public money to the citizens of Sheffield.

8.2.3 Financial governance will be aligned with the adult health and social care strategy to ensure that opportunities for efficiency and improvement are recognised and developed by accountable owners. An emphasis on enablement and less formal support will be embedded through processes that identify a strengths-based practice at the point of assessment and review.

8.2.4 Given the overall financial position of the Council there is a requirement on the committee to address the overspend position in 2022/23 and support plans to mitigate it.

8.3 Legal Implications

8.3.1 As this report is designed to provide information about background to and an update about the financial position rather than set out particular proposals for the budget and implications, there are no specific legal implications arising from the content. The ongoing process will however assist the local authority in meeting its obligations and legal duties.

8.4 Climate Implications

8.4.1 There are no significant climate impacts to consider arising directly from this decision.

8.5 Other Implications

8.5.1 There are no further implications to consider at this time.

9 ALTERNATIVE OPTIONS CONSIDERED

9.1 Not applicable – no decision or change is being proposed.

10 REASONS FOR RECOMMENDATIONS

10.1 These recommendations are made to support strategic planning and operational decisions that are necessary for the long-term sustainability of adult health and social care and the long-term benefit of people in Sheffield.

Appendix 1: Financial and Resource Management Delivery Plan

Category	Objective	Next action(s)	Who	When
Strategic (high level plan and review**)**				
1. Financial strategy	Update and approve financial strategy for AHSC (derived from, aligned to and dependent on AHSC vision/ strategy)	• Annual update to financial strategy	Liam Duggan	April 2023
2. Budget strategy	Develop medium term budget strategy for AHSC – linked to Adult Social Care future Target Operating Model (provision mix, unit cost, overhead etc)	• Formal multiyear budget strategy to be developed and brought to Committee	Liam Duggan	November-December 2022
3. Budget setting	Support to the committee, in line with the corporate timeline, for the delivery of a balanced budget for 2023/24	• Report to Committee on proposals for balancing budget *to take learning from Alders best practice guide as per LGA suggestion	Liam Duggan	November 2022
4. Benchmarking	Ongoing use of benchmarking to inform Target Operating model (provision mix, unit costs, overheads) and to guide budget strategy	• Reporting of latest benchmarking to Policy Committee	Liam Duggan	May 2023
5. Market Shaping Statement	Medium term plan for the reshaping of the care market to meet changing needs in line with our vision and strategy and future target operating model. This will set out how we will achieve a sustainable market with clear oversight and governance along with clear messages for providers on our commissioning intentions, potential use of capital development and the outcomes we want to achieve for the people in Sheffield.	• Engagement with providers over winter to develop detailed a market position statement for working age adults and Ageing and Living Well • In depth Market Position Statements to Committee	Catherine Bunten	In progress February 2023
6. Fair Cost of Care and Market Sustainability	A Care Market Sustainability Plan covering any move towards the fair cost of care and proposals for setting fee rates for commissioned care. This includes mechanisms for annual uplifts and review, mitigating key risks to the local market and particular consideration of the further commencement of Section 18(3) of the Care Act 2014.	• Further engagement with providers on market sustainability plan to develop final plan for submission in February 2023 • Market Sustainability Plan to be brought back to Committee and submitted to DoC	Catherine Bunten	February 2023

