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Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 8 December 2022 at 9.30 am

Town Hall, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Angela Argenzio	
Dr David Black	Sheffield Teaching Hospitals NHS FT
Ruth Brown	NHS Trust
Sandie Buchan	Sheffield CCG
Alexis Chappell	
Greg Fell	Director of Public Health, Sheffield City Council
Councillor Douglas Johnson	
Andrew Jones	People Services
Kate Josephs	
Benn Kemp	South Yorkshire Police
Emma Latimer	ICB Place Committee
Kate Martin	
Sharon Mays	Sheffield Health & Social Care NHS Foundation Trust
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
Joe Rennie	Sheffield Hallam University
Kathryn Robertshaw	Sheffield Health and Care Partnership
Judy Robinson	Chair, Healthwatch Sheffield
Councillor Mick Rooney	
Helen Sims	Voluntary Action Sheffield
Martin Smith	BCF
Robert Sykes	University of Sheffield
Laura White	

Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

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

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

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

PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

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

FACILITIES

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

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

8 DECEMBER 2022

Order of Business

1.	**Apologies for Absence**	
2.	**Declarations of Interest** Members to declare any interests they have in the business to be considered at the meeting.	(Pages 7 - 10)
3.	**Public Questions** To receive any questions from members of the public.	
4.	**Healthwatch Update** Verbal Update	
5.	**Health Protection Update** Report of the Director of Public Health - SCC	(Pages 11 - 18)
6.	**Better Care Fund Update** Report of the Director Adult Health, and Social Care and Director Commissioning Developments, South Yorkshire Integrated Care Board.	(Pages 19 - 134)
7.	**Health & Wellbeing Board - Co-Chairing** Report of the Director of Public Health-SCC	(Pages 135 - 138)
8.	**Oral Health** Report of the Director of Public Health- SCC	(Pages 139 - 154)
9.	**Learning Disabilities/LeDeR Update**	(Pages 155 - 160)
10.	**Commercial Determinants of Health** Report of the Director of Public Health-SCC	(Pages 161 - 170)
11.	**Sheffield Health and Care Partnerships** Verbal Update	
12.	**Primary and Community Mental Health Transformation**	(Pages 171 - 248)
13.	**Infant Mortality**	(Pages 249 -

256)

Report of the Director of Public Health - SCC

14. Forward Plan (Pages 257 - 258)

Report of the Director of Public Health - SCC

15. Minutes of the Previous Meeting (Pages 259 - 264)

16. Date and Time of Next Meeting

The next meeting is on 30th March 2023 at 2pm, at the Town Hall, Sheffield.

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

Further advice can be obtained from David Hollis, Interim Director of Legal and Governance by emailing david.hollis@sheffield.gov.uk.

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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell Director of Public Health
Date:	December 2022
Subject:	Health Protection Update
Author of Report:	Ruth Granger, Consultant in Public Health 0114 273 5093 ruth.granger@sheffield.gov.uk

Summary:

The Health and Wellbeing Board agreed in June 22 to have a twice yearly update on the health protection system. This paper highlights the key issues facing the Health Protection system in Sheffield and makes recommendations to address these challenges for the Board to consider. Issues include:

- Uptake of routine immunisations particularly routine childhood immunisations
- Managing respiratory diseases for autumn winter 2022/23 winter season
- Reviewing the Sheffield Mass Treatment and Vaccination Plan
- The cost of living crisis increasing risk of spread of food borne disease.
- Learning from Covid and the Covid 19 Public Inquiry

Action following previous update

Following the previous meeting and the discussion about vaccination uptake, the Chairperson wrote to NHS England to highlight the concerns about the funding system for vaccination contributing to exacerbating inequalities.

Questions for the Health and Wellbeing Board:

How can organisations who are part of the Health and Well Being Board contribute or strengthen the response to the following risks?

- Uptake of routine immunisations particularly routine childhood immunisations
- Managing respiratory diseases for autumn winter 2022/23 winter season.
- Reviewing the Sheffield Mass Treatment and Vaccination plan
- Cost of living crisis increasing risk of spread of food borne disease.
- Learning from Covid and the Covid 19 Public Inquiry

Recommendations for the Health and Wellbeing Board:

The Board are recommended to:

- Note the key health protection issues including the impact of winter pressures and cost of living.
- Support increased uptake of immunisation
- Ensure their organisation is engaged with review of the Mass Treatment and Vaccination plan and work to embed this into partner organisations.
- Continue to support cross system learning from Covid-19 including contributing to and learning from the UK Public Inquiry.

Background Papers:

none

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

This connects to the overall aim of the Health & Wellbeing Strategy of reducing health inequalities in Sheffield.

Who has contributed to this paper?

This paper is based on discussions between partners at the Health Protection Committee and internal discussions within the Public Health Specialist Service.

SHEFFIELD HEALTH PROTECTION SYSTEM UPDATE

1.0 SUMMARY

1.1 This paper is a twice yearly update setting out the key issues facing the Health Protection system in Sheffield and makes recommendations to address these challenges for the Board to consider.

1.2 The Director of Public Health for Sheffield has a statutory role to be assured that there are safe and efficient systems in place to manage, as far as possible, threats to health.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 The Covid pandemic has shown how the impact of health protection issues can be wide reaching, affecting most severely those with least money, who are vulnerable and those with protected characteristics. A well functioning health protection system is therefore crucial for addressing health inequalities.

3.0 HEALTH PROTECTION IN SHEFFIELD

3.1 Health protection includes immunisation, infectious diseases and preparing and responding to emergencies such as outbreaks or floods. This work requires collaboration and expertise across a range of teams and organisations who all have different roles for planning, prevention and management. This includes Environmental Health, Primary Care, NHS Trusts, NHS England, voluntary and community sector organisations, UK Health Security Agency and Local Authority teams.

3.2 How risks with health protection are identified

Key areas of risk in relation to health protection are identified through a combination of:

- The Public Health Outcomes framework – this provides data on how we compare with other areas
- The Health Protection Committee risk log – high and medium risks from this log are included in the information below

4.0 KEY ISSUES IN HEALTH PROTECTION

4.1 Uptake of routine immunisations particularly routine childhood immunisations

Uptake of vaccination is a key part of protecting children from disease. While rates are improving there is still insufficient vaccination coverage for some communities to prevent cases and spread of preventable diseases. There are persistent geographical inequalities in

uptake of vaccination. A map showing inequalities in uptake across the city, linked to deprivation is shown in the appendix.

Following a discussion at the June 2022 Health and Well Being Board the Chairperson wrote to NHS England regarding concerns about how the funding of primary care for childhood vaccinations exacerbates health inequalities.

4.2 Managing respiratory diseases for autumn winter 2022/23 winter season.

There are intense pressures on health and social care system. Uptake of seasonal flu and covid booster vaccinations are at similar rates nationally as for previous years for those aged over 65 or under 65 with underlying health conditions but lower for 2 and 3 year olds. Learning from Covid has influenced ongoing delivery of vaccination. For example the Moor Market continues to be used as a setting for delivery of vaccination with 5300 vaccinations delivered there since April 2022.

4.3 Reviewing the Mass Treatment and Vaccination plan

In 2022 there has been a situation in Sheffield where vaccination of over 50 contacts for Hepatitis A was required. Following this there is a need, as a system, to review the Sheffield Mass Vaccination and Treatment plan considering the learning from this incident and embedding the new plan in organisations.

An important component of this work includes confirming arrangements for how responding to outbreaks is funded. The current arrangements are that where there is a clear commissioner they will pay (for example the ICB commission TB services so pay to respond to TB outbreaks or screening) and where there is no obvious commissioner it is a three way split between NHS England, the ICB and Local Authority Public Health. This needs to be confirmed with the new ICB structures.

4.4 Cost of living crisis increasing risk of spread of food borne disease.

Environmental health colleagues have extensive work to do to catch up with food inspection visits. Alongside this there are reports of food businesses cutting costs in ways which increase the risk of infectious diseases for example buying lower quality ingredients (such as meat) and incorrect storing of ingredients to save costs (for example turning off fridges).

4.5 Learning from Covid and the Covid 19 Public Inquiry

The previous update to the Health and Well Being Board outlined the work that is being done locally to debrief from the Covid 19 Pandemic. The UK Covid 19 Public Inquiry has now started with 3 initial ‘modules’ including 1. Resilience, planning and preparedness 2. Core political decision making and 3. Health care system. Further modules will be announced in the future. Core Participants have been selected for the first module of the

Inquiry including Government Departments, the Local Government Association and the Association of Directors of Public Health. This is likely to lead to recommendations for local systems.

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

5.1 We need to continue to work as a system to address health protection risks – for example with the Mass Vaccination and Treatment Plan

We learnt in the pandemic that taking a cross-system approach increases effectiveness. The Health and Wellbeing Board having oversight of the Health Protection Committee aids that approach.

A collective approach is required with organisations being involved and engaged with the review of the Sheffield Mass Treatment and Vaccination Plan. Leads from the Health Protection Committee and emergency planning leads from Sheffield organisations will be involved in this work. Commitment to support this work and organisational support to adopt and embed the plan will be crucial.

5.2 Increased focus on addressing inequalities in vaccination uptake

Coverage of childhood immunisations and adolescent immunisation programmes is lower than before the pandemic. The continuing inequalities in uptake are shown in the map in the appendix. All organisations have a role to take opportunities to promote and where appropriate offer vaccinations.

5.3 Strengthening the system – capacity is an issue

The system for Health Protection in Sheffield has traditionally been quite ‘lean’ and benchmarking shows that we do have low capacity compared to other cities. This is related to staff at operational, tactical and strategic level.

Included within this there continues to be risks in relation to lack of capacity for community Infection Prevention and Control support.

6.0 Questions for the board

How can organisations who are part of the Health and Well Being Board contribute or strengthen the response to the following risks:

- Uptake of routine immunisations particularly routine childhood immunisations
- Managing respiratory diseases for autumn winter 2022/23 winter season.
- Reviewing mass treatment and vaccination plan
- Cost of living crisis increasing risk of spread of food borne disease.

- Learning from Covid and the Covid 19 Public Inquiry

7.0 RECOMMENDATIONS

The Board are recommended to:

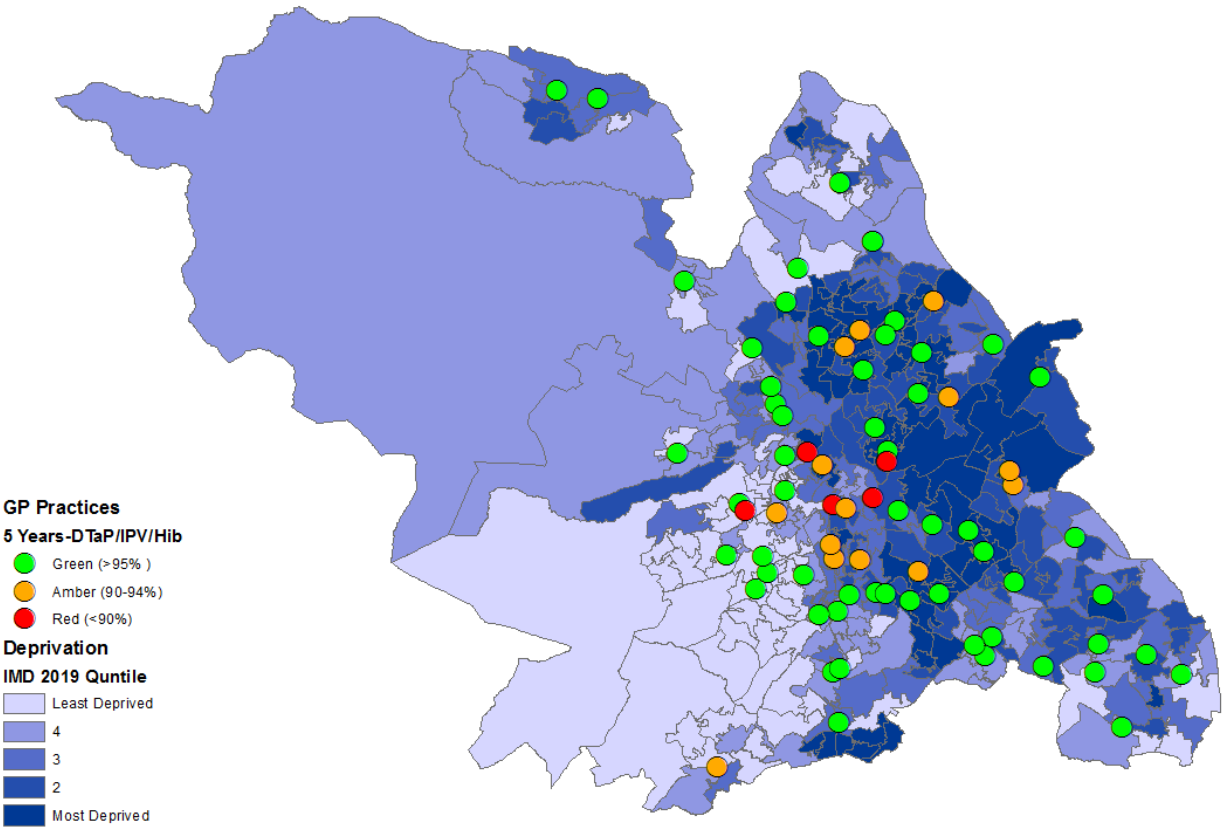
1. Note the key health protection issues including the impact of winter pressures and cost of living.
2. Support increased uptake of immunisation
3. Ensure their organisation is engaged with review of the Mass Treatment and Vaccination plan and work to embed this into partner organisations.
4. Continue to support cross system learning from Covid-19 including contributing to and learning from the UK Public Inquiry.

Ruth Granger 25th November 2022

Appendix: Geographical inequalities in vaccination uptake as shown in uptake of the '6 in 1' vaccination by age 5.

This vaccine provides protection against Diphtheria, Pertussis (whooping cough), Polio, Haemophilus influenzae type B and Hepatitis B

2020/21 Childhood Imms Coverage (% of eligibile registered children): 5 Years-DTaP/IPV/Hib



Data represent childhood vaccination coverage (at 1, 2 and 5 years) collected through the Cover of Vaccination Evaluated Rapdily (COVER) collection as a % of eligible registered population.

Public Health Intelligence Team

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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.
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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

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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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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.