7. Change Programme	Manage and maintain a multiyear transformational change programme for delivery of the Adult Social Care Vision and Strategy and multiyear savings/ efficiencies	• Annual review of programme	Jon Brenner	March 2023
8. Innovation and legislation	Understanding of changes to national legislation and examples of innovative practice provide a regular horizon scanning discussion. Engagement with staff and partners and access to national fora to compare and develop practice and innovation.	• Update to Committee on timeline for Charging reform • LPS	Charles Crowe	March 2023
9. External assurance	Benchmark our financial performance against national frameworks and secure external challenge and assurance	• Incorporate LGA suggestions into plan • Incorporate CQC framework into SCC P&O Framework	Liam Duggan	September 2023
10. System efficiency	Efficient and effective system makes best use of shared resources	• BCF update provided to Committee	Judith Town	November 2022
11. Workforce Plan	Develop costed medium term staffing structure for adult social care as part of the Target Operating Model	•		
Tactical (monitoring and oversight)				
12. Cost driver analysis	Clarity on AHSC budget income, expenditure and pressures aligned to leadership team portfolios, legal obligations and strategic priorities	• Annual update to the Committee	Jonathan McKenna Moore	June 2023
13. Transparent funding and spend	Transparent funding of adult health and social care to improve understanding, understand risks, opportunities and to inform budget strategy	• Update to Committee on use of NHS funding to support early adoption of National Living wage	Liam Duggan	September 2023
14. Clear budget portfolios	Aligned budgets, contracts and staffing to leadership portfolios so that all portfolios have total budget, contractual and staffing oversight and are able to implement service budget plans	• Reallocated staffing budgets under new operating structure now aligned to Finance structure	Jon Brenner	February 2023

	(including service governance and actions to balance budgets)			
15. Budget monitoring, reporting and financial forecasting	Full compliance with high quality forecasting based on financial management reports which meet the needs of the leadership teams and escalates intelligence appropriately resulting in responsive/ corrective action.	• Review of purchasing meeting format following implementation of new structure	Liam Duggan/ Tim Gollins	February 2023
16. Contracts register	Single register of all AHSC 3rd party service contracts, grants and call off orders to support monitoring, planning and review alongside equivalent register from CCG and identification of inefficiency.	• Recommendations from project group as to whether contracts register can be held 'on system' (ContrOCC)	Liam Duggan/ Catherine Bunten	November 2022
17. Establishment control	Processes for maintaining the AHSC establishment, providing reporting information and ensuring spend is controlled in line with the budget.	• Establishment and budgets to be updated following restructure	Jane Wilby	November 2022
18. In year project tracking	Active initiatives to deliver savings are tracked, reviewed on a project-by-project basis with regard to delivery against stated objectives and continued funding or disinvestment	• Process for management and forecast of savings to be updated	Liam Duggan	February 2023
Operational (process/ controls)				
19. Behaviours and culture	Staff understand the funding of adult social care and are aware of the financial impact of the decisions they make. Budget discussions take place in teams and financial considerations are a part of all decision making. Financial Risks & Issues are reported and managed at an appropriate level. Staff are empowered to mitigate risks rather than escalate and transfer responsibility.	• Financial controls implemented • Performance Management Framework implemented • Practice Quality Framework developed	Liam Duggan	Nov 22- March 23
20. Care package approval	Individual packages of care are authorised at the required level according to a scheme of delegated authority. The delegated authoriser is confident that alternatives have been explored and the funding request offers the best value for money to achieve a good outcome for the person.	• New formal financial approval to be required within the case management system	Liam Duggan	November 2023

21. Recruitment controls	Controls to ensure that recruitment takes place in support of the budget.	• Annual review of controls as part of the wider establishment control process.	Liam Duggan	March 2023
22. Contracts	Controls and flexibility written into contracts and providers incentivised to promote independence	• Working age contracts to be drafted (Homecare now live tender)	Catherine Bunten	March 2023
23. Transition planning	Planning is carried out on a collaborative basis to determine the best route to a good quality of life as an adult and to derive a long-term forecast for demand.	• Preparation for Adulthood Team to start to work with people under 18.	Andrew Wheawall	September 2022
24. Data quality	Care is recorded accurately and in a timely way to improve safety, efficiency, planning and financial management, facilitate high quality payments and charging and improve intelligence from benchmarking	• Develop Practice Quality Framework with focus on recording of care • Care Trust recording of community care to be standardised • Property income to be accounted for as contribution income for benchmarking purposes	Janet Kerr Tim Gollins Jane Wilby	March 2023 March 2023 March 2023
25. Payment processes	Payment processes are efficient and effective, and include validation and fraud control measures	• Implement new Homecare payment and charging model	Liam Duggan	April 2023
26. Income management and financial inclusion	Online advice and guidance, assessment and care management support, funding support, charging and collection processes are high quality, joined up, person centred and promote financial understanding, optimisation of personal income and financial inclusion	• Implement Charging Reform • Develop financial self-service processes	Liam Duggan	October 2023

APPENDIX 2 – USE OF ADULT SOCIAL CARE RESOURCES

1. **Introduction:**

Our vision is that everyone in Sheffield lives in a place they can call home, in communities that care, doing things that matter to them, celebrated for who they are and, when they need it, they receive care and support that prioritises independence, choice, and recovery.

Finance reports to the Adult Health and Social Care Policy Committee detail how the Directorate is using available resources to support individuals, carers, and communities in order to deliver our vision and strategy.

The purpose of this appendix to the report is to provide detailed information about:

- Adult Health and Social Care Policy Committee Cash Limit budget for 2022/23 compared against previous years.

- Adult Health and Social Care Directorate budget pressures and mitigation.

2. **Recommendations for Policy Committee**:

- Note the diminishing proportion of cash limit in the Adult Health and Social Care budget and increased proportion of external income, especially grant funding. This reflects the transfer of funding by central government, away from Revenue Support Grant to specific Adult Social Care grants.

- Note the analysis of cost pressures for the last five years, that shows the cost of increasing demand is in excess of local resources. In addition to which must be considered cost pressures from inflation, staff pay and loss of external funding.

- Adult Health and Social Care directorate has delivered over £48m savings over the last five years and is forecast to deliver a further £15.6m in 2022/23 – a total of £63.8m.

APPENDIX 2 – **USE OF ADULT SOCIAL CARE RESOURCES**

3. **Adult Health and Social Care Policy Committee Budget Overview**

The Adult Health and Social Care Policy Committee cash limit budget for the period 2022/23 is **£150m**.

Additional income is received through grants, fees and charges as described to Committee on 15th June 2022.

Table A: Adult Social Care Policy Committee Budget 2022/ 2023				
Total Budget			**Directorate**	**Responsible Director**
Overall Budget (£000's)	**SCC Cash Limit** (£000's)	**Grants & Other Income** (£000's)		
£274.9m	£132.5m	£142.4m	Adult Health and Social Care	Alexis Chappell (DASS)
£19.8m	£8.5m	£11.3m	Public Health (Integrated Commissioning)	Greg Fell (DPH)
£9m	£9m	£0	Resources (Corporate Recharges)	Ryan Keyworth (DoF)
£303.7m	**£150m**	**£153.7m**		

Key points for the Committee to note are:

- The Committee is accountable for a cash limit of £150m. When including grants and other income the total budget is £303.7m.

- £132.5m (88%) of the Committee's cash limit budget is the responsibility of the Director of Adult Health and Social Care. This represents 48% of the total Adult Health and Social Care Directorate budget and 44% of the total Committee budget. The 44% Adult Health and Social Care cash limit is the part of Adult Social Care Directorate budget which the Committee can apply efficiency savings to.

- £16.6m (11%) of the Committee budget is the responsibility of Corporate Services and Public Health Services, under the Integrated Commissioning service.

- Due to the decision at Strategy and Resources Committee on 5th July 2022 to put in place a cash standstill for 23/24 for all Committees, the cash limit described for 2022/23 will be the same cash limit which the Adult Health and Social Care Policy Committee receives for 2023/24.

- Pressures applied to date have been to Directorate Budgets. From the year 23/24 onwards they will be applied to the Committee Budget including both Adult Health and Social Care and Director of Public Health (Integrated Commissioning).

4. Adult Health and Social Care Directorate Income

Table B shows the Adult Health and Social Care Directorate cash limit and external income. Comparisons have been provided for the last 5 financial years to enable the Committee to understand the trajectory of income and other funding.