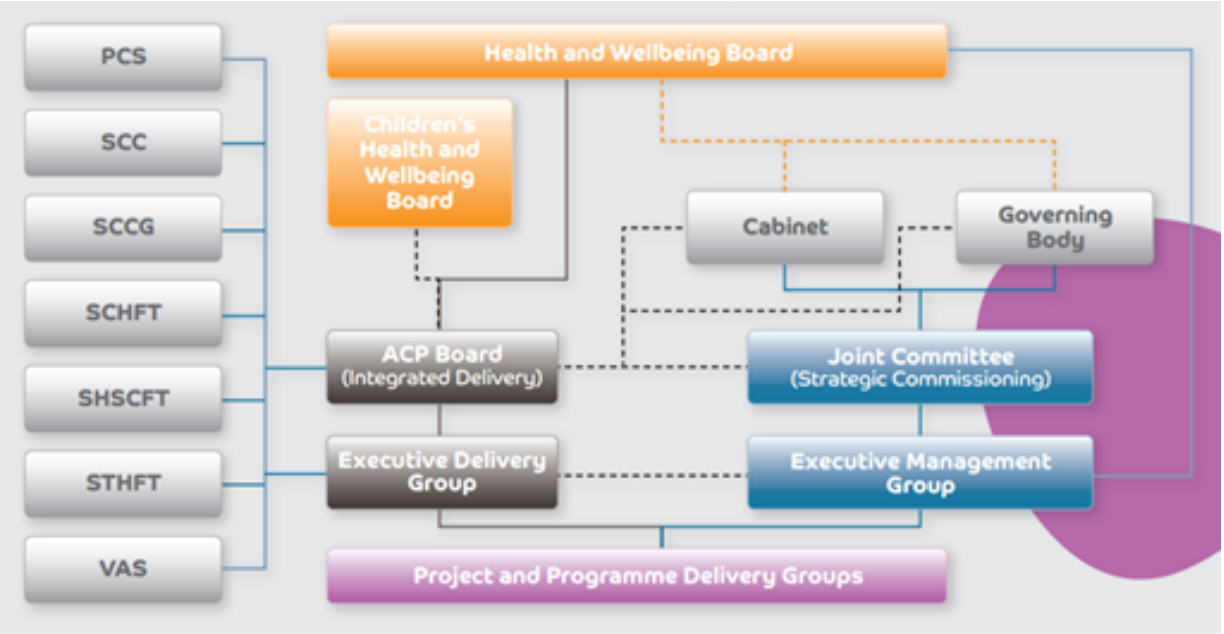
ACP Board T of R FINAL.pdf

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)

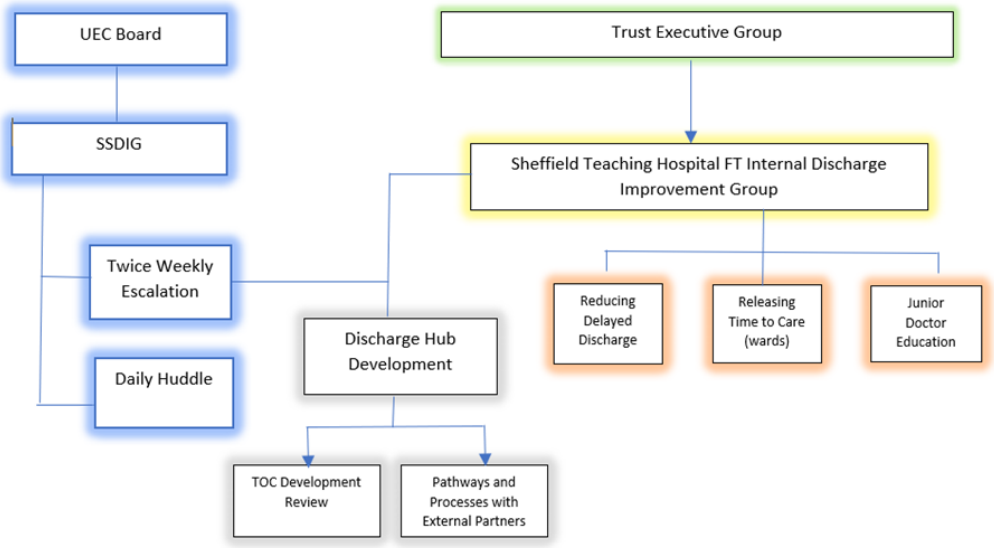
Utilising existing partnership relationship SSDIG was initially set up during the pandemic to streamline the discharge process and ensure delivery and implementation against the new national discharge operating model. As part of the command and control structure the group provide the system with assurance 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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Sheffield City Council

NHS Sheffield Clinical Commissioning Group

Better Care Fund 2021-22 Annual Report

23 June 2022

The Better Care Fund

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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.

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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.

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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.

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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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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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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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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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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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REF 25.1

HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	8th December 2022
Subject:	Health & Wellbeing Board Chairing Arrangements
Author of Report:	Dan Spicer, 273 4554

Summary:

This paper sets a proposed change to the Board's Terms of Reference to maintain the historic co-chairing arrangement between the Council and local NHS, following the Board's previous discussion on Terms of Reference changes in September 2022.

Questions for the Health and Wellbeing Board:

N/A

Recommendations for the Health and Wellbeing Board:

The Board are recommended to:

- Agree that chairing of the Board will be shared between the Chair of the Sheffield City Council Adult Health and Social Care Policy Committee, and the NHS Medical Director for Sheffield; and
- Propose the necessary changes to the Board's Terms of Reference to Full Council at the next available opportunity.

Background Papers:

- *Board Review and Terms of Reference Update*

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

This report addresses the functioning of the Board and as a result relates to the Strategy as a whole.

Who has contributed to this paper?

Health & Wellbeing Board Steering Group

HEALTH & WELLBEING BOARD CHAIRING ARRANGEMENTS

1.0 SUMMARY

1.1 This paper sets a proposed change to the Board's Terms of Reference to maintain the historic co-chairing arrangement between the Council and local NHS, following the Board's previous discussion on Terms of Reference changes in September 2022.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 As the body with principal responsibility for addressing health inequalities in Sheffield, ensuring the Health and Wellbeing Board is fit for purpose is critical to this mission.

3.0 CHAIRING ARRANGEMENTS FOR THE HEALTH AND WELLBEING BOARD

3.1 At their September meeting, the Health and Wellbeing Board agreed to recommend to Full Council a number of changes to their Terms of Reference, based on the outcome of a review conducted over the last year. These changes have now been approved by Full Council at their meeting on 2nd November 2022, and been incorporated into the Council's Constitution.

3.2 One outstanding issue remains that could not be agreed at the Board's September meeting: that of chairing arrangements for the Board's meetings. Since its inception the Board has been co-chaired by an elected member of the Council and the Chair of the Clinical Commissioning Group Governing Body, with this shared arrangement seen as an important symbol of partnership working.

3.3 With the recent changes to NHS governance following the Health and Care Act 2022, there is a need to identify a new co-chair if this shared approach is to be maintained. At their September meeting, the Board were offered two options for consideration but were unable to make a decision on a preferred approach. As a result of this the Board's Steering Group were asked to consider the issue and propose a way forward.

3.4 The Steering Group have discussed the issue at length, considering the following issues:

- The value of the statement of partnership
- The limited number of Sheffield-specific non-executive roles in the new NHS governance structures
- The issue of executive accountability to governance structures
- A desire to maintain primary care clinical input into the Board
- The potential for a co-chair who is independent of the major statutory organisations

3.5 Following these discussions the Steering Group have agreed that to balance all of these aims, they propose that the co-chairing arrangement be maintained, with the role

being shared between the Chair of the Sheffield City Council Adult Health and Social Care Policy Committee, and the Medical Director for Sheffield Place, South Yorkshire Integrated Care Board.

3.6 The Steering Group make this proposal as the best available option to manage the trade-offs set out above, with a particular focus on the clinical primary care experience and expertise that the current occupant of the role can offer. However, in acknowledgement of the possibility that a different occupant of this may not offer the same skill set, it is recommended that this arrangement is reviewed whenever there is a change in personnel in these roles.

3.7 The Health and Wellbeing Board are now asked to agree this proposal, and put it to Full Council at the next available opportunity for incorporation into the Board's Terms of Reference.

4.0 RECOMMENDATIONS

4.1 The Board are recommended to:

- Agree that chairing of the Board will be shared between the Chair of the Sheffield City Council Adult Health and Social Care Policy Committee, and the Medical Director for Sheffield Place, South Yorkshire Integrated Care Board;
- That this arrangement will be reviewed whenever there is a change in personnel in the relevant role(s); and
- Propose the necessary changes to the Board's Terms of Reference to Full Council at the next available opportunity.

HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	(Health and Wellbeing Board Member) Greg Fell, Director of Public Health
Date:	8th December 2022
Subject:	Oral Health in Sheffield
Author of Report:	Debbie Stovin, Dental Commissioning Manager, NHS England Tel: 077024 18302 / d.stovin@nhs.net Sarah Robertson, Consultant in Dental Public Health, NHS England s.robertson5@nhs.net Debbie Hanson, Health Improvement Principal, Public Health, Sheffield City Council

Summary:

The purpose of this report is to provide an overview of how NHS England and Sheffield local authority (LA) are working to improve oral health and reduce oral health inequalities in Sheffield. The report and appendix covers: population oral health data; a summary of the recent oral health needs assessment (OHNA); an update on the challenges facing dental services, access to dental care and the work taking place to strengthen future service provision; and an overview of local community oral health improvement programmes.

Questions for the Health and Wellbeing Board:

How do you think oral health would be better represented and integrated into the South Yorkshire ICB and Sheffield Health & Wellbeing Strategy?

Recommendations for the Health and Wellbeing Board:

1.0 Ensure that the Health and Wellbeing Board continues to support the water fluoridation agenda in South Yorkshire.

2.0 Ensure that oral health is mentioned in the Sheffield Health & Wellbeing Strategy.

Background Papers:

NHS England Stakeholder Bulletin – Dental Services in Yorkshire & Humber – July 2022

Dental briefing FINAL.docx

Yorkshire & the Humber Rapid Oral Needs Assessment – May 2022, and South Yorkshire ICS level supplement.

Rapid OHNA May 2022.pdf

SY_ICS level OHNA .pdf

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

NHS dental services and the oral health promotion programmes in Sheffield aim to support oral health improvement throughout the whole life course, which contributes to the Starting Well and Ageing Well agendas in the Health and Wellbeing Strategy.

Who has contributed to this paper?

Margaret Naylor, South Yorkshire Local Dental Network (LDN) Chair

REPORT TITLE - Oral Health in Sheffield

1.0 SUMMARY

1.1 The population of Sheffield experiences high levels of poor oral health. The appendix provides data and trends around tooth decay, gum disease, and oral cancer.

1.2 NHS dental services are commissioned by NHS England, and oral health improvement programmes are commissioned by Sheffield City Council.

1.3 **NHS England Yorkshire and the Humber (Y&tH) is responsible for the commissioning and contracting of all NHS dental services across Sheffield.** These are described in detail in the appendix and include:

- Primary care (general high street dentistry)
- Community Dental Services (CDS)
- Orthodontics
- Intermediate minor oral surgery
- Urgent care
- Secondary care

1.4 Dentistry for the armed forces is commissioned separately by the NHS England Armed Forces team, and the Health and Justice Team commissions dentistry in prisons, with the nearest prison dental services located in Doncaster.

1.5 **Local Authorities (LAs) have the statutory responsibilities around oral health improvement**, for commissioning evidence-based oral health improvement programmes, and commissioning the dental epidemiology programme which helps to identify need and target resources.

1.6 Partnership working and complementary commissioning between local authorities and NHS England is important to improve oral health. An example of this is the flexible commissioning programme described in section 3.1.4.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 Good oral health is essential for good general health and wellbeing, yet the people of Sheffield experience some of the highest levels of tooth decay, gum disease, and mouth cancer which can have a negative impact throughout life and can cause pain and infection, leading to difficulties with eating and drinking affecting nutrition, sleeping, communicating, socialising and quality of life.

2.2 Oral diseases are largely preventable and share common risk factors (e.g. dietary sugars, tobacco, alcohol) with other health problems such as obesity, diabetes, stroke, heart disease and aspiration pneumonia.

2.3 Oral diseases place significant costs on the NHS, and as with other conditions, the impacts of poor oral health disproportionally affect the most vulnerable and socially disadvantaged individuals and groups in society.

2.4 By the age of 5, 41.0% of children in Sheffield had tooth decay in 2019 (PHE, 2019). Sheffield has higher levels of tooth decay than other South Yorkshire LA areas, Y&tH and England. Tooth decay was significantly higher amongst the more deprived and non-white ethnic groups.

2.5 Almost 9 out of 10 hospital tooth extractions among children aged 0 to 5 years are due to preventable tooth decay, and tooth extraction is still the most common hospital procedure in 6 to 10 year olds (OHID, 2022), leading to missed education, and time off work for parents/carers. Sheffield experiences some of the highest levels of hospital extractions seen nationally.

3.0 MAIN BODY OF THE REPORT – Maintaining and improving oral health

3.1 Improving oral health and reducing oral health inequalities through NHS dental services

3.1.1 The Yorkshire and the Humber Oral Health Needs Assessment (OHNA) has recommended that consideration should be given to commissioning services for those that have both the greatest dental need and experience challenges in accessing routine and urgent dental care including:

- individuals and communities that are deprived and vulnerable children known to the social care system
- individuals with severe physical and/or learning disabilities,
- individuals with poor mental health
- individuals who are overweight or obese
- older adults

- individuals affected by substance misuse
- prison leavers
- homeless
- Gypsy, Roma and Traveller Communities
- asylum seekers, refugees and migrants

Dental services are not equitably distributed, and a health equity audit approach has been developed to determine equity of access to dental services in Sheffield. This has identified areas which experience the highest levels of poor oral health yet have no NHS dental services or insufficient services to meet the need, and will be used to guide future commissioning of services in Sheffield. The recommendations from both the OHNA and oral health equity profile for Sheffield and other LAs in Yorkshire and the Humber have informed the NHS England Dental Strategy for Yorkshire and Humber, and a programme of work is being developed to address inequalities and enable the commissioning of NHS dental services to meet need and demand.

3.1.2 Supporting access for all

NHS England is working to reduce perceived barriers to NHS dental care. The OHNA has identified high levels of poor oral health amongst asylum seekers and refugees. Many face barriers around understanding how to access care. Work has taken place to raise awareness amongst dental practices and charities who support asylum seekers and refugees, that migrants do not require proof of address or proof of immigration status to access NHS dental care, as described in the Migrant Health Guide. Some people may also face language barriers. Sheffield dental practices are fortunate to have access to interpreting and sign language services commissioned by SY ICB from the provider DA Languages.

3.1.3 Key Challenges to dental access

There are several challenges to dental access, that pose real difficulties when looking to improve access for all.

Historical and ongoing contractual factors – The existing contracts were rolled out in 2006 and have limited flexibility meaning inconsistent and often inequitable access to dental services.

Patient Perceptions – Patients aren't registered with dental practices and practices are only obliged to deliver a course of treatment not regular care.

Cost of treatment – Whilst many will pay for their treatment, NHS dental care is free of charge to children, pregnant women, mothers of a baby under 12 months, and those on certain low-income benefits.

Capacity – Practices have set capacity to deliver treatment packages or Units of Dental Activity (UDAs). Many practices offer a mix of private and NHS dental care. Demand for NHS care is high which may mean that once the time allocated to NHS care has been filled, the only available appointments left are for private care, which also potentially increases the cost of treatment.

New patient availability – Practices are asked to keep their profile on the NHS Find a dentist webpage up to date. This isn't mandated in their contracts but is now being built in as a requirement in new contracts. The 'practices accepting new patients' are a constantly changing picture.

COVID-19 pandemic – This led to several months of practice closures, followed by months of limited patient through-put due to heightened infection prevention and control requirements, significantly impacting on access to dental services. The resulting back-log has created increased demand and waiting times for dental services.

3.1.4 Initiatives to strengthen and improve access

National £50m investment in NHS Dental Services - Between January and March 2022, six practices in Sheffield received additional funding to improve access and increase dental appointment availability outside of core hours. Between 632 and 948 additional urgent care and subsequent stabilisation appointments were delivered.

Dental Access Project and Flexible Commissioning Programme - NHS England will continue to work with the 10 Sheffield practices who received additional access funding to support patients to access regular dental care. There are currently 21 flexible commissioning practices in Sheffield taking part in the flexible commissioning programme, and this is due to increase by a further 7 practices.

Additional sessions for patients experiencing poorest oral health - As part of a regional initiative, funding has been allocated specifically for dental services (general dental services, community dental services, urgent dental care, secondary care and intermediate minor oral surgery) to deliver additional sessions/services to improve access and increase dental appointment availability until 31st March 2023. Seven general dental practices in Sheffield have expressed an interest.

Waiting List Initiative – General dental services are being asked to complete a survey to determine numbers of patients waiting and waiting times for NHS general dental services. Additional work on waiting list management processes is being piloted.

One off payments to incentivise recruitment – 22 practices in Sheffield have been invited to apply for funding to recruit and retain dentists in areas of high deprivation and need, and where access challenges have been identified through local intelligence.

Improving access to Community Dental Services
A recent review of Community Dental Services has proposed a number of recommendations for service development to improve access to services and care pathways.

Improving access for the housebound - With the aging population, there are increasing needs for dental care for older people. In Sheffield, unlike other areas there is already a system of residential oral care (Residential Oral Care Sheffield- ROCS) which has been established for over 20 years providing an annual screening service for all care home residents with follow up treatment as required. Alongside this are oral health training sessions for care home staff provided by the oral health improvement service to promote good daily mouthcare for residents. This has proved very successful at addressing the oral health needs of the residents and can be delivered to a good standard for all. However, provision of domiciliary care for the housebound of all ages who still live in their own homes is still a challenge. NHS England is reviewing their commissioning of domiciliary care across Yorkshire and the Humber.

3.2 <u>Improving oral health and reducing oral health inequalities through community oral health programmes</u>

Sheffield City Council are in the process of updating the Oral Health Promotion Strategy 2019-22. Sheffield City Council commissions oral health improvement services from the community and special care dentistry services. Some of the main activities they currently provide or facilitate are:

- Supervised toothbrushing clubs – there are currently 90 schools and nurseries in the more socially-deprived areas of Sheffield taking with approximately 7000 children enrolled. Children learn the important life-skill of brushing their teeth in a supportive environment, and benefit from the protection of the fluoride toothpaste in preventing tooth decay.

- Provision of oral health packs by health visitors at 9-12 month assessments; and targeted provision of packs to 2 year olds in most deprived areas via health visitors and family centres. Dental packs are also provided 3 times a year to children living in 5 local authority children's homes.

- Oral health is included in the Sheffield Healthy Child Programme.