Table B: Adult Health and Social Care Directorate Cash Limit and Income							
	FY 17/18	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
Total Cash Limit - (from SCC income)	£128.2m	£131m	£140.1m	£150.2m	£129.2m	£132.5m	£132.5m
Total Grants and Other Income	£79.2m	£92.1m	£99.2m	£105.9m	£144.8m	£142.4m	N/A
% Cash Limit of total budget	62%	59%	59%	59%	47%	48%	N/A
Total Budget	**£207.4m**	**£223.1m**	**£239.3m**	**£256.1m**	**£274m**	**£274.9m**	N/A
Breakdown of Grants and Other Income (£000's) (Data from lginform.local.gov.uk)							
Better Care Fund	14,708	20,372	25,723	28,429	28,429	29,290	N/A
Income from Other Sources	34,235	33,355	34,998	36,424	37,608	50,364	N/A
Winter Pressures Grant	No grant listed	2,705	2,705	From 19/20 Winter Pressures became part of the Better Care Fund and was not paid separately.			
Social Care Grant	2,717	1,691	4,621	16,863	21,806	29,511	N/A

Source: Sheffield City Council.

Key points for the Committee to note are:

- Following a sequence of annual cash limit increases, the cash limit budget for Adult Social Care Directorate has now reduced close to the level set in 2018/19.
- Increases in the Better Care Fund, Social Care Grant, and other income (mainly Public Health Grant) have led to an increased over-all budget to fund increasing service provision and meet inflationary pressures.
- The proportion of the total budget made up of cash limit has reduced by 14% from 62% in 2017/18 to 48% today.
- Cash limit represents the proportion of the budget over which the Council has autonomy and the part of the budget against which the Council mitigates annual cost pressures.
- Any expenditure over the total budget is determined as an overspend against the cash limit.

5. Changes to Cash Limit Between 2020 and 2022

As noted in Table B, the cash limit reduced between 2020/21 and 2021/22 but the grant amount under other income increased at the same time. This is due to Revenue Support Grant that was identified as cash limit being replaced by Adult Social Care specific grants as part of national funding changes.

For the Financial Year 2021/ 2022 the cash limit budget for Adult Social Care reduced rather than increased because £39m of budget previously treated as cash limit was accounted for as grant and the growth in the cash limit budget was not enough to fully offset this.

In 2021/22 the Integrated Commissioning Service was developed by the Council with £8.5m of the Adult Health and Social Care cash limit assigned to this service from 22/23.

6. Benchmarking Cash Limit and External Income against Core Cities

Table C shows the proportion of Adult Social Care budget made up of cash limit in comparative core cities. Data is sourced from the annual published accounts of each Local Authority. Not all core cities are comparable due to the structure of published accounts (i.e., not all Councils detail Adult Social Care as a separate entity).

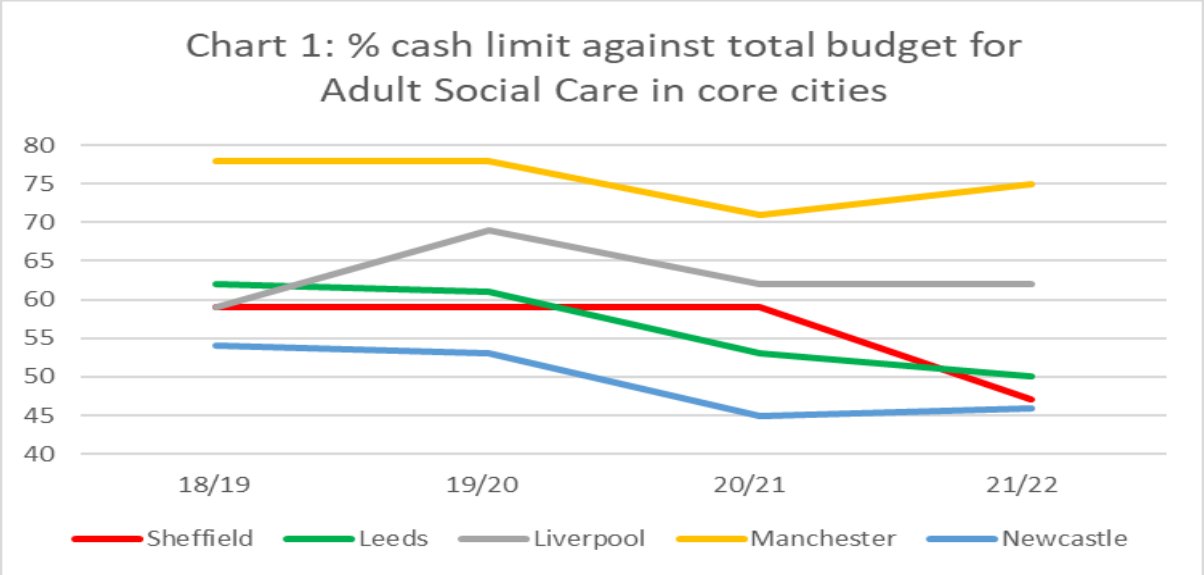
Table C: Comparative proportion of cash limit against gross budget in core cities