- Oral health care training is also provided to early years practitioners, staff working in health, social care and education. Training is also provided to staff working in residential care homes for older adults and adults with learning disabilities as part of the Residential Oral Care Sheffield (ROCS) programme.

- Focus on links with other health initiatives to address common risk factors (e.g. sugar, tobacco and alcohol) to Make Every Contact Count, including the healthy early years' award in place for all early years settings, signposting to stop smoking, mental health and weight services, and involvement in the Sheffield is Sweet Enough campaign.

- Mini Mouthcare Matters programme in Sheffield Children's Hospital to improve mouthcare on the wards.

Oral Health Survey - Sheffield City Council commissions the dental epidemiology programme field work team which gathers data on the oral health of the population, to guide targeting of resources and monitor improvements.

Water fluoridation - Although previously LAs were responsible for investigating the feasibility of new water fluoridation schemes and proposing new schemes, this responsibility has recently moved to the Secretary of State for Health and Social Care in line with the Health and Care Act 2022. Sheffield Council have been working with the other local authorities in South Yorkshire to investigate the feasibility of water fluoridation in South Yorkshire, and this work will may be used to inform the Secretary of State. Any proposals for water fluoridation would involve a public consultation. This would potentially have the biggest impact on improving oral health and has been shown to be the most cost-effective means of improving oral health, with the lowest carbon footprint.

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

4.1 Dental System Reforms

The outcome of the national 2022/23 dental contract system reform negotiations were confirmed by NHS England; this represents the first significant change to the contract since its introduction in 2006.

These initial reforms seek to address the challenges associated with delivering care to higher needs patients and making it easier for patients to access NHS care. The NHS England Y&tH dental commissioning team is working through these changes in line with national guidance and to consider opportunities for additional local schemes. Some changes are dependent on the timescale for legislative changes.

4.2 Commitment to further engagement

There is a commitment from NHS England dental commissioners to engage with patients, the public and wider stakeholders to ensure continued oversight of the local position for dental services. There are regular stakeholder briefings, and Healthwatch are now a member of the South Yorkshire Local Dental Network.

4.3 Continued development of community oral health improvement programmes

Whilst a substantial amount of money is used to commission dental services in Sheffield, only £120,000 p.a. is provided by the council for oral health improvement programmes. Currently, most programmes (e.g. the supervised toothbrushing scheme) are targeted to schools and nurseries in the most deprived areas of Sheffield, which experience the poorest oral health. Additional funding would enable both an increase in workforce capacity and resources to deliver a wider programme of activities to more of the population. This funding needs to be protected year on year to ensure continuity of programmes.

5.0 QUESTIONS FOR THE BOARD

5.1 How do you think oral health would be better represented and integrated into the South Yorkshire ICB and Sheffield Health & Wellbeing Strategy?

6.0 RECOMMENDATIONS

6.1 Ensure that the Health and Wellbeing Board continues to support the water fluoridation agenda in South Yorkshire.

6.2 Ensure that oral health is mentioned in Sheffield Health & Wellbeing Strategy.

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Appendix 1: Additional Information and Data

A) Dental services commissioned by NHS England in Sheffield

- **Primary care (general high street dentistry)**- accessed by patients directly, typically these are at high street dental surgeries. NHS England commissions primary care services from 66 general dental practices in Sheffield.
- **Community Dental Services (CDS)** – Community & Special Care Dentistry (within Sheffield Teaching Hospitals NHS Foundation Trust) provides special care dentistry in Sheffield and is also a significant provider of paediatric dentistry. The service provides dental care in community settings for patients who have difficulty getting treatment in their "high street" dental practice. They look after people with severe learning and/or physical disabilities or who have a profound mental illness and patients who are elderly or housebound or have a medical condition which compromises dental care provision. Patients are referred into the service by a health care professional. They also undertake dental treatment for homeless patients at the Cathedral and support children at Aldine House, a secure children's home in Sheffield.
- **Orthodontics** – There are 3 NHS orthodontic practices in Sheffield providing this service by referral, plus 4 completing existing courses of treatment. NHS orthodontic care is only provided for those with moderate to severe needs meeting selection criteria. Private care may be an option for those with milder needs.
- **Intermediate minor oral surgery** – There are 2 service providers for IMOS in Sheffield.
- **Urgent care** – This is available via NHS primary care practices directly or through NHS111. Urgent Care is for conditions clinically assessed as requiring treatment within 24 hours.
- **Secondary care** – specialist services including paediatric dentistry, and oral and maxillofacial surgery by referral only, are provided by Sheffield Teaching Hospitals NHS Foundation Trust. Many of these services are provided at the Charles Clifford Dental Hospital, through staff and students at the University of Sheffield School of Clinical Dentistry. Other sites include the Sheffield Children's Hospital, the Royal Hallamshire Hospital and the Northern General Hospital.

B) Poor levels of oral health in Sheffield

A Rapid Oral Health Needs Assessment for Yorkshire and the Humber (OHNA) was completed in May 2022 (NHSE, 2022). It has highlighted groups which have greatest dental need and experience challenges in accessing dental care, including: individuals and communities that are deprived; vulnerable children known to the social care system; individuals with severe physical and/or learning disabilities; those with poor mental health; older adults; homeless; asylum seekers, refugees and migrants; Gypsy, Roma and Traveller communities; those affected by substance misuse and prison leavers.

Tooth decay is a progressive disease. At the age of three, 14.7% of children in Yorkshire and the Humber were found to have experience of tooth decay (one or more decayed, missing or filed teeth) tooth decay (PHE, 2020). However, by the age of 5, 41.0% of children Sheffield have tooth decay (PHE, 2019). Sheffield has higher levels of tooth decay than those seen in other South Yorkshire local authority areas, Y&tH, and England, and is not observing the national trend of improvement seen elsewhere (**Table 1**).

Table 1: Percentage of 5-year-old children with experience of tooth decay over time in South Yorkshire

Year	Barnsley	Doncaster	Rotherham	Sheffield	Yorkshire and Humber	England
2007/08	39.5	47.2	36.6	40.7	38.7	30.9
2011/12	41.0	33.6	40.4	35.8	33.6	27.9
2014/15	30.2	31.0	28.9	31.4	28.5	24.7
2018/19	**39.6**	**37.2**	**31.6**	**41.0**	**28.7**	**23.4**

Source: https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2019

In Sheffield, experience of tooth decay amongst 5-year-olds was around three times higher in the more deprived Index of Multiple Deprivation (IMD) quintiles than the least deprived, and significantly higher amongst non-white ethnic groups.

Each child had an average of 4 teeth affected. Furthermore 38.8% of children had active untreated decay. In 10.3% this had gone into the pulp of the tooth and some children had abscesses (1.3%), indicative of severe pain and infection. These children may have experienced sleepless nights, difficulties eating and time off school. 4.2% of 5-year-olds in Sheffield had had teeth extracted (compared with 2.2.% for England), which is usually undertaken in hospital under a general anaesthetic at this age.

Tooth extraction is still the commonest reason for a child to attend hospital, and usually involves a general anaesthetic. **Table 2** shows the pre- pandemic (2019-20) and during pandemic (2020-21) hospital extraction data for South Yorkshire. There was a significant reduction in dental extractions rates between 2019-20 and 2020-21, reflecting the limited to access to hospital lists for dental extractions due to the pandemic, which is now improving. However, despite the pandemic, Sheffield continues to experience above average levels of hospital extractions with some of the highest levels seen nationally.

Table 2: Finished Consultant Episodes tooth extraction rate with caries as the primary diagnosis per 100,000 target population

LA name	0-5 year olds		6-10 year olds		0-19 year olds	
	19-20	**20-21**	**19-20**	**20-21**	**19-20**	**20-21**
Barnsley	825.2	413.1	1936.0	896.1	889.2	427.4
Doncaster	1028.6	230.2	2800.8	535.2	1172.8	245.9
Rotherham	1243.7	381.6	2488.3	803.0	1167.4	367.0
Sheffield	916.4	677.4	2095.5	1390.2	943.0	620.2
England	**265.1**	**113.0**	**526.6**	**214.7**	**264.9**	**109.9**

Source: https://www.gov.uk/government/statistics/hospital-tooth-extractions-of-0-to-19-year-olds-2021

Tooth decay in childhood is a predictor of tooth decay in later life, and supports the need for early intervention including Dental Check by 1 (DCby1) and local oral health promotion interventions at individual and community level.

The last Adult Dental Health Survey in 2009 demonstrated that only 7% of adults in Yorkshire and the Humber had no natural teeth (compared with 37% in 1968), with 88% having more than 21 teeth (termed a 'functioning dentition'). This reflects the significant improvements in oral health seen nationally over the last 40 years. Another adult dental survey is currently underway, which will provide more up to date data at regional level. However, there are broadly 3 groups of adults: the under 30s who have low restorative needs reflecting their exposure to fluoride toothpaste; the 30-65's who have experienced high levels of disease and have lots of restorations (referred to as the "heavy metal generation") requiring ongoing maintenance; and some older people needing denture care.

In Yorkshire and the Humber (2009) there was a greater proportion of adults with moderate and severe forms of gum diseases relative to the national average: 42% of adults had mild gum disease, 10% had moderate and 2% had severe disease.

The incidence and mortality of oral cancer for Sheffield appears to be higher than both regional and national levels (**tables 3 and 4**). Oral cancer disproportionately affects males and its incidence and mortality increase with deprivation and age, and has been increasing over the years. Known risk factors for oral cancer are linked to social determinants and include smoking or chewing tobacco, drinking alcohol, and infection with the human papilloma virus (HPV). Screening of the oral mucosa for oral cancer/pre-cancer at dental appointments is essential, with referral to specialist services where necessary. In time it is hoped that the incidence of oral cancer will be mitigated by the HPV vaccination now offered to both teenage girls and boys.

Table 3: Standardised incidence of oral cancer per 100,000 (C00-C14)

Year	Barnsley	Doncaster	Rotherham	Sheffield	Yorkshire and Humber	England
2012-2016	13.59	14.36	15.47	15.27	15.26	14.55

Table 4: Standardised mortality from oral cancer per 100,000 (C00-C14)

Year	Barnsley	Doncaster	Rotherham	Sheffield	Yorkshire and Humber	England
2012-2016	4.72	4.14	4.20	4.85	4.70	4.54

Source: https://www.gov.uk/government/publications/oral-cancer-in-england

The population of Sheffield is increasing, which will increase demand on dental services. In particular, the predicted 27% increase in the population of older adults (65+ years) and 44% increase in the population of the 85+ age group between 2020 and 2040 will bring challenges of its own to develop dental services that meet the dental needs of this ageing population, in terms of managing patients with co-morbidities, consent issues and polypharmacy, training for the dental team and suitable estates. In addition, a greater number of older people are cared for in their own homes than in residential/nursing homes, with the 2016 survey of mildly dependent older people suggesting that over 6% in Sheffield are likely to need domiciliary dental care, for example, though the Residential Oral Care scheme (ROCs). This survey also found that 25% of those surveyed in Sheffield had full dentures needing replacement, and 10% reported current pain. The World Health Organisation recognises that good oral health is an essential part of active ageing.

C) Access the NHS dental care for all

To support access to care for all, practices may need to use translators and interpreters for patients who require support with communication. It is contractual requirement that Dental practices and the Urgent Care providers have arrangements in place to support patients who access care and require translation services. Sheffield dental practices are fortunate to have access to interpreting services commissioned by SY ICB from the provider DA Languages. This is for telephone interpreting and face to face interpreting. Languages available includes British Sign Language.

NHS England continues to work with partners to make healthcare services more inclusive and has identified the need to gather a baseline assessment of access to interpreter services across all NHS healthcare settings. The survey has been developed with input from a range of stakeholders across our region and is supported by the Health Inequality Senior Responsible Officers for each of our Integrated Care Systems. Feedback from this survey will support improvement work to address healthcare inequalities among people with limited English proficiency and deaf people who use British Sign Language. NHS Dental services and commissioners have been contacted with a request that they complete this survey.

Whilst many people are able to attend regular high street dental practices, the Community Dental Services (CDS) provide dental care for adults and children with additional needs and those from other vulnerable groups whose needs cannot be met by the general dental services. A recent service review of the Yorkshire and Humber Community Dental Services has set out key recommendations to inform discussions in relation to future service design, including commissioning intentions for paediatric GA services and other pathway approaches. There has been recent communication with partners working with those with learning difficulties in Sheffield, to provide clarity that whilst those with milder learning difficulties may be treated in general practices, referrals may be made into the community dental services for those with moderate to severe learning difficulties.

D) Key challenges to dental access

Historic and ongoing contractual factors - NHS England inherited a range of contracts, from Primary Care Trusts, when it was established, nearly a decade ago and these 'legacy' arrangements mean that there is inconsistent, and often inequitable, access to dental services, both in terms of capacity in primary care and of complex and inconsistent pathways to urgent dental care, community dental services and secondary care. The current primary care dental contract, which was rolled out in 2006 is held by a general dental practice in perpetuity (subject to any performance concerns), with limited flexibility for change. In addition, procurement laws introduce further challenges and barriers to changing commission arrangement, with an inability to introduce innovative ways of working without testing the market. As a result, it is extremely difficulty to make system-wide changes.

Patient perceptions - In addition to commissioning challenges, there are also difficulties around patient perceptions as it may not always be clear to patients how NHS dental services work. Patients often think that they are registered with a dental practice in the same way that they are registered with a GP, however, this is not the case. GP practices contracts are based on patient lists, but dental practices are contracted to delivery activity. Practices are obliged to only deliver a course of treatment to an individual, not ongoing regular care, however many practices do tend to see patients regularly. A dental practice only has 'responsibility' towards a patient whilst they are under a course of treatment and for 2 months thereafter, but many practices will continue to be available to that patient for urgent treatment for the next couple of years purely as a gesture of goodwill.

Cost of treatment - Unlike many other NHS services which are free at the point of delivery, NHS Dental services are subsidised with fee paying, non-exempt adult patients contributing towards the cost of NHS dental treatment with the contribution determined by the course of treatment. The national dental charges are set on a three-band tariff related to complexity of treatment needs each year. Practices must display this information within their clinics. Whilst many will pay for their treatment, NHS dental care is free of charge to children, pregnant women, mothers of a baby under 12 months, and those on certain low-income benefits. Others on low incomes may also get full or partial assistance with costs though the NHS low income scheme.

Capacity - Dental practices have set capacity to deliver NHS dental care, which is largely determined by the number of units of dental activity they are commissioned to provide. Commissioned dental activity is based on Courses of Treatment (CoT) and Units of Dental Activity (UDAs). Depending on the complexity of the treatment, each CoT represents a given number of UDAs. For example, one UDA for an examination, three UDAs for a filling and 12 UDAs for dentures.

Many dental practices offer both NHS and private dental care, which, as independent contractors, they are at liberty to do. Mixed practices, offering both NHS and private treatment, tend to have separate appointment books for both NHS and private treatment, with the same staff teams often employed to provide these different arrangements. NHS provision must be available across the practice's contracted opening hours. However, demand for NHS treatment is such that they could have used up their available contracted NHS appointments and if this is the case practices may, therefore, offer private appointments to patients. Private care has different charging and regulatory arrangements to NHS dental care, and it must be made clear to patients if they are undergoing private care.

New patient availability - Practices are asked to keep their NHS profile page up to date such that a patient seeking to 'Find a Dentist' using the NHS search engine (https://www.nhs.uk/service-search/find-a-dentist) can see which practices in their locality are taking on new NHS patients. However, this is not contractually mandated in the 2006 contracts, and many practices are not currently providing up to date information for the public. In response to this, NHS England has ensured that in any new contracts, or contract variations across Yorkshire and the Humber, that this has been made a compulsory deliverable. NHS England does not keep records of practices who are accepting new patients, as it is a constantly changing picture.

The COVID-19 pandemic - Pre-pandemic, around 59% of adults and 68% of children who live in Sheffield saw an NHS dentist in the preceding 24 and 12 months respectively up to 31st December 2019. This was similar to neighbouring local authorities, yet higher than England. In addition to these figures, some will have chosen to access private dental care, but there are no data available for this. With several months of practice closures due to COVID-19, followed by months of limited patient through-put due to heightened infection prevention and control requirements, there was a significant impact on access to dental services. **Table 5** shows how this affected access for those in local authorities in South Yorkshire and England.

Due to the back-log of care, demand for NHS care is now significantly higher than pre-pandemic levels at all practices. While the number of available appointments for regular and routine treatment is increasing, and access figures are gradually improving, dental practices continue to balance the challenge of clearing any backlog with managing new patient demand. In addition, dental teams are facing significant workforce challenges as staff are continuing to leave the NHS, which hinders opportunities to increase appointment levels.

Whilst restoration of NHS dental activity continues, it will be some time before dental services return to providing care at previous activity levels, with many dental practices still catching up.

Table 5: Adult patients seen in the last 24 months and child patients seen in the last 12 months as a percentage of the population for local authorities in South Yorkshire and England overall.

LA	% seen to 31 Dec 2019		% seen to 31 Dec 2020		% seen to 30 June 2021		% seen to 31 Dec 2021		% seen to 30 June 22	
	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child
Barnsley Metropolitan Borough Council	61.4	68.0	55.5	29.8	51.4	31.9	43.7	47.1	45.4	52.8
Doncaster Council	66.2	66.0	58.7	31.6	53.3	32.7	45.6	45.6	47.6	50.4
Rotherham Metropolitan Borough Council	59.6	61.7	55.7	28.7	51.4	32.3	44.8	42.9	46.8	46.8
Sheffield City Council	59.4	68.0	55.2	32.8	52.5	36.4	46.3	49.6	48.6	54.1
England	**49.6**	**58.4**	**44.3**	**29.6**	**40.8**	**32.5**	**35.5**	**42.5**	**36.9**	**46.2**

Source: NHS Digital
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-biannual-report
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2021-22-biannual-report
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2021-22-annual-report

E Initiatives to strengthen and improve access

National £50m investment in NHS Dental Services

As part of a national initiative, funding was allocated specifically for dental services to improve access and increase dental appointment availability outside of core hours, between January and March 2022. The care was delivered outside core hours, and in Sheffield 6 practices participated in the scheme delivering sessions, and between 632 and 948 additional urgent care and subsequent stabilisation appointments were provided for patients.

Dental Access Project and Flexible Commissioning Programme

NHS England will continue to work with the 10 practices who have received additional access project funding in Sheffield to support patients to access regular dental care.

A recent evaluation of the Yorkshire and Humber Flexible Commissioning programme demonstrated that it is possible to commission dental services differently in a format that supports delivery of preventive care to improve oral health and reduce inequalities, offer access to new patients and develop the full dental practice team. The scheme has been extended for a further 12 months from 1 April 2022, which is enabling further refinement and evaluation to support targeting of resources based on the OHNA to reduce oral health inequalities.

There are currently 21 flexible commissioning practices in Sheffield taking part in the flexible commissioning programme. Practices may twist up to 10% of their contracted UDA's in order to provide dedicated patient focused care. One of the conditions is that the practice must have a dedicated Oral Health Champion who leads the practice in delivering both in-house preventive programmes and Making Every Count through signposting to other health and wellbeing support such as Stop Smoking Services, Alcohol Services, mental health services and live Lighter Sheffield Weight Management services. They also accept referrals for children at high risk of poor oral health from health visitors and social care, and former community dental services patients who are now in a position to accept care in a general practice.

NHS England has recently sought expressions of interest from dental practices with the aim of extending the scheme to other practices across the region. An additional 7 Sheffield practices have been successful in their application. These are expected to commence before the New Year.

Additional sessions for patients experiencing poorest oral health
As part of a regional initiative, funding has been allocated specifically for dental services to deliver additional sessions/services to improve access and increase dental appointment availability until 31st March 2023. Funding has been offered for:

Primary Care - targets those patients in greatest need of accessing available NHS Dental Care at General Dental Practices. This offer is to target urgent/high risk patients in addition to practices existing contracted activity. Expressions of interest have been received from 7 practices in Sheffield delivering 1192 sessions (subject to change), providing a minimum of 7 appointments per session.

Community dental services - NHS England have requested for plans on how they may use additional funding to increase capacity to reduce waiting lists, with a focus on hospital children dental extraction services (under general anaesthesia) due to high waiting lists of up to 2 years in some areas. At the time of writing this paper bids were being received and would then be reviewed.

Secondary care and minor oral surgery providers – expressions of interest from providers have been requested on how they may use additional funding to increase capacity and reduce waiting lists. STHFT has submitted a bid to address waiting lists which is currently being reviewed.

Urgent dental care services – providers have been asked to use additional funding to provide additional appointments (subject to staffing availability) as data continues to demonstrate a high level of unmet demand for the service.

Waiting List Initiative
All GDS practices in Y&H will be asked to provide NHS England with information regarding the number of patients waiting and waiting times for NHS dental treatment through a survey. This will give NHS England and dental practices a more accurate view on the numbers of patients waiting for NHS dental treatment at the point in time that data is collected. A weighting list management process is also being piloted.

One-off payments to incentivise recruitment
This is a commitment from NHS England in Y&H to assist local NHS dental providers in the recruitment and longer-term retention of dentists in targeted areas of high deprivation, patient need and local intelligence as evidenced by the OHNA. The overarching aim of the

scheme is to ultimately increase local NHS dental access for patients in the targeted areas. To date 22 practices in Sheffield have been invited to apply.

NHS South Yorkshire Integrated Care Board

Improving Physical Health for people living severe mental illness (SMI), people with learning disabilities (LD), and autistic people

1. In January 2022, Sheffield CCG presented to the Health and Wellbeing Board on the LeDeR (*Learning from Lives & Deaths – People with a learning disability and autistic people*) programme and the citywide *Improving Physical Health for People with Severe Mental Illness, People with LD, and Autistic People Strategy*.

2. There was a particular focus in the presentation to HWB on the LeDeR programme. However it was highlighted that as outlined in the *Improving Physical Health Strategy,* people living with severe mental illness[1] also share some of the significant health inequalities and reduced life expectancy of people with learning disabilities and autistic people.

3. For all three groups these disparities are often due to physical health needs being overlooked (including in some cases through diagnostic overshadowing) and to preventable illnesses. For too many people this means living for many years with a long-term physical health condition/s and with reduced quality of life, as well as on average a dramatically reduced life expectancy:
    - The average life expectancy for someone with a long-term mental health illness is at least 15-25 years shorter than for someone without
    - On average men with LD die 23 years earlier than men without a LD and for women it's 27 years earlier
    - Autistic people die on average 16 years earlier than the general population

4. To note, the prevalence of particular health conditions and in some cases the contributing factors due to some extend vary across these three groups of people, and some examples of this are summarised at the end of this document[i]. Please also see below information about population size for these three groups of people[ii].

5. Following the presentation, the HWB requested that the cross-organisational *LeDeR Steering Group* and Implementation Group for the *Improving Physical Health for People Living with SMI, People with LD, and Autistic People Strategy:*
    - Provide steer on what HWB partners should be doing to improve LD/autism/SMI health inequalities
    - Develop a locally co-produced vision regarding improved health for people with LD, autism, and SMI, and share this with HWB.

6. Steer from the steering groups was that rather than "re-inventing" a local vision, HWB should refer back to the *Improving Physical Health for People with SMI, LD, and Autism Strategy 2019-22*, and the key commitments within this. There is also an Easy Read version of the Strategy. Please see below for a summary of the commitments in the Strategy. All 5 commitments are of relevance to HWB partners.

[1] NHS England defines 'severe mental illness' (SMI) as anyone diagnosed with schizophrenia, bipolar disorder or other psychosis or is having lithium therapy.

7. Of particular note for HWB organisations is Commitment 5: *Key organisations and decision making bodies in the city will ensure that they identify and embed opportunities for improving the physical health of people living in with these conditions, in their decisions, activities, strategies, and policies.*

8. Key milestones already highlighted under this commitment that HWB can contribute towards are:
   - Embed physical health for people living with these conditions in key health and wellbeing strategies / action plans / initiatives and frameworks.
   - Partner organisations to develop their own physical health action plans that will fulfil the commitments.
   - Health and social care services will work more closely together closely to improve physical health outcomes for people.
   - There will be a cross-organisational approach to cross-cutting themes such as: Meeting the needs of diverse communities; Supporting adherence to the Accessible Information Standard; Increasing and developing local research opportunities; Ensuring that larger organisations support smaller organisations to achieve the commitments

9. Also to note, and as highlighted in the summary above, one of the key commitments in the strategy is for people with lived experience (and family/informal carers) to have the opportunity to influence how organisations work together to develop new and better ways of improving people's physical health in Sheffield. Engagement has shaped the development and implementation of the strategy. Person centred care (ensuring the people who use our services are at the centre of everything we do) is also an important part of realising this commitment.

10. Most recently, in 2022 Disability Sheffield has been commissioned to gain feedback on the physical health care experiences of people with LD, SMI, and autism. This will help us to monitor the impact of the strategy so far and to shape the refresh of the strategy for 2023-2026. We will also continue to

engage via the LD and Autism Partnership Board and other mechanisms, and would be keen to hear the views of the HWB on priorities for 2023-2026 as part of the consultation.

11. As described in the presentation to HWB in January 2022, good progress has been made towards all 5 of the Strategy's commitments, including commitment 5. However the scale of the health inequalities faced by people living with SMI, people with LD, and autistic people, which have been compounded by the challenges brought by the pandemic, means that there is still much that the HWB as a Board (and its partners within their own structures and organisations) can contribute towards. Through this the HWB can help to reduce the persistent health inequalities experienced by these groups of people.

12. A proposed way that the Board could progress this is that the Board holds each member organisation "to account" for impacting on the mortality gap faced by these populations, for example:
    - By asking for an annual update to Board, on the opportunities that each partner have created to improve access and experience in their organisations for the above populations.
    - Through an annual HWB Health Inequalities Champion "award", that could be created to highlight positive practice, judged by Experts by Experience and/or family carers to make this visible and transparent for the public.

Update provided by Heather Burns (Deputy Director Mental Health Transformation) and Liz Tooke (Project Manager), on behalf of:

- *The Sheffield LeDeR Steering Group*
- *The Sheffield Improving Physical Health for people SMI, LD, Autism Strategy Implementation Group*
- *NHS South Yorkshire Integrated Care Board (Sheffield) - Mental Health, Learning Disability, Dementia and Autism and Commissioning Team*

06 July 2022

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[i] **Examples of different health inequalities experienced by people living with SMI, people with LD, and Autistic people:**

People living with SMI

- As outlined in the Quality and Outcomes Framework, due to the combination of lifestyle factors and side effects of antipsychotic medication, there is a high incidence of cardiovascular disease (CVD) causing premature death in people with SMI
- As outlined in a 2018 PHE briefing, Compared to the general population, people aged under-75 in contact with mental health services in England have death rates that are:
    - 5 times higher for liver disease
    - 4.7 times higher for respiratory disease
    - 3.3 times higher for cardiovascular disease
    - 2 times higher for cancer
    - have a higher prevalence of obesity, asthma, diabetes, COPD, CHD, stroke and HF and similar prevalence for hypertension, cancer and AF
    - Findings from this analysis show that 41.4% of patients with SMI have one or more of the 10 physical health conditions examined. This is higher than the proportion recorded for all patients (29.5%).
- Smoking prevalence for people on the Sheffield SMI registers in primary care was 36.6% (2022) (compared to 15% for the wider population aged 18+) and for people admitted to secondary care mental health inpatient services around 60% (2019)
- People living with SMI are at increased risk from flu, pneumonia and covid-19.
- People living in the community with an SMI are less likely to take up the offer of screening and are specifically identified as needing additional support to access national cancer screening.
- Type 2 diabetes, is twice as common amongst those with a SMI
- People with mental health difficulties are disproportionately affected by poor oral health. For example, people with SMI are almost three times more likely to have lost all of their teeth compared to the general population.

People with Learning Disabilities

- Learning from LeDeR includes that:
  - Respiratory conditions remain the most significant causes of premature deaths for people with a learning disability. In relation to this, we need to consider:
    - Tooth decay, frequency of brushing and dependence on others for oral care is associated with pneumonia due to increased levels of oral bacteria in the saliva
    - Flu, covid and pneumococcal vaccination as part of respiratory health
    - Dysphagia is one of the key causes of aspiration pneumonia.
  - In the national 2018 report, sepsis was identified as the second leading cause of death for people with a learning disability, and 12 people also died from constipation.
  - People with a learning disability are much more likely than the general population to have epilepsy, and a lack of understanding of epilepsy and how to support someone may have been a contributory factor in some recorded of deaths.
- People with a learning disability have died from Covid-19 disproportionately from the general population.
- Prevalence of diabetes is around 10% for people with LD, mostly Type 2 diabetes.
- People with learning disabilities have poorer oral health and more problems in accessing dental services than people in the general population.
- Local data GP data suggests that adults with a learning disability have smoking rates that are in line with the wider population.

Autistic people

- There is still very limited awareness and understanding of the scale of premature mortality for autistic people in the UK – National charity Autistica describes this as a "hidden crisis"
- Autistica highlights that autistic people:
  - Can have a more restricted diet, limited access to exercise and increased use of medication
  - Face social and cultural pressures, including bullying, pressure to conform (which can result in 'masking' serious problems) and social isolation
  - Experience depression, anxiety and sensory overload
  - Can face significant issues in accessing healthcare
- Research shows that autistic people die on average 16 years earlier than the general population and this increases (to 30 years) if they also have learning disabilities.
- According to new research, although autistic individuals are more likely to have chronic physical health conditions, particularly heart, lung, and diabetic conditions, lifestyle factors (which increase the risk of chronic physical health problems in the general population) do not account for the heightened risk among autistic adults. To note that local data shows that autistic adults have 'average' smoking rates.
- The research also showed that autistic women are more likely to report increased risks of physical health conditions
- Research shows that between 20% and 40% of autistic people have epilepsy and this rate increases steadily with age – in contrast to a one percent prevalence rate in the general population.
- Autistic adults without a learning disability are 9 times more likely to die from suicide.
- *Autism Speaks* highlights gastrointestinal disorders are nearly eight times more common among children with autism than other children.

[ii] **SHEFFIELD POPULATION ESTIMATES (please note that there will be some "double counting", e.g. if someone has a learning disability and an SMI.**

- **People living with SMI –** 5,241 people with an SMI (excluding those in remission) on Sheffield GP Registers
- **People with Learning Disabilities –** 4,330 people aged 14 and above on Sheffield GP LD Registers.
- **Autistic people –**
  - The Sheffield Joint Strategic Needs Assessment states: the total number of autistic people in the population is unknown. It is estimated that between 8,500 to as many as over 20,000 people (all ages) in Sheffield could have ASC.
  - 2022 GP practice data indicates that there are 4,543 people aged 18 and over with a recorded autism diagnosis on Sheffield GP Registers:
    - With 3,407 people of these with a recorded autism diagnosis but no recorded learning disability
    - An additional 1,136 people recorded with autism and learning disability.

LeDeR Takehome fact sheet:

North East and Yorkshire

University of Central Lancashire
UCLan

KING'S College LONDON

Sex demographics

57% of people in the data who died in 2021 were male. 43% female.

Age at death

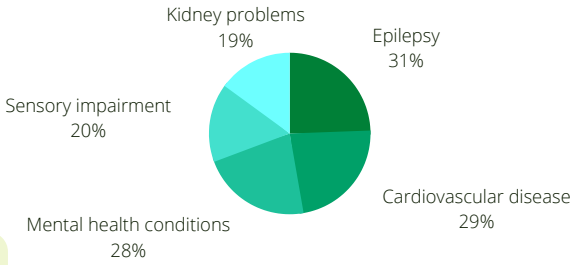
61 Years

The median age of death for people with a learning disability in the North East and Yorkshire in 2021 was 61. The median age of death for the general population in 2018-2020 was 82.7.

DNACPR

63.9% of people who died in 2021 had a DNACPR recommendation in place at the time of their death compared to 69.1% in 2018. Reviewers judged this was correctly followed 68.7% of the time. This compares with 84.4% of the time in 2018.

THE MOST FREQUENT LONG TERM HEALTH CONDITIONS IN THE NORTH EAST AND YORKSHIRE

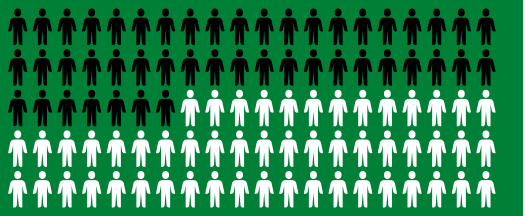


THE AVERAGE NUMBER OF LONG-TERM HEALTH CONDITIONS IN THE NORTH EAST AND YORKSHIRE

2.28

TOP 5 CAUSES OF DEATH IN THE NORTH EAST AND YORKSHIRE

1. COVID-19
2. Cancer.
3. Congenital malformations, deformations and abnormalities.
4. Influenza and pneumonia.
5. Cerebral palsy and other paralytic syndromes.