City	Year	Gross expenditure	Gross income	Net expenditure	Gross Spend per Head	% Cash Limit
Sheffield	18/19	223,225	92,120	131,105	379	59%
(Population	19/20	239,288	99,146	140,142	406	59%
589,000)	20/21	256,077	105,908	150,169	435	59%
	21/22	274,019	144,834	129,185	465	47%
Leeds	18/19	345,302	132,782	212,520	432	62%
(Pop. 799,000)	19/20	361,016	139,265	221,751	452	61%
	20/21	404,457	191,120	213,337	506	53%
	21/22	399,384	200,379	199,005	500	50%
Liverpool	18/19	296,034	122,811	173,223	592	59%
(Pop. 500,000)	19/20	267,484	82,271	185,213	535	69%
	20/21	318,304	121,029	197,275	637	62%
	21/22	312,894	117,817	195,077	626	62%
Manchester	18/19	245,499	55,222	190,277	442	78%
(Pop. 556,000)	19/20	272,674	60,059	212,615	490	78%
	20/21	284,455	81,530	202,925	512	71%
	21/22	298,485	74,350	224,135	537	75%
Newcastle	18/19	175,428	81,272	94,156	571	54%

Upon Tyne	19/20	185,663	87,981	97,682	605	53%
(Pop. 307,000)	20/21	209,430	114,536	94,894	682	45%
	21/22	203,118	110,234	92,884	662	46%

Note: 22/23 income has not been published for other local authorities at this time.

Chart 1 shows this data as a trend for each Council from 2018/19 to 2021/22:



Key points for the Committee to note are:

- Sheffield has followed a general trend for the cash limit percentage of adult social care budgets to reduce, with a greater emphasis on grant income to meet increasing cost pressures.
- However, Sheffield's trajectory is only matched by Leeds, with the percentage change of 12% taking it almost level with the lowest comparator of Newcastle, while Liverpool is above its starting position and Manchester maintains a much higher proportion of cash limit budget, reversing the initial trend in 21/22.
- This data set includes income from personal contributions to the cost of care, as well as grant income previously discussed.
- This data set will not include the full extent of Public Health Grant received by the local authority, as this will be distributed across service areas.

7. **Adult Health and Social Care Directorate Expenditure and Pressures –**

Comparison Over Last five Financial Years.

Table D shows the final outturn position for Adult Social Care spend over the last five years. Budgets are adjusted in-year with temporary budgets and additional funding. Overspends in any given year will create a budget pressure for the following year.

Table D: Adult Health and Social Care Directorate Income vs Expenditure over past 5 years						
	FY 17/18	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**
Income (Source: Sheffield City Council)						
Cash Limit Budget	£128.2m	£131m	£140.1m	£150.2m	£129.2m	£132.5m
Gross Budget (Cash Limit + Grants + Contributions)	£207.4m	£223.1m	£239.3m	£256m	£274m	£274.9m
Total Gross Expenditure (Outturn at year end)	£233.5m	£245.7m	£255.3m	£304m	£322.4m	n/a
Temporary expenditure budgets removed from outturn	+£13.8m	+£8.9m	+£12.7m	+£9.4m	+£15.5m	n/a
Overspend outturn against budget	-£12.3m	-£13.7m	-£3.3m	-£38.5m	-£32.9m	n/a

Table D shows the Adult Health and Social Care Directorate expenditure and pressures for the last five years to enable the Committee to understand trajectory of cost pressures and the corresponding savings which Adult Health and Social Care have been required to make to mitigate those pressures.