AVOIDABLE DEATHS

Of the 404 deaths where data was available, 47% of deaths in the North East and Yorkshire were recorded as avoidable.

47%

Find out more at www.kcl.ac.uk/research/leder

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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	8th December 2022
Subject:	**Commercial Determinants of Health**
Author of Report:	Amanda Pickard, Magdalena Boo

Summary:

Exposure to unhealthy commodities – high fat salt sugar foods, tobacco, alcohol, drugs, gambling products, fossil fuels (this list is not exhaustive) – can directly cause, contribute to, or exacerbate existing *non*-communicable diseases. Non-communicable diseases are now the leading cause of death and poor health both globally and in Sheffield.

These are known as Commercial Determinants of Health – this phrase means that it is not individual vulnerability, genetics or choice alone, but interaction with corporate environmental and social factors which determines health and health inequalities (Dahlgren and Whitehead, 1991)[i]. As a city, we suggest we should use our powers to protect our residents from harms from exposure to these unhealthy commodities.

Unhealthy Commodity Industries are noted for the common set of tactics they use to delay and undermine evidence and Public Health policy – this is known as the Industry Playbook[ii] and was first documented in litigation history for the Tobacco Industry but has since been adopted by other Unhealthy Commodity Industries. The power is unequal, particularly with wealthy global corporate industries, but the World Health Organisation Framework on Tobacco Control[iii] demonstrates what is possible when we choose to use our powers collectively.

In this paper, we suggest that we can choose to use our powers in Sheffield to address Unhealthy Commodity Industries, reduce exposure and harms, reduce health inequalities, and halt some of the main drivers of non-communicable disease. In this paper we suggest developing a Public Health Playbook to help counter the Industry Playbook. This will save

Sheffield lives and increase healthy life expectancy and contribute to our local economy by reducing non-communicable disease.

Questions for the Health and Wellbeing Board:

- Do the Health and Wellbeing Board agree that Sheffield should have a Commercial Determinants of Health (CDOH) /Unhealthy Commodity Industry (UCI) approach to framing local policy and strategy? A Public Health Playbook to counter the Industry Playbook.
- How much exposure to harmful unhealthy commodities is acceptable and how much is too much, in Sheffield? Knowing that Unhealthy Commodity Industries drive non-communicable disease, should we use our Local Authority powers to turn off the pump?
- Should we have a Conflict of Interest policy in relation to Unhealthy Commodity Industry direct funded education, prevention, treatment, support – e.g. schools education (Gambleaware, Drinkaware etc) patient education, research, treatment – and restrict advertisements and sponsorship (with/without exemptions for local brands)?

Recommendations for the Health and Wellbeing Board:

- That Sheffield develops a Commercial Determinants of Health / Unhealthy Commodity Industry (UCI) approach/strategy;
- That we have a structured “Public Health Playbook” to counter the Industry Playbook;
- That we use our existing powers as a Local Authority to address the negative impact Unhealthy Commodity Industries have on local residents, namely that we adopt the following;
    - Advertising and sponsorship policy to limit exposure to Unhealthy Commodity Industries,
    - Conflict of Interest Policy particularly in relation to commercial influence/involvement in education.
    - Cumulative Impact Policy for alcohol and the night time economy (NTE) strategy through Licensing,
    - Use planning powers and the Local Plan to restrict density and proliferation of high fat salt sugar foods, tobacco, alcohol, gambling;
    - Use our powers of regulation, for example Trading Standards age regulation to reduce avoidable exposure and harms (this list is not exhaustive);
    - Advocate caps and limits on exposure in certain settings and locations e.g. zero limit in certain areas and sensitive location, sensitive receptors e.g. schools, hospitals, addiction services;

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

This addresses health inequalities and determinants of health in their broadest sense.

Who has contributed to this paper?

Amanda Pickard, Magdalena Boo, Greg Fell.

Commercial Determinants of Health and Unhealthy Commodity Industries

1.0 SUMMARY

1.1 Exposure to pathogens of a susceptible host is the direct cause of communicable disease. During the Covid-19 pandemic, as a city, we did our utmost to reduce exposure to the coronavirus and therefore protect our residents– we used our resources and powers to reduce avoidable harms as far as possible. Exposure to unhealthy commodities – high fat salt sugar foods, tobacco, alcohol, drugs, gambling products, fossil fuels (this list is not exhaustive) – can directly cause, contribute to, or exacerbate existing non-communicable diseases.

1.2 These are known as Commercial Determinants of Health – this phrase means that it is not individual vulnerability, genetics or choice alone, but interaction with corporate and profit led environmental and social factors which determines health and health inequalities (Dahlgren and Whitehead 1991)[iv]. As a city, we suggest we should use our powers to protect our residents from harms from exposure to these unhealthy commodities.

1.3 Unhealthy Commodity Industries are noted for the common tactics they use to influence their market, distort, distract and undermine evidence and delay regulation and Public Health policy – this is known as the Industry Playbook[v]. These structured tactics were first documented since the 1950's in the litigation history of the Tobacco Industry but has since been adopted and refined by the majority of other Unhealthy Commodity Industries. The Industry Playbook includes undermining of evidence, reframing discussion to a narrow focus on individual choice, lobbying politicians, undermining critics. The power is unequal, particularly with wealthy global corporate industries, but the World Health Organisation Framework on Tobacco Control[vi] demonstrates what is possible when we choose to use our powers collectively.

1.4 In this paper, we suggest that we can choose to use our powers in Sheffield to address Unhealthy Commodity Industries, reduce exposure and harms, reduce health inequalities, and halt some of the main drivers of non-communicable disease. John Snow, the Father of Epidemiology, famously removed the handle from the Broad Street pump which was contaminated with the cholera pathogen and saved lives in his lifetime and ours. Taking the handle off the pump that is spreading non-communicable disease

means addressing Unhealthy Commodity Industries and applying a Public Health Playbook to the Industry Playbook. This will save Sheffield lives and increase healthy life expectancy by reducing non-communicable disease.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 Commercial Determinants of Health describes the interaction between the individual and their environment through private sector activities which can positively or negatively affect health. These Commercial Determinants particularly impact on non-communicable disease such as obesity, diabetes, cancer, mental health impacts such as addictions. The World Health Organisation states that "*Commercial determinants of health affect everyone, but young people are especially at risk, and unhealthy commodities worsen pre-existing economic, social and racial inequities*"[vii]

2.2 The burden of death and ill health from tobacco, alcohol, high fat salt sugar foods falls disproportionately on the most deprived[viii] With gambling as an example, although participation is higher in more educated, employed and affluent groups, the most harmful outcomes of gambling are typically found in younger, male, unemployed, and more deprived groups. The risk profile seems to track the social-demographic profile so that the higher the deprivation, the higher the risk which suggests that harmful gambling is related to health inequalities (PHE 2019). Dental decay and extraction, the most common cause of hospital admissions for children in England, is linked to sugar sweetened beverages has a social gradient, and this avoidable hospital admission impacted 1 in 100 children under 5 in Sheffield and 2 in 100 children under 10 in 2018/19 (Levine, 2021)[ix]. These are just a few examples.

2.3 Taking a Commercial Determinants of Health and Health Inequalities perspective is to understand that it is not as simple as thinking that some people are making unhealthy choices. The choice architecture in more deprived neighbourhoods directly influences the health outcomes that communities face.

3.0 MAIN BODY OF THE REPORT

3.1 The Commercial Determinants of Health (CDOH) refers to adverse influence of Unhealthy Commodity Industries (UCI) on population health. This includes commodities sold, marketed, promoted and lobbied as subjects for non-regulation or de-regulation such as high fat salt sugar foods, tobacco, gambling products and services, fossil fuels, alcohol amongst others and also the tactics used by these industries to shape and create an environment that is in their favour, known as the Industry Playbook.

3.2 Just as exposure to pathogens drives communicable disease, exposure to Unhealthy Commodity Industry products, via availability, marketing and behavioural architecture drives non-communicable diseases. Non-communicable disease includes cancer, diabetes, coronary heart disease, mental health difficulties such as addictions. Harmful products such as tobacco, high fat salt sugar foods, alcohol, gambling may directly

cause disease or conditions, contribute to in ‘attributable fractions’ (PHE 2020)[x], or exacerbate existing conditions.

3.3 A Commercial Determinants of Health approach means that we understand that it is not individual vulnerability, genetics or choice alone, but interaction with corporate profit-led environmental and social factors which determine health and health inequalities (Dahlgren-Whitehead 1991)[xi] However, the consumption and use of Unhealthy Commodity Industry products is traditionally framed as personal choice by Governments and by the industries manufacturing and marketing them. For example since 1997 we have had 700 different policies on obesity in England, most of which focus on the individual making healthier choices[xii] rather than the environment in which those individuals are expected to make those choices. However individual choices are not made in a vacuum and are responses to the wider context in which we live - the role of the UCI in shaping those choices by the population is now strongly evidenced.

3.4 Local Authorities have many potential powers to address exposure to Unhealthy Commodity Industries, for example we could apply advertising and sponsorship policy towards harmful products, progress Cumulative Impact Policy for alcohol and the night time economy (NTE) strategy through Licensing, use Planning powers and the Local Plan to restrict density and proliferation of high fat salt sugar foods, tobacco, alcohol, gambling; use our powers of regulation, for example Trading Standards age regulation to reduce avoidable exposure and harms (this list is not exhaustive). These will be discussed in more detail in relation to each industry, below.

3.5 *Advertising* - Commercial companies manufacturing and offering unhealthy commodities or services spend vast amounts on marketing and advertising their products. For example in 2019 MacDonalds alone spent £90M on marketing in the UK[xiii], the alcohol industry spends more than £800 million per year on advertising in the UK (Petticrew, 2020[xiv], 2016[xv]). Advertising is effective for Unhealthy Commodity Industries in recruiting participants to consume harmful products. A body of literature exists demonstrating how powerful broad-spectrum advertising is, from social and online to traditional TV and outdoor advertising. For example teenage exposure to alcohol advertising is associated with increased underage drinking and development of alcohol problems [xvi] and children exposed to high fat, sugar and salt (HFSS) or ‘junk food’ brands show a preference for those branded foods[xvii]. The Royal Society of Public Health notes YouGov polls which find high public support for tighter regulation, restrictions and bans on gambling advertising (RSPH 2021)[xviii]. The research showed overwhelming support for tighter curbs on gambling advertising, with almost two thirds (63%) of the adult respondents and over half (53%) of the young people surveyed in favour of a total ban on ads for gambling products. Only 14% of adults and children opposed a total ban. A recent (unpublished) study by University of Sheffield medical students which explored exposures to gambling travelling normal student routes at normal walking speed found that a route from Endcliffe student village to the train station (2.1 miles) contained 40 individual gambling advertisements and exposure of 1.03 advertisements per minute (Culkin, 2022)[xix].

3.6 *Licensing* – Local Authorities hold the powers of Licensing within national regulations and can refuse licenses on certain grounds or apply restrictions and 'conditions' to Licensing. In 2018, the Director of Public Health presented the Evidential Basis for Cumulative Impact Policy for the West St/Devonshire Green area. This included evidence from public consultation, local residents and elected members, South Yorkshire Police and Anti-Social Behaviour Team data. This also included evaluation of different policy initiatives to address the identified problems and benchmarking against Core Cities. The evidence to support Cumulative Impact Policy was presented to Licensing Committee in October 2018 which resolved: That the Committee, after considering all the information contained in the report and the recommendations made, authorises the Chief Licensing Officer to carry out all the necessary work required to undertake a formal consultation and bring a final report back to a future meeting of the Committee. An update of the evidence was requested. Unlike all other Core Cities at the time - Birmingham, Bristol, Leeds, Liverpool, Manchester, Nottingham, Newcastle – Sheffield was alone in not using Cumulative Impact Policy to address problems in the Night Time Economy. Many of these Core Cities also had Purple Flag demonstrating that safer night time economy and CIP were not incompatible. This is one example of not using our local powers, which means we are unable to restrict 24/7 off-licenses opening in proximity to treatment services and student areas.

3.7 *Planning* – a policy is currently being consulted upon in the Local Plan which restricts hot food takeaways near schools which are open during school hours. There is good quality systematic review evidence of geographical proximity of schools to fast food takeaway being positively correlated to childhood obesity, and from a health inequalities angle, those schools in more deprived areas, had higher density and those children had higher body mass index, leaving them open to greater risk of non-communicable disease (Turbutt et al., 2019)[xx]. Reported opposition to this policy approach cites individual choices, but as discussed, taking a Commercial Determinants of Health approach means understanding the choice architecture of increased targeted advertising exposure and increased availability, particularly in more deprived parts of the city, leads to less healthy choices being made.

3.8 'Choice Architecture' is also known as 'Nudge Theory' and has been developed further by a body of Behavioural Scientists, for example the Behavioural Insights Team who have evaluated UK obesity prevention policies and obesogenic environment factors including locational restrictions within stores of high fat salt sugar products and given a net present social value of £68,152m over 25 years for this policy[xxi]. The team found that there was more moderate support for more effective and evidence-based structural policies that alter the food environment, which had greater potential for preventing obesity than less effective, less evidence-based policies and they hypothesise that this is because people are guided by thoughts and beliefs about causes of obesity and non-communicable disease, rather than the evidence. However, the big alcohol industry has now entered this Behavioural Insights space, using what has been described as "dark nudges" and "sludge" (Petticrew et al., 2020) to influence consumer behaviour,

downplaying risks, and fostering uncertainty. This includes providing educational materials to schools under the charity Drinkaware.

3.9 *Trading Standards https://www.sheffield.gov.uk/business/trading-standards*– Trading Standards are involved in the regulation of industry, such as through age verification test purchasing and enforcement on illegal tobacco products, sales to children and packaging and display regulations. The Licensing Authority has a Test Purchasing Strategy for Gambling contained within its updated (2022) Statement of Principles (11.2.2) where joint operations may be carried out by South Yorkshire Police and Trading Standards. Sheffield Trading Standards, South Yorkshire Police Licensing, and the Licensing Project Manager from the Sheffield Safeguarding Partnership train premises staff and conduct test purchases for alcohol underage sales. These powers can restrict the saturation of communities with cheap and illicit tobacco and alcohol, and safeguard young people from underage consumption of smoking, alcohol, and gambling products.

3.10 These brief examples – *Advertising and Sponsorship, Licensing, Planning, Trading Standards* – demonstrate the potential for a joined-up, cross-authority approach to addressing Commercial Determinants of Health and Unhealthy Commodity Industries. The examples given describe the powers of Local Authorities, but other stakeholders and anchor organisations also have powers in terms of advertising, sponsorship and promotions, procurement of food franchises and vending in premises, smoke free sites (Sheffield Teaching Hospitals and Sheffield Health & Social Care Foundations Trusts have smoke free sites).

3.11 The Industry Playbook is a term used to describe the tactics used by Unhealthy Commodity Industries which was first documented in the Tobacco Industry but has since been adopted by other Unhealthy Commodity Industries. The Industry Playbook tactics include undermining of evidence, reframing discussion to a narrow focus on individual choice, lobbying politicians, undermining critics. The power is unequal, particularly with wealthy global corporate industries and is frequently described in “David and Goliath” terms, but the World Health Organisation Framework on Tobacco Control demonstrates what is possible when we choose to use our powers collectively.

3.12 Lacy-Nichols et al. (2022)[xxii] propose the adoption of a Public Health Playbook to counter the Industry Playbook. The Public Health Playbook that they propose includes coalition building, collective solidarity, and shared goals with non-Public Health personnel and using this diverse coalition of the willing to train, monitor, debunk, inform, and expose on the Industry Playbook and tactics. This may feel uncomfortably political with a small ‘p’ for some actors. However, in this paper to the Health and Wellbeing Board we hope we have demonstrated that a Public Health Playbook is about sharing the evidence-base with salient stakeholders and inviting a discussion by decision makers on the local appetite for action using existing powers as a normal activity within a democratic organisation. As a board, you may not wish to use all the powers at your disposal, and even if you recommend that all these powers are used, other Boards and Committees may have a different view.

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

4.1 We advocate structured discussions on Commercial Determinants of Health and Unhealthy Commodity Industry so that there is a joined-up, cross-council approach on a range of industries rather than ad hoc action on selected areas under individual strategies – high fat salt sugar food, tobacco, gambling, alcohol.

4.2 We propose that we seek or develop tools that will allow us, our settings, stakeholders, and anchor organisations across the city to recognise the industry tactics and counter the harmful influence of the unhealthy commodity industry. We have termed this the "Public Health Playbook" after the Lancet article, to counter the "Industry Playbook". This includes sharing the evidence base, as we have started to briefly describe in this paper.