It highlights, as did the benchmarking information to September Committee, that:

- The service has overspent in the years before the pandemic, but that has increased since the pandemic in 2020/21.
- Expenditure for Adult Social Care significantly increased during the pandemic and this was reflected in increased reliance on care at home to keep people safe from harm.
- Despite increases in the total budget, the resources available have not kept pace with increasing demand, leading to an overspend at the end of each financial year.

Table E: Pressure Mitigation – Required by Council to Balance Budget (Source: Sheffield City Council)						
	FY 17/18	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**
Savings Target	£13.4m	£22.8m	£25.7m	£18.8m	£18.7m	£25.2m
Savings Delivered (pressures mitigated)	£9.9m	£14.8m	£9.5m	£8.5m	£5.5m	£15.6m (forecast)
Savings not met (impact on overspend)	£3.5m	£8m	£16.2m	£10.3m	£13.2m	£9.6m (forecast)

During the first year of the Covid pandemic, adapting to the pandemic and ensuring people's safety were prioritised over planned savings. In effect this meant the budget plans for 2020/21 were rolled over to 2021/22.

Key points for the Committee to note are:

- Adult Health and Social Care directorate has delivered over £48m savings over the last five years and is forecast to deliver a further £15.6m in 2022/23 – a total of £63.8m.
- In past years, some unachieved savings were carried over into the following year and allowed to build a cumulative effect on the budget overspend that was irretrievable. These cumulative overspends were written off in 2021/22 and greater scrutiny was applied to the deliverability of budget savings.
- Adult Health and Social Care has overspent each year and has not delivered savings targets in full and has never been able to fully mitigate its own pressures.

Table F: Adult Health and Social Care Directorate Pressures/ Savings Overview Comparison over 5 Years					
	FY 18/19	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**
Reason for the Pressures					
Overspend (pressures carried forward from additional growth or undelivered savings)	n/a	n/a	n/a	n/a	21.8m
Growth in demand for services from new people or increased support	15.8m	14.4m	10.7m	12.3m	12.2m
Uplifts to provider fees to meet inflation	3.3m	4.5m	6.2m	7.3m	6.0m
Loss of income (inc. one-off Health funding and reduction to ILF)	3.6m	5.6m	0.05m	1.7m	2.2m
Legislation Changes	0	1.1m	0.5m	0.2m	0
Short term investments to mitigate overspend	0	0	0	0	0

Staff pay award/Staff pressures/Increments	1.5m	1.8m	2.0m	0.7m	2.1m
Total Pressures*	£24.1m	£26.4m	£19.4m	£22.2m	£44.4m
How were the Pressures Met by Savings					
Funding from Council Wide Efficiencies /Reserves	£6.3m	£10.3m	£6.5m	£-	£6.2m
Mitigations / Savings identified	£12m	£7.8m	£7.8m	£4.2m	£25.2m
Reviews	1.1m	1.1m	2.7m	0	12.8m
Commissioning	1.1m	1.7m	0.9m	3.4m	3.6m
New Starters	1.4m	2.0m	1.7m	0	1.9m
Health Funding (CHC)	4.9m	0.07m	1.5m	0	0.4m
Staffing	0.3m	0.1m	0	0	4m
Income	3.2m	2.8m	1.0m	0.8m	1.4m
Other	0	0	0	0	0.9m
New Grant allocations from central government	n/a	£7.3m	n/a	£17.9m***	£8.6m
Social Care Precept**	£5.8m	£338k	£4.5m	£6.4m	£3.3m

* Due to portfolio restructuring the pressures described here are indicative of those added to all budgets now within the responsibility of this committee. However due to significant restructuring over this period there is a possibility that some inaccuracies exist within this retrospective analysis.