4.3 We suggest that as a Local Authority we choose to use our powers as regards Advertising and Sponsorships policy (drawing on the work of other authorities and Transport for London), density, proliferation, and proximity to sensitive locations of Unhealthy Commodity Industries through Licensing and Planning powers and use our enforcement powers proactively to protect the underage from exposure.

4.4 We propose further discussion on an unhealthy commodity industry conflict of interest policy which would mean we no longer accept Unhealthy Commodity Industry direct funded education, prevention, treatment, support into Sheffield. This would include use of Gambleware and Drinkaware industry body educational materials in schools, use of sponsored products which greenwash such as Ineos, a fossil fuel company involved in fracking, sponsoring the Daily Mile in schools and MacDonalds, a brand associated with high fat salt sugar foods, involvement in grassroots football, Coca-Cola partnering with Fareshare, a food poverty and food waste organisation. The partnership of a sugar sweetened beverage company with a food poverty organisation is particularly of concern given the avoidable rates of hospital admission of children under 10 for dental decay extractions linked to sugar sweetened beverage consumption. 2018/19 data shows that 1 in 100 Sheffield children aged 0-5 and 2 in 100 Sheffield children aged 6-10 were admitted for this reason with sugar sweetened beverages driving this process, which also has a social gradient (Levine, 2021).

4.5 The World Health Organisation states that young people are particularly at risk of Commercial Determinants of Health and these are examples of industry tactics which purport to be helping to be part of the solution to Public Health issues, which by promoting products and brands to children, can actually perpetuate the problems we are trying to address in the next generation.

5.0 QUESTIONS FOR THE BOARD

5.1 Do the Health and Wellbeing Board agree that Sheffield should have a Commercial Determinants of Health (CDOH) /Unhealthy Commodity Industry (UCI) approach to framing local policy and strategy? A Public Health Playbook to counter the Industry Playbook.

5.2 How much exposure to harmful unhealthy commodities is acceptable and how much is too much, in Sheffield? Knowing that Unhealthy Commodity Industries drive non-communicable disease, should we use our Local Authority powers to turn off the pump?

5.3 Should we have a Conflict of Interest policy in relation to Unhealthy Commodity Industry direct funded education, prevention, treatment, support – e.g. schools education (Gambleaware, Drinkaware etc) patient education, research, treatment – and restrict advertisements and sponsorship (with/without exemptions for local brands)?

6.0 RECOMMENDATIONS

6.1 That Sheffield develops a Commercial Determinants of Health / Unhealthy Commodity Industry (UCI) approach/guidance;

6.2 Conflict of Interest Policy particularly in relation to commercial influence/involvement in education.

6.3 That we have a structured "Public Health Playbook" to counter the Industry Playbook;

6.4 Advocate caps and limits on exposure in certain settings and locations e.g. zero limit in certain areas and sensitive location, sensitive receptors e.g. schools, hospitals, addiction services;

6.5 That we use our existing powers as a Local Authority to address the negative impact Unhealthy Commodity Industries have on local residents, namely that we adopt the following;

- Advertising and sponsorship policy to limit exposure to Unhealthy Commodity Industries,
- Cumulative Impact Policy for alcohol and the night time economy (NTE) strategy through Licensing,
- Use planning powers and the Local Plan to restrict density and proliferation of high fat salt sugar foods, tobacco, alcohol, gambling;
- Use our powers of regulation, for example Trading Standards age regulation to reduce avoidable exposure and harms (this list is not exhaustive);
- Advocate caps and limits on exposure in certain settings and locations e.g. zero limit in certain areas and sensitive location, sensitive receptors e.g. schools, hospitals, addiction services;

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Sheffield University Management School.

NHS Sheffield Clinical Commissioning Group

Evaluation of the Sheffield Primary and Community Mental Health Transformation Programme

Final Report:

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Foreword by **Professor Tim Kendall**

The commitments to transform community mental health services for people with severe mental health problems were some of the most ambitious in the NHS Long Term Plan.

In 2019, we began making the biggest investment into community mental heath services in the history of the NHS. With an additional investment of almost £1bn per year by 2023/24, the NHS committed itself not just to increasing the number of people able to access help – although that is a key aim. It also asked every area of the country to rethink what 'help' looks like and to reconsider how they provide that help so that people from all parts of their communities can more easily and quickly access support.

These are big ambitions, and I do not underestimate the task that twelve early implementer sites, Sheffield included, embarked upon in 2019. Of course, this challenge was made even harder with the Covid-19 pandemic, and it is the result of an extraordinary effort that so much progress was made in spite of such unforeseen obstacles.

I am pleased to say that Sheffield has risen to the challenge and can rightfully be proud of its key achievements in delivering the new models of care, closer to home to greater numbers of people. Community mental health services are now embedded in Primary Care Networks with an increase in the workforce and access to evidence-based treatments. I am particularly pleased that this includes increased reach into communities previously under-served by existing services. As the report makes clear, strong collaborative bonds have established across organisations in Sheffield, with primary, secondary and voluntary sector partners amongst others working closer than ever. These relationships are surely the key building blocks upon which further improvements to services will be built.

Of course, the transformation programme in Sheffield has experienced setbacks and learned important lessons. The scale of under-met need is clear and demand for support has increased. While significant investment has been made, there is a need to invest more and to further expand the clinical and non-clinical mental health workforce, whilst continuing to work in new ways with primary care, local authority and voluntary sector partners. Important steps forward have also been made to embed co-production but there is always more we can do in this area to make sure we are getting the most out of the vital input that people with lived experience of using services can bring.

Undoubtedly, Sheffield's report will be a valuable resource for others delivering similar transformations across the country, supporting them to improve the provision of community mental health support. Moving forwards, we'll be focusing on addressing key challenges raised by our programme teams as part of the next phase of transformation. This includes ensuring our programme is meeting the scale of demand in Sheffield, how we can bring together different organisational cultures to work seamlessly as one team and ensuring this programme is seen as a key priority in the emergent ICB structure.

As National Clinical Director for Mental Health I have been clear of the importance of this work and while these are the first steps on a longer journey, I am pleased to say these first steps have been confidently taken in Sheffield.

Professor Tim Kendall,
National Clinical Director for Mental Health, NHS England

Contents

Executive Summary

Background and Context to the Programme

- The Community Mental Health Framework for Adults and Older Adults (hereafter, "the Framework"), published in September 2019, seeks to overcome multiple identified problems with existing provision of mental health care.
- The Framework builds on the NHS Long Term Plan and seeks to support new models of "integrated, personalised, place-based and well-coordinated care" for people with severe mental illness.
- The Framework encourages models of care which break down barriers between mental health and physical health, between health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and between primary and secondary care.
- The Sheffield Primary and Community Mental Health Transformation Programme (hereafter, "the Programme") is one of 12 early implementer sites testing the Framework across England
- The Sheffield Programme was designed to test and inform a new way of delivering services for adults and older adults with serious mental illnesses, with a particular focus on people with a diagnosis/characteristics of personality disorder.
- The priority was to offer care at neighbourhood level, built around Primary Care Networks (PCNs), strengthening relationships with VCSE organisations, and addressing health inequalities across the city of Sheffield.
- The Sheffield Programme was established as a partnership between NHS Sheffield Clinical Commissioning Group, Sheffield Health and Social Care NHS Foundation Trust (SHSC), Primary Care Sheffield (PCS), Sheffield City Council and Sheffield Mind.
- Sheffield Mind were selected as a partner to lead the commissioning of the VCSE sector, leading to a total of 6 further VCSE partners across the 4 PCNs.
- The Sheffield Programme was initially tested across 4 Primary Care Networks in Sheffield, representing one third of the city's population. Test sites were selected based on inequalities (socio-economic deprivation and ethnic minority populations) and degree of mental health need.
- Multi-disciplinary teams were created in the four participating PCNs, including 5 Mental Health Practitioners, 3 Clinical Psychologists, 2 Psychotherapists, 10 trainee Clinical Assistant Psychologists (CAPs), 4 Community Connectors, 3 Health Coaches, 1 Occupational Therapist, and 1 Pharmacist.
- The programme governance arrangements included a programme board, with partners from the CCG, SHSC, PCS, Sheffield Mind, Local Authority, Primary Care, NHS England, and South Yorkshire & Bassetlaw Integrated Care System (ICS).
- Implementation was impeded by the COVID-19 pandemic but was nonetheless launched in June 2020.
- In total, 2,692 referrals were made into the Programme; around 60% of people referred were female. The vast majority of the referrals were people of working age (18-65) with only 3.6% over 65. 20% of the total seen were of minority ethnic backgrounds.

Evaluation Methodology and Methods

- The evaluation team were commissioned in January 2021 to conduct a process evaluation of the Programme; this was conducted between March 2021 and July 2022, structured as five 3-month cycles. At the end of each cycle, an update of findings was shared with the Programme steering committee and the Programme Board.
- The evaluation sought to identify lessons learned through the implementation and to share actionable learning with partners in a timely manner.
- A panel of Experts by Experience, recruited from Rethink, provided feedback on the evaluation design, and contributed to producing service user friendly information sheets and consent forms.
- Data was generated through semi-structured interviews with 20 senior staff (defined as key informants), 42 staff working within the Programme (including all 36 staff directly employed through the Programme) and 10 service users.
- Key informants were selected through a combination of purposive and snowball sampling to ensure representation of all partner organisations and to include senior staff not directly involved but affected by the Programme.
- Service users interviewed were nominated by clinical leads to ensure no vulnerable individuals were approached. Services users all had meaningful experience of the Programme and leads were asked to nominate users with a range of experiences, not only those with positive views.
- Interviews took place online or via telephone and were recorded, transcribed, anonymised and stored securely on University of Sheffield servers.
- Researchers also observed and took field notes at the monthly Programme Board and on invitation, team meetings, and reviewed Programme documentation.
- Interviews were analysed using NVivo qualitative data analysis software. Data was coded according to a framework derived from the evaluation objectives, which was iteratively refined through discussion by the evaluation team. Ethical approval was received from the University of Sheffield.

Summary of Cycle 1 Evaluation Findings

- A rapid lessons-learned report was produced during the first evaluation cycle, based on the first 14 key informant interviews.
- The cycle 1 findings reported that the Programme was delivering on its objectives (despite the pandemic) and was showing evidence of the potential for collaborative or integrated working across health, care and other systems.
- Achievements were ascribed to the widespread recognition of a problem with current mental health provision, the focus afforded by a dedicated Programme, the strength of the core Programme team at both leadership and operational levels, and a general openness and commitment to learning through the Programme.
- Three challenges were identified in the cycle 1 report, which was presented to the Programme Committee in September 2021
- Firstly, that the scale and nature of undermet need in mental health was greater and more complex than many anticipated, presenting challenges of workload and capacity.
- Secondly, that cultural differences between the different partners in the Programme, in particular between primary and secondary care, between NHS and non-NHS providers, and between public sector providers and VCSE providers, impacted on the ability to deliver care in a coordinated way.
- Thirdly, that work needed to be done to raise the visibility of the Programme at senior levels in Sheffield City Council, Sheffield Health and Social Care NHS Foundation Trust, and within the emergent Integrated Care System for South Yorkshire and Bassetlaw.

Evaluation Findings

- The findings are organised around 5 sections: Context, Achievements, Challenges and Barriers, Enablers, and Roll-out and Sustainability.
- These themes reflect the coding framework developed from the evaluation protocol and used to analyse both Programme staff interviews and service user interviews.

Context:

- We found a widespread perception that there was a high level of undermet mental health need in all four sites, from both the professional and service user perspective.
- This degree of need provided strong motivation for the kind of provision offered by the Programme, but gauging and responding to this demand resulted in significant pressure on the Programme.
- This pressure was also experienced by the local mental health Trust, and over time these system pressures had led to tensions between primary and secondary care.
- In this context, the prioritisation of PCNs with the highest mental health need by the Programme was logical.
- Interviewees also emphasised the significant variation between the sites in terms of demographics, resulting in different profiles of mental health need in each PCN, and noted that sites also varied in terms of the strength of engagement with VCSE organisations.
- The COVID-19 pandemic had a significant impact at the start of the Programme and throughout on the design, management and delivery of care through the Programme.

Achievements:

- We found widespread and deep pride in the achievements of the Programme across all staff involved in delivery and leadership, reflecting a strong conviction that the Programme had extended the reach of mental health services and had a palpable impact.
- Many felt that the success in helping under-served groups was facilitated by the flexible approaches adopted through the Programme, a view echoed by the majority of services users interviewed.
- Furthermore, Programme staff and GPs described in detail how the service had provided valuable support to GPs, directly and indirectly.
- The Programme also described success in building strong collaborative bonds across professional and organisational boundaries, although this appeared to vary somewhat between the sites.

Barriers and Challenges:

- We found that there were multiple and sometimes inconsistent views of what the Programme was, which partly reflected the process by which the focus was gradually refined.
- Nonetheless, as this ambiguity persisted, there was a risk of scope creep and of unrealistic expectations being placed on the Programme.
- Some described issues with vertical communications and with communication and engagement with VCSE partners.
- The ability of the Programme to build internal coherence limited by a lack of estates provision and the inability of staff to co-locate, and gaps in administrative infrastructure led to less efficiency overall as clinical staff dealt with administrative tasks themselves.
- The estates and administrative issues also led to demotivation as some staff felt this reflected a lack of value placed on the Programme.
- More broadly, staff highlighted challenges engaging with secondary mental health care and IAPT, suggesting work was needed to position the Programme more clearly within the wider system.
- Finally, staff discussed concerns about caseloads and the need to balance workload more equitably across the team, and the need for attention to be paid to certain HR issues, such as equity in employment conditions and availability of training and development opportunities.

Enablers

- We found several specific enabling factors to have made a difference.
- Flexibility was seen to be one of the great strengths of the service, with several dimensions including flexibility in access, in how time and space were used when working with service users, and in the degree of creativity in treatments which were possible and encouraged, an approach which was already quite normal among the VCSE providers.

- The depth of commitment to the Programme, reflecting both the acute awareness of undermet need and belief in the Programme to make a difference, was a powerful motivating factor.
- The Programme further benefited from the quality of staff recruited, their 'fit' with the ethos of the Programme and their willingness to support each other.
- This extended to the leadership team also, where some felt the composition, including the representation of GPs, was critical.

Roll-out and Sustainability:

- Reflections on roll-out and sustainability focused on two themes.
- The first was the appropriate design of work. This covered important but arguably universal Human Resources (HR) and Organisational Development (OD) concerns such as supportive leadership, staff involvement and engagement, and opportunities for continuing professional development.
- More specifically, there was a need for greater role clarity, particularly for Mental Health Practitioners (MHPs) and Clinical Associates in Psychology (CAPs); a need to ensure the right composition of teams at a neighbourhood level (reflecting local need and potentially including additional new roles); and the need to align the service more effectively alongside new mental posts recruited between mental health providers and primary care under the Additional Roles Reimbursement Scheme (ARRS).
- The second theme related more to sustainability at scale, ensuring sufficient capacity and sufficient funding, again tailored to local need at a PCN level.
- Many recognised the importance of focusing at an early stage on capturing meaningful data and evidence in order to justify investment in mental health provision of this kind.

Discussion

- The Discussion section draws together seven themes which cut across the different Findings sections, summarised in seven points below.
- The Programme demonstrated an ability to reach marginalised groups and to tailor mental health care to match local need. This was enabled by the location of care within communities, the insights provided by general practices and third sector organisations who were familiar with local needs, and the flexible way in which care was made accessible and delivered.
- The Programme was also strengthened by effective engagement with general practice, despite a degree of scepticism among some GPs who had experienced difficulty accessing mental health services for their patients. This engagement ensured that it reflected the mental health needs of patients and the pressures experienced in general practice seeking to support these patients.
- The scale and complexity of demand presented various challenges, including perceptions of inequitable workload among teams and requiring tailored support reflecting local demographics in each PCN. The primary care model of 'patient lists' did not fit neatly with the intensive referral-treatment-discharge model of secondary care, presenting challenges in how caseloads were managed and how services users and staff understood referrals and discharges.
- While the discrete nature of the Programme enabled focus, challenges were encountered positioning the Programme within secondary and specialist mental health services. Effective integration of the Programme would require clarification and coordination of policies and processes with other providers, and strategic engagement at a senior level, with SHSC and South Yorkshire and Bassetlaw ICS.
- The contribution of VCSE providers to date, and the potential for greater contribution, was widely recognised, although various challenges and barriers to involvement were also identified. VCSE leads requested greater involvement in the design and oversight of Community Mental Health services and several highlighted variable experiences when seeking to engage with MDTs in places, suggesting a need to strengthen relationships between VCSE providers and general practices to maximise the contribution of the third sector.
- Staff and service users attested to the importance of flexibility in the delivery of care, with staff feeling empowered to develop innovative solutions to meet service users needs, and service users welcoming the flexibility which they felt valued their own autonomy and choices. However, some felt this presented certain challenges to consistency and parity of care and clinicians discussed the need to balance innovation with evidence-based care.

- The challenge of sustainability for the service as the scale expanded was seen to be significant, with four aspects being highlighted; the financial viability of the service at scale; the work needed to be done to ensure good staff could be recruited and retained; the importance of embedding the service within the wider health and care system; and the need to identify reliable and appropriate evidence of the impact of the service going forwards.

Recommendations

1. **Estates**
   - 1.1 Ensure the service delivers care within neighbourhoods and in convenient locations for service users.
   - 1.2 In each PCN, a set of options should be developed for estates provision, addressing space for clinical consultations and other meetings, and for a physical base or hub for the service teams.
   - 1.3 The impact of the service on primary care estate should be considered at ICS level where capital investment in estates is considered.
   - 1.4 Given pressures on estates in general practice, alternative spaces should be considered, such as council premises and Third Sector buildings.
2. **Administrative support**
   - 2.1 A plan should be developed stipulating necessary administrative support for service teams at a PCN level.
   - 2.2 This plan should be developed in discussion with GP practices or other premises used, recognising pressures on existing GP administration and the peripatetic nature of work for staff within service teams.
3. **Communications**
   - 3.1 A targeted briefing should be composed for delivery to GP practices and VCSE organisations in remaining PCNs across the city of Sheffield and, if appropriate, more widely to summarise and communicate lessons learned from Programme.
4. **Mental Health Needs Analysis and Mapping at PCN level**
   - 4.1 Analysis should be commissioned at PCN level to establish the level and nature of mental health need in each locality.
   - 4.2 This analysis should draw on data and expertise from primary care, secondary care, the city council and the Third Sector.
   - 4.3 The analysis should also be informed by the experience of the Programme and the insights of Programme team leads, including VCSE providers.
5. **Team Composition**
   - 5.1 Using the Needs Analysis (Recommendation 4), further work is required to ascertain the appropriate and affordable design of service provision required to deliver an equitable level of care in each PCN.
   - 5.2 This work would also need to take into account any changes in secondary care provision as well as emergent contribution of any ARRS mental roles.
6. **Caseload Review**
   - 6.1 An assessment should be undertaken to review caseload distribution across teams, with senior clinical input, to confirm appropriate and manageable workloads for each group within the teams.
   - 6.2 This review should determine and articulate an agreed approach to caseload management, recognising the different expectations of primary and secondary care.
   - 6.3 This review should inform a training intervention to address conflicting assumptions across teams about expectations of caseload and associated issues of risk and staff capacity.
   - 6.4 This review may also form the basis for explicit policy as regards safe and sustainable caseloads.
7. **Engagement with Secondary Mental Health Services**
   - 7.1 A strategy for clear and direct engagement with SHSC at senior level to articulate formation and impact of the Programme, presented in the light of national policy and CMHF expectations, and to share lessons learned through the Programme.
   - 7.2 This will involve the creation of a focused briefing clarifying the mission, focus and achievements of the Programme which should be delivered to relevant senior boards in other parts of the health and care provider system, including acute trusts, social care providers and, critically, the secondary mental health care provider.

7.3 This communication should focus on the impact of the Programme and the expected contribution the service can make to the goals and objectives of secondary mental health services.

8. Organisational Development

8.1 An OD (Organisational Development) initiative should be considered, ideally delivered collaboratively with SHSC, to build mutual understanding between primary and secondary care mental health providers (and should include ARRS mental health workers who are not part of Primary and Community Mental Health teams).

8.2 This intervention should aim to explore cultural differences and risks of miscommunication across mental health services, to support clinicians and managers to work collaboratively across primary and secondary care.

8.3 This intervention could be extended to incorporate other partners, in particular VCSE organisations and local authority staff and support whole-system collaboration and integration.

9. System Integration

9.1 Collaborative discussions should be initiated with SHSC also required at a system level (between primary and secondary care as well as commissioners) to agree processes and criteria for service users to transition to/ from more specialist/intensive care and to/ from lower intensity IAPT care.

9.2 This discussion may also encompass work to clarify eligibility criteria for the service, which should be consistent with those applied by other MH providers.

10. Governance and Multi-Partner Engagement

10.1 The design of the board or oversight committees for the future service should ensure representation from all partners, including the secondary mental health provider, local council, general practice and VCSE organisations.

10.2 In particular, the board/committee design should ensure that the range of VCSE providers have input into the design and operation of Primary and Community Mental Health services; engaging with VCSE provider alliance may facilitate a wide range of engagement, including smaller VCSE organisations.

11. VCSE and General Practice Liaison

11.1 A targeted initiative should be undertaken to improve communication between VCSE organisations and GP practices, potentially supported at scale by the establishment of a VCSE provider alliance.

11.2 This work may take place at scale, to share evidence of effective support provided through VCSE organisations, and at a PCN level to strengthen two-way communication between local VCSE providers and general practices.

11.3 Community Mental Health Teams and PCNs should consider ways in which to strengthen VCSE partnerships across primary care at a neighbourhood level, including opportunities for collaborative applications for funding, to enhance capacity to provide care, support and treatment through Third Sector providers.

12. Facilitation of MDT Participation between Partners

12.1 Guidance should be developed on the operation of MDT meetings to facilitate participation of different providers, both clinical and non-clinical.

12.2 Respecting the clinical autonomy of GP practices, it would be helpful for GPs and GP leads to share experiences of MDT operations and evidence of positive impact of more inclusive practices.

13. Commitment to Flexibility, Innovation and Learning

13.1 The service should develop a clear statement of principle on the issue of flexibility and innovation in service delivery, including a definition of the positive dimensions of flexibility that the service will embrace and encourage.

13.2 Given the high value placed on flexibility and patient-centred care by both staff and services users, guidance should be developed to ensure staff have the confidence to explore adaptive, patient-centred care but do so safely and informed by evidence where available.

13.3 To ensure lessons are learned and innovations are assessed and shared, processes should be established to facilitate rapid sharing and assessment of innovative practice between clinicians, with checks and balances to ensure safe care.

13.4 This is likely to require a dedicated, clinician-led piece of work to develop guidance and to identify the processes by which innovation should be assessed and shared.

14. Recruitment and Retention of Staff

14.1 Attention to certain key elements of the job offer is necessary to optimise ability to recruit and retain staff, in terms of both agreeing policy and communicating this to existing and prospective staff. These include;

14.2 Clear articulation and communication of the ethos, mission, and expected impact of the service, in both recruitment and selection, and through induction processes.

14.3 Clarification of roles and responsibilities, particularly for new roles such as MHP and CAPs as well as relevant ARRS roles, to ensure a shared understanding of respective responsibilities and to support smooth collaboration across teams

14.4 Work to ensure appropriate estates space for teams, potentially including a home-base to enable a degree of co-location and access to good quality spaces for meetings and consultations.

14.5 Standardisation of employment conditions as far as possible given multiple employer organisations

14.6 Clarification and articulation of provision of development and training opportunities.

15. Measurement of impact

15.1 A detailed project is needed to measure the impact of the Programme and current/future Primary and Community Mental Health provision, potentially with an economic impact evaluation.

15.2 To inform this work, a focused project would be necessary involving clinical leads, service leads, technical leads and commissioners to establish appropriate measures of impact, which may include patient reported measures and prescription rates for psychotropic medication or antidepressants

15.3 Equally, mechanisms should be put in place to routinely capture feedback from service users and from staff on a regular basis, and to demonstrate to users, staff and commissioners how the service learns from and acts upon this feedback.

15.4 This work should however recognise the points made above about the scale of undermet need, the degree to which the Programme may have reached under-served groups, and the likely identification of need at an early stage through the Programme, all of which will affect the degree of impact measured.

15.5 There would be substantial value in a broader commissioned piece of research drawing together learning on implementation and impact across the 12 CMHF early implementer sites at a national level.

15.6 Similarly, given the number of new roles being introduced across mental health services, there is a need for a broader evaluation of the impact, challenges and benefits of these new roles implemented as part of the Community Mental Health Framework.

A

Background and Context to Programme

A. Background and Context to Programme

In this section, the broad policy context leading up to the Sheffield Primary and Community Mental Health Transformation Programme (henceforth, "the Programme") will be described, before presenting the structure and implementation of the Programme. Data will then be presented summarising the activity which took place within the Programme.

1. The Community Mental Health Framework

The Community Mental Health Framework for Adults and Older Adults[1], published in September 2019, was developed by NHS England, NHS Improvement, and the National Collaborating Centre for Mental Health (NCCMH). The Framework responds to the NHS Long Term Plan which promised investment and a radical transformation in the care, support and treatment for people with severe mental illness (SMI).

The NHS Long Term Plan describes the need for new and integrated models of primary and community mental health care, support and treatment, stating that local areas will be "supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks."[2] (NHS Long Term Plan, p.69). These changes have the aim of addressing health inequalities and avoidable variation in care, giving "370,000 adults and older adults with severe mental illnesses in England greater choice and control over their care and support them to live well in their communities by 2023/24"[3].

The Community Mental Health Framework (hereafter, "the Framework") takes this forward, recommending the development of new models of "integrated, personalised, place-based and well-coordinated care" for people with severe mental illness. The Framework seeks to overcome multiple identified problems with existing provision, including mental health system fragmentation and risks of discontinuity of care, the limitations of the Care Programme Approach (CPA), high barriers to access and long waiting times for specialist secondary care in many areas, and the damaging effect of multiple transitions between services. Instead, the Framework seeks to encourage models which can break down barriers between;

- Mental health and physical health,
- Health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and
- Primary and secondary care.

The Framework states that people with mental health problems will be enabled to be active participants in their care, and that this will be delivered in the community. It suggests that health and social care commissioners should collaborate with providers "on a sustainably-funded partnership basis – that is, without recurrent short-term tendering cycles and complex contract management processes"[5], and aims to direct more resources into community-based services according to agreed local priorities.

1. NHS England, NHS Improvement and National Collaborating Centre for Mental Health. *The Community Mental Health Framework for Adults and Older Adults*. NHS England; 2019 https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf .
2. NHS England (2019) *The NHS Long Term Plan* London: England https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ p.69
3. Ibid. p.73
4. NHS England, NHS Improvement and National Collaborating Centre for Mental Health. *The Community Mental Health Framework for Adults and Older Adults*. NHS England; 2019. https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf. p.4
5. Ibid. p.5

Community Mental Health Framework for Adults and Older Adults: Key Aims

People with mental health problems will be enabled as active participants in making positive changes rather than passive recipients of disjointed, inconsistent and episodic care. Delivering good mental health support, care and treatment in the community is underpinned by the following six aims:

1. Promote mental and physical health, and prevent ill health.
2. Treat mental health problems effectively through evidence-based psychological and/ or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that:
   - builds on strengths and supports choice;
   - is underpinned by a single care plan accessible to all involved in the person's care.
3. Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
4. Maximise continuity of care and ensure no "cliff-edge" of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
5. Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
6. Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.

Source: The Community Mental Health Framework for Adults and Older Adults. NHS England; 2019

The Framework argues for "a renewed focus on people living in their communities with a range of long-term severe mental illnesses, and a new focus on people whose needs are deemed too severe for Improving Access to Psychological Therapies (IAPT) services but not severe enough to meet secondary care 'thresholds'"[6] . However, it is intended that the Framework will be more widely applicable to people irrespective of their SMI diagnosis/presentation, and should cover those with coexisting frailty, coexisting neurodevelopmental conditions, eating disorders, anxiety or depression, personality disorder, drug or alcohol-use disorders and other addictions, and severe mental illnesses such as psychosis or bipolar disorder[7].

2. The Sheffield Primary and Community Mental Health Transformation Programme

The Sheffield Primary and Community Mental Health Transformation Programme (hereafter, 'the Programme') is one of 12 early implementer sites[8] selected through a competitive process to pilot how the Framework could be applied through the development and delivery of new models of mental health care.

The Programme in Sheffield was designed to be a new way of delivering services for adults and older adults with serious mental illnesses, with a particular focus on people with a diagnosis/characteristics of personality disorder. The priority was to offer care, support and treatment in a 'place-based way' built around Primary Care Networks (PCNs), strengthening relationships with VCSE organisations, and addressing health inequalities across the city of Sheffield.

The Sheffield Programme was therefore established as a partnership between NHS Sheffield Clinical Commissioning Group, Sheffield Health and Social Care NHS Foundation Trust (SHSC), Primary Care Sheffield (PCS), Sheffield City Council, South Yorkshire & Bassetlaw Integrated Care System and Sheffield Mind (ICS).

6. Ibid. p.3
7. Ibid. p.8
8. Details of the CMHF early implementer programme, including the list of all twelve sites, can be found at https://www.england.nhs.uk/mental-health/adults/cmhs/

The Sheffield Programme set out distinctive five elements of the new provision;

1. A single 'right door' for all
2. Reduced waiting times
3. An integrated team within primary care
4. Enhanced voluntary sector support
5. Improved physical health[9]

The Programme, along with other early implementers, also sought to develop and test methodologies to establish new 4-week waiting time metrics, in line with NHSE/I expectations.

This approach to providing support, care and treatment was tested within 4 Primary Care Networks in Sheffield, representing one third of the city's population, with the intention to expand the offer across the city in the future.

These networks were selected based on; inequalities (measured by Index of Multiple Deprivations and Public Health Fingertips[10] data) and degree of mental health need (measured by referrals to Single Point of Access to secondary mental health services for under 65s (SPA)), prescription of psychotropic medications and the number of patients on GP Serious Mental Illness registers (SMI registers).

3. Programme implementation

The Sheffield Programme therefore brings together health, social care and VCSE partners, with collective accountability for the success of the programme. Clear objectives and requirements were established at the outset, informed by the Framework, and a small core team of executive leads, clinical leads and management were established to lead delivery of the Programme.

The programme governance arrangements included a programme board, with partners from the CCG, SHSC, PCS, Sheffield Mind, Local Authority, Primary Care, NHS England, and South Yorkshire & Bassetlaw ICS. The programme board was created to reflect the joint integrated governance of the multi organisational partnership of the early implementer bid. Sheffield Mind were selected as a partner to support the commissioning of the VCSE sector, leading to a total of 6 further VCSE partners across the 4 PCNs.

The Programme leadership team comprises 2 part time Senior Responsible Officers (based in Primary Care Sheffield and Sheffield Health and Social Care NHS Foundation Trust, respectively), 2 Senior Managerial Leads and sessional clinical leadership input.

Multi-disciplinary teams were created in the four participating PCNs, including 5 Mental Health Practitioners, 3 Clinical Psychologists, 2 Psychotherapists, 10 trainee Clinical Assistant Psychologists (CAPs), 4 Community Connectors, 3 Health Coaches, an Occupational Therapist, and a Pharmacist. In addition, the leadership team included 3 team lead roles; a principal clinical psychologist leading the psychologists/psychotherapists, a lead Mental Health Practitioner, and a Community Connector manager **(see Table 1: Programme Roles and Staffing Numbers).**

Table 1: Programme Roles and Staffing Numbers during the period of evaluation (2021-22)

Role	Number of posts
Mental Health Practitioner	**5**
Psychological therapists	**5**
CAP	**10**
Community Connector	**4**
Health Coach	**3**
Occupational Therapist	**1**
Pharmacist	**1**
Leadership team (inc. team leads)	**7**
TOTAL	**36**

Each of the PCNs therefore had a dedicated team, composed of 1-2 Mental Health Practitioners, 1 Psychologist or Psychotherapist, 2 trainee CAPs, and 1 community connector. The OT, pharmacist and health coaches operated across all four PCNs.

9. Source: Sheffield Primary & Community Mental Health Transformation Programme presentation (April 2020)
10. https://fingertips.phe.org.uk/

One of the aims of the programme and wider national policy was to improve the physical health of people with severe mental illness, given reduced life expectancy. To meet this aim, the programme took a whole-system approach to 'making every contact count', employing band-3 health coaches to work with people with SMI who have identified physical health needs (doing work around behaviour change, motivation, nutrition, and exercise).