**Income from the Social Care Precept has been a key part of the council strategy to support the funding of adult social care. The social care precept is not directly applied to Adult Social Care budgets because it is collected through council tax mechanisms and administered centrally because it is liable to incur bad debt from non-payment and constant changes to the household tax base.

***The overall value for grants and other income funding for adult social care increased by £39m in 2021/22. A corresponding £21m reduction in cash limit budgets resulted in a net increase to the total budget of £17.9m seen in Table B, comparing 2021/22 with 2020/21.

Key points for the Committee to note are:

- Social Care Precept has been applied most years, but the value of additional income raised is a fraction of the total pressures.
- As noted above, the budget plans for 2021/22 were mainly a carry-over from 2020/21 plans that were halted due to the Covid pandemic. Some additional savings were applied related to income changes and contract changes.
- Use of Council reserves tends to be applied retrospectively rather than quantified at the start of the annual budget, because the amount of reserves required are determined by the overspend in the previous financial year.

Report to Policy Committee

Author/Lead Officer of Report: Ryan Keyworth, Director of Finance and Commercial Services

Tel: +44 114 474 1438

Report of:	*Ryan Keyworth & Alexis Chappell*
Report to:	*Adult Health and Social Care Policy Committee*
Date of Decision:	*16 November 2022*
Subject:	*2023/24 Budget Position*

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	x	No	x
If YES, what EIA reference number has it been given? *1248*				
Has appropriate consultation taken place?	Yes		No	x
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	x
Does the report contain confidential or exempt information?	Yes	x	No	

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

Appendix 1 is not for publication because it contains exempt information under Paragraph 3 of Schedule 12A of the Local Government Act 1972 (as amended).

Purpose of Report:

This report updates in the Policy Committee on the progress of the 2023/24 budget process.

Appendix 1 contains specific budget proposals that the Committee are asked to endorse.

Recommendations:

The Committee is recommended to:

1. Note the update on the Council's 2023/24 budget position.
2. Endorse the budget proposals set out in Appendix 1

Background Papers:

12 October 2022 Strategy and Resources Committee Reporthttps://democracy.sheffield.gov.uk/documents/s50376/3 - Revenue Budget Report 2022-23.pdf

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**: *Ryan Keyworth, Director of Finance and Commercial Services*
		Legal: *David Hollis, Assistant Director, Legal and Governance*
		Equalities & Consultation: *James Henderson, Director of Policy, Performance and Communications*
		Climate: n/a
	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:**	*Ryan Keyworth*
3	**Committee Chair consulted:**	*Angela Argenzio and George Lindars-Hammond*
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 EMT member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	
	Lead Officer Name: *Ryan Keyworth*	**Job Title:** *Director of Finance and Commercial Services*
	Date: 1st *November 2022*	

1. PROPOSAL

1.1. This report updates in the Policy Committee on the progress of the 2023/24 budget process.

1.2. **S&R received the sum of the Policy Committee Budget Proposals on 12 October. This left a £19.6m remaining gap assuming that all proposals Noted by Policy Committees are ultimately approved**

General Fund Revenue Budget (£m)	Pressure	Noted by Committee	Mitigations to find
AHSC	25.0	-25.0	0.0
ECF	12.4	-6.9	5.5
Housing	0.7	-0.5	0.2
TRC	3.4	-0.8	2.6
EDS	0.6	-0.5	0.1
WSS	11.5	-0.9	10.6
CPL	2.3	-2.3	0.0
S&R (Corporate)	16.7	-16.7	0.0
S&R (Committee)	7.8	-7.2	0.6
Total	**80.4**	**-60.8**	**19.6**

1.3. **There are some potential improvements to this position**

Work is still in progress, particularly with the Education, Children and Families Committee which is resulting in further savings being identified.

It is hoped that this will improve the position to leave around £15m still to be found.

1.4. **We need to find options to close most, if not all of this gap**

Based on the latest budget monitoring, by the end of the financial year we will have used around £54m of the £70m reserves we earmarked to support a return to financial sustainability.

That means we can't use reserves to balance next year's budget – we don't have the scope to fill recurrent overspends with one-off reserves and if we do, we'll find ourselves under increasing external scrutiny.

1.5. **We can afford some one-off costs for change**

We can use the remaining £16m of reserves to help us change our organisation to both deliver on our plans and operate at a lower ongoing cost.

1.6. **Ultimately, it's for S&R to recommend a budget to Council**

In the Council's constitution, it is for the Strategy and Resources Committee to recommend a budget to Full Council. This applies to both the Housing Revenue Account business plan and rent setting report to the 1 February 2023 full Council meeting and the rest of the budgets and Council Tax level report to the 1 March 2023 Full Council meeting.

The process we have followed this year with Policy Committees was designed to provide the maximum level of individual Policy Committee involvement in the process that is allowed by the Constitution.

Time is now against us, and it may be necessary for S&R to make recommendations to Council that have not been

explicitly approved by the relevant Policy Committee in a public meeting.

November Policy Committees and December Strategy and Resources Committee

1.7. **The November Policy Committees can be the first step to approval**

The original intention was for Policy Committees to endorse their overall budgets and recommend them to Strategy and Resources which would in turn recommend the budget to Full Council.

That is still be possible for some Committees where proposals have widespread political support and where the necessary consultations with stakeholders have taken place to allow proposals to be set out in public.

Adult Health and Social Care Committee proposals are set out in Appendix 1 to this report.

1.8. **5 December S&R will need an almost final position**

There will be no time to alter the Housing Committee's Housing Revenue Account business plan and budget after Christmas if the Housing Rent setting decision is to be made at the 1 February Council.

There may be time leading up to Christmas to make minor changes to the General Fund budget leading up to 1 March Council, but not much.

There will also be significant work to do on public consultation, equality and climate impacts and other stakeholder engagement in the time between Christmas and mid-February.

We need a solid position ahead of what could be an uncertain and late Local Government Finance Settlement.

2. HOW DOES THIS DECISION CONTRIBUTE?

The recommendations in this report are central to the process of completing the Council's 2023/24 budget process in good time.

3. HAS THERE BEEN ANY CONSULTATION?

There has been no consultation on this report, however, it is anticipated that the budget process itself will involve significant consultation as the Policy Committees develop their budget proposals.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1. Equality Implications

There are no direct equality implications arising from this report. It is expected that individual Committees will use equality impact analyses as a basis for the development of their budget proposals in due course.

4.2. Financial and Commercial Implications

There are no direct financial implications from this report.

4.3. Legal Implications

Under section 25 of the Local Government Act 2003, the Chief Finance Officer of an authority is required to report on the following matters:

- the robustness of the estimates made for the purposes of determining its budget requirement for the forthcoming year; and
- the adequacy of the proposed financial reserves.

There is also a requirement for the authority to have regard to the report of the Chief Finance Officer when making decisions on its budget requirement and level of financial reserves.

By the law, the Council must set and deliver a balanced budget, which is a financial plan based on sound assumptions which shows how income will equal spend over the short- and medium-term. This can take into account deliverable cost savings and/or local income growth strategies as well as useable reserves. However, a budget will not be balanced where it reduces reserves to unacceptably low levels and regard must be had to any report of the Chief Finance Officer on the required level of reserves under section 25 of the Local Government Act 2003, which sets obligations of adequacy on controlled reserves.

4.4. Climate Implications

There are no direct climate implications arising from this report. It is expected that individual Committees will consider climate implications as they develop their budget proposals in due course.

4.5. Other Implications

No direct implication

5. ALTERNATIVE OPTIONS CONSIDERED

The Council is required to both set a balance budget and to ensure that in-year income and expenditure are balanced. No other alternatives were considered.

6. REASONS FOR DECISION

The Council is required by law to set a balanced budget each year. This report is pursuant to that objective and is in line with the process and timetable agreed by the Strategy and Resources Committee on 31 May 2022 and 5 July 2022.

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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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