It should be noted that Sheffield did not have existing primary care mental health infrastructure for SMI at Programme inception, so these roles needed to be created and recruited through the Programme as new services were designed "from scratch". As the timeline below shows **(Figure 1: Programme Timeline 2019-2022)**, this work was carried out between November 2019 (NHSE funding awarded) and June 2020 when activity commenced and the first patients/service users[11] were seen.

It is important to note that the Programme implementation period coincided with the COVID-19 pandemic across the world. This not only impeded implementation processes such as staff recruitment, team-building and forging relationships at the PCN level, but also restricted the scale of care which could be offered through certain elements of the Programme. The pandemic also meant that staff had to engage with patients and service users in different and unfamiliar ways, often virtually while working from home due to social distancing and during lockdowns. At the same time, pressure across broader health and care services was intense and many people living with mental illness faced severe challenges, resulting in an increase in demand for support. Older adults, those with learning difficulties and autism were particularly affected here, and the Programme was asked by NHSE/I to maintain contact and increase online care and self-harm assessments through 2020-21. In parallel, there was clearly pressure from the pandemic on other parts of the health and care system, which continued as the vaccination programme took up time and resources through 2021.

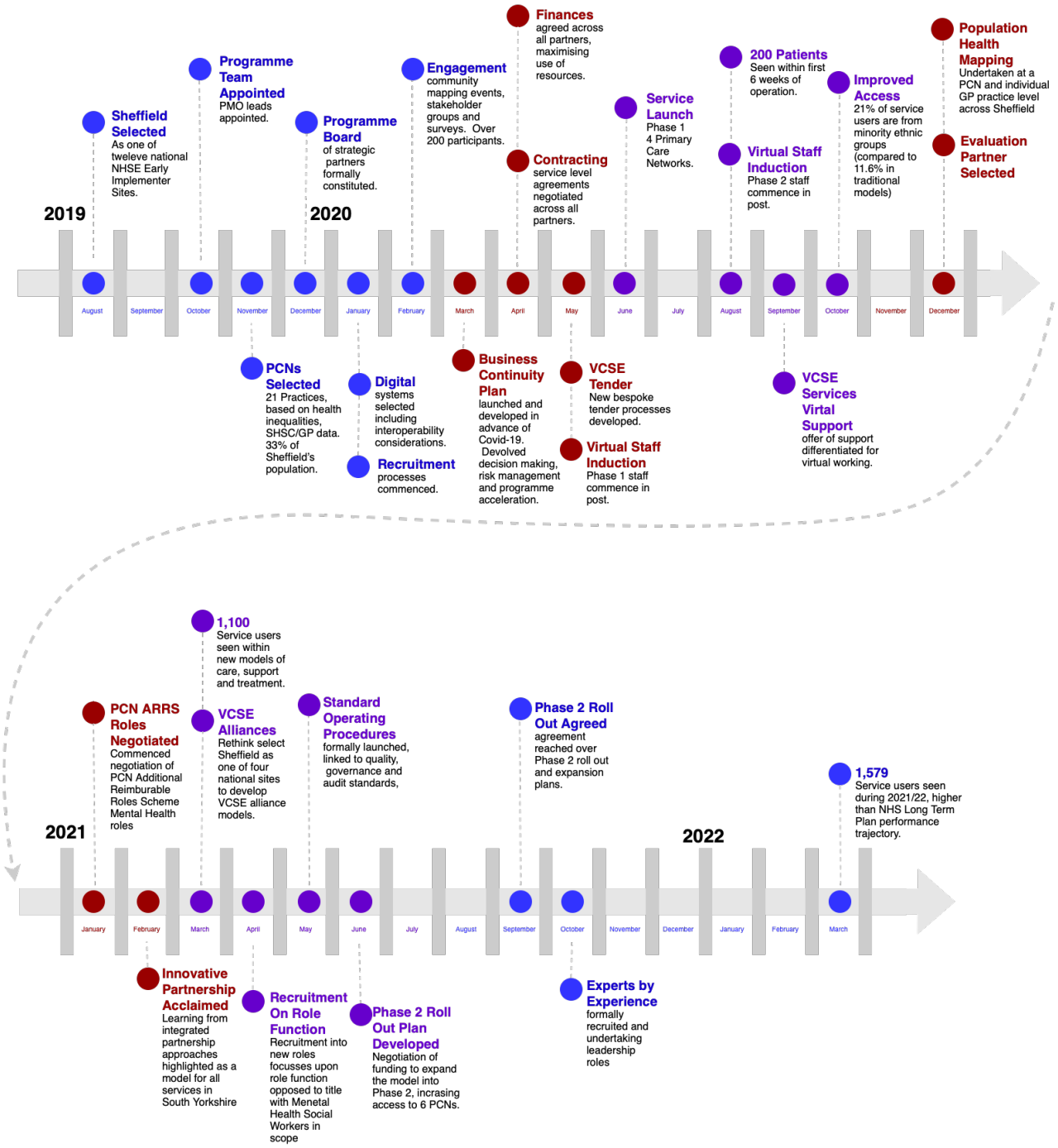
While many of the other Framework pilot sites postponed implementation during this period, the Sheffield Programme managed to recruit to and set up many services despite the challenges of COVID-19 and social distancing regulations, aided by their business continuity plan. As discussed below, this did however result in severe pressures affecting leadership, management, administration, and the delivery of care.

A parallel initiative which complemented and supported the Programme was the involvement of Rethink Mental Illness, who selected Sheffield as one of four national sites in which to develop a VCSE alliance model. With additional funding from the Charitable Aid Foundation (and match funding provided by Sheffield CCG), Rethink Mental Illness appointed staff to roles in Sheffield from March 2021. Working with SHSC, CCG, NHS England and other stakeholders, Rethink Mental Illness went on to build relationships with over 90 VCSE organisations. From February 2022, meetings were held involving all VCSE partners and a statement of intent was drafted to frame the vision and intended outcomes of a VCSE alliance in the city from August 2022.

The Programme was shortlisted for a Health Service Journal Award in 2021 in the category of Provider Collaborative of the Year, and was nominated for a British Medical Journal award in 2021.

11. Hereafter we have adopted the convention, common in mental health, of identifying those people using Primary and Community Mental Health services as service users from the point at which they access the service. However GP practices and primary care services more commonly refer to those on their practice lists as patients and many of the quotes in the report reflect this.

Figure 1: Programme Timeline 2019-2022



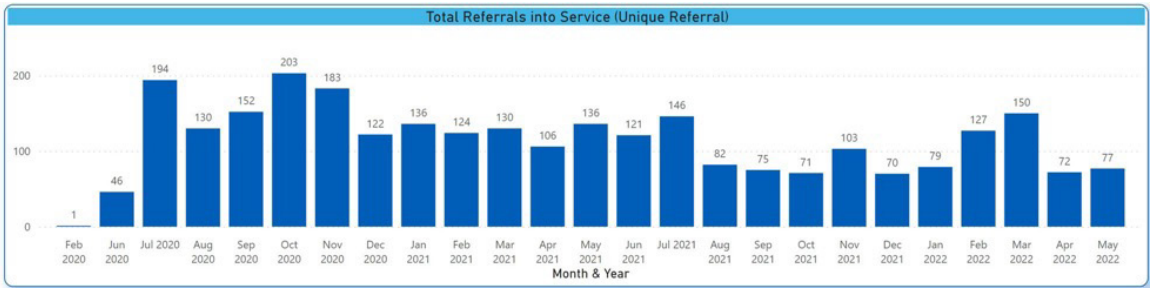
Key:

- Denotes non-Covid restrictions in effect
- Denotes times of UK National Covid lockdowns
- Denotes times where social distancing/tiering was in effect in regards to Covid

4. Programme Activity

The number of unique referrals into the service by month from June 2020 until May 2022 can be seen in **Figure 2: Referrals into Service by Month (Jun 2020-May 2022)**.

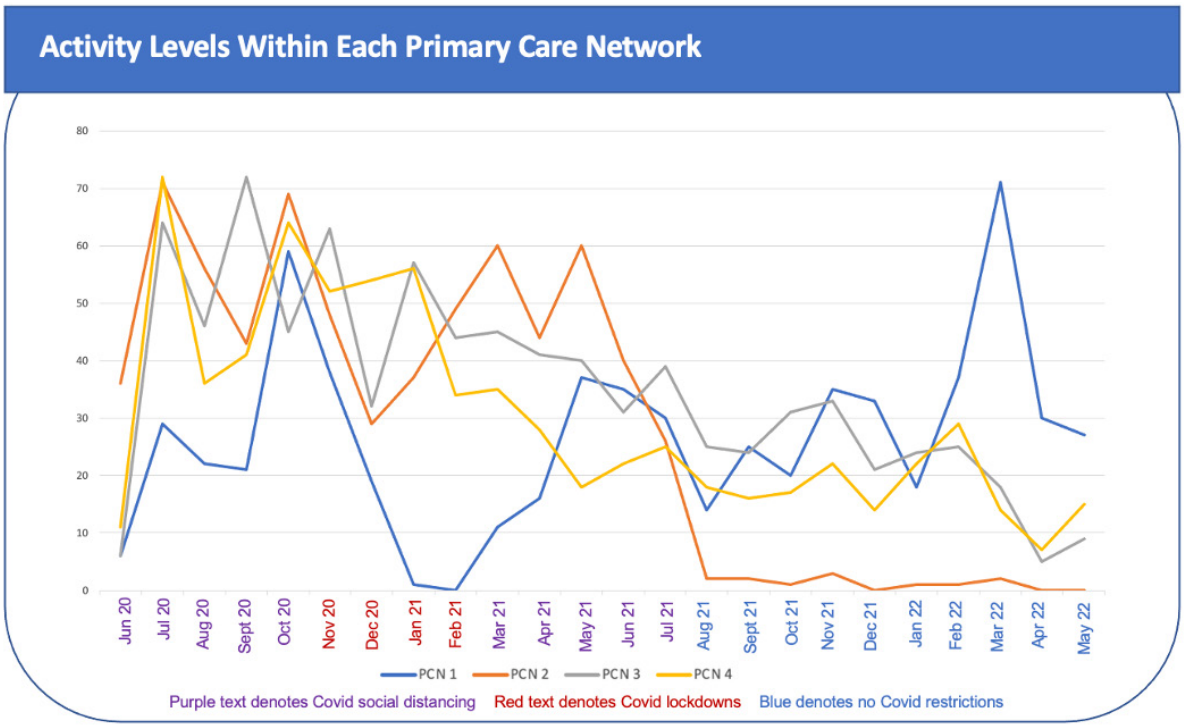
Figure 2: Referrals into Service by Month (16 Jun 2020-31 May 2022)



The breakdown of referrals by network can be seen in **Figure 3: Activity by PCN,** with additional colour-coding to clarify the impact of COVID through the implementation period.

This graph shows fluctuations in each PCN but a general picture of around 50-60 referrals per month in each PCN from June 2020 to June 2021, then a lower average of around 20-30 referrals per month from July 2021 onwards which is largely consistent across networks.

Figure 3: Activity by PCN (16 Jun 2020-31 May 2022)



Three points where referrals depart from this pattern merit some explanation;

- PCN1 shows a dip in referrals in January-February 2021. The reason for this was due to a staff member leaving their role and the programme not having any floating resources to back fill the role while the staff member was replaced.
- PCN1 also shows an erroneous data point in March 2022. This was caused by new referrals not being processed in January/February 2022. When this issue was identified the backlog of referrals were processed resulting in the spike in March 2022. A more realistic plot would be increased referrals in January and February and fewer in March 2022

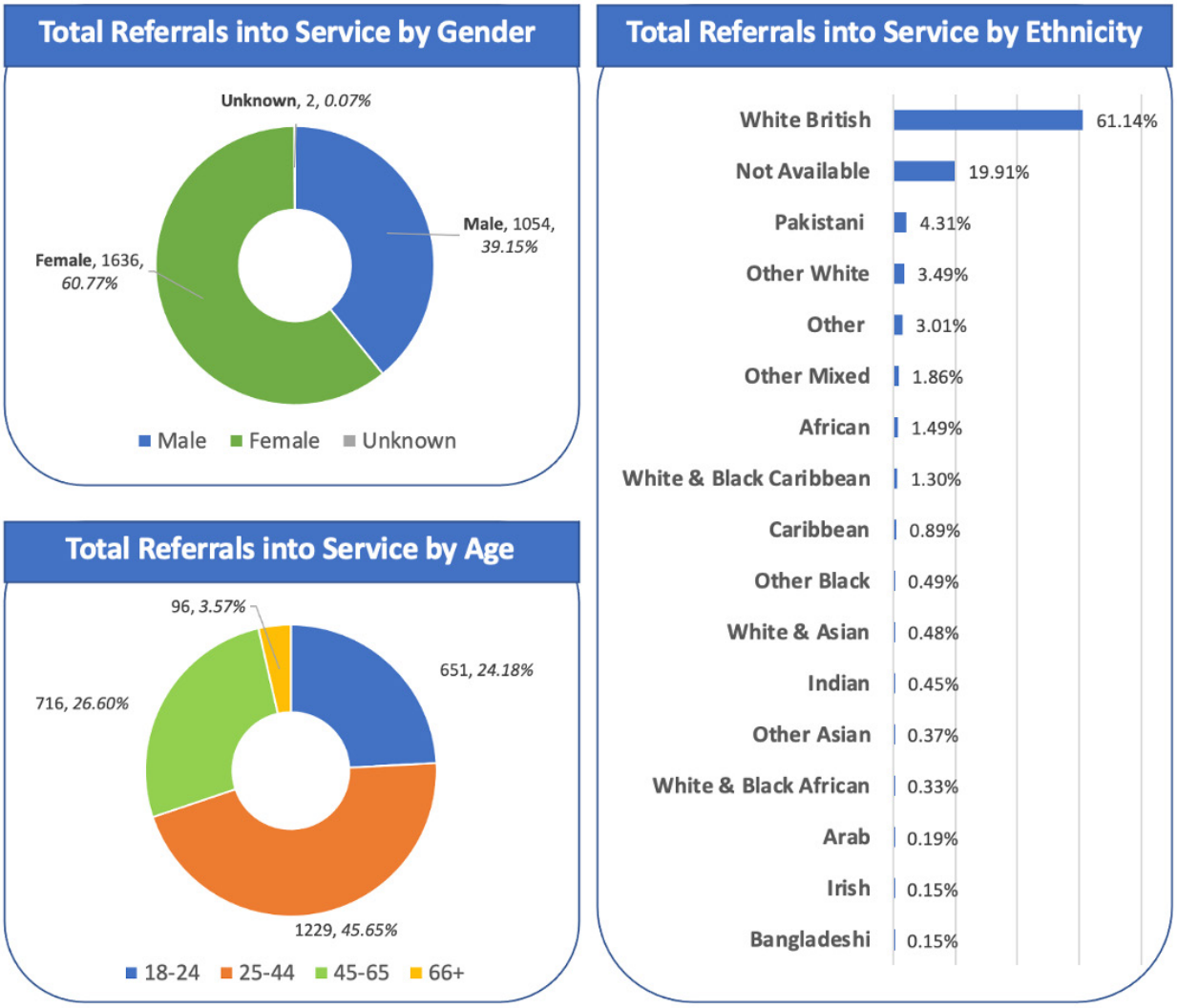
leading to a more controlled activity rate for PCN1 during this time period.

- PCN2 shows a reduction in activity from August 2021. There are two reasons for this reduction, firstly, this PCN had historically had high numbers of referrals, with many of the individuals having additional needs such as interpreters (where English was not a first language). Agreement was reached in August 2021 to temporarily pause new referrals to enable a historic backlog to be addressed, which coincided with a staff member being off sick for a period of time. In early 2022, a staff member left their role in PCN2 which reduced the capacity of the team and resulted in a further pause on new activity whilst a new member of staff was recruited.

a. Summary of Activity by Gender, Age and Ethnicity

Demographic information on all patients referred to the Programme across the Programme can be seen in **Figure 4: Total Referrals into Service (by Gender, Age and Ethnicity).**

Figure 4: Total Referrals into Programme (by Gender, Age and Ethnicity) Jun 2020-May 2022



As Figure 4 shows, around 60% of people referred to the Programme across all sites were female, and the vast majority were of working age (18-65), with the largest group being in the 25-44 age-range. Around 20% of those using the service were of minority ethnic backgrounds. The demographic breakdown of service users by PCN is presented **(Figure 5: Gender of service users by PCN; Figure 6: Age of service users by PCN; and Figure 7: Ethnicity of service users by PCN).**

Figure 5: Gender of service users by PCN (Jun 2020-May 2022)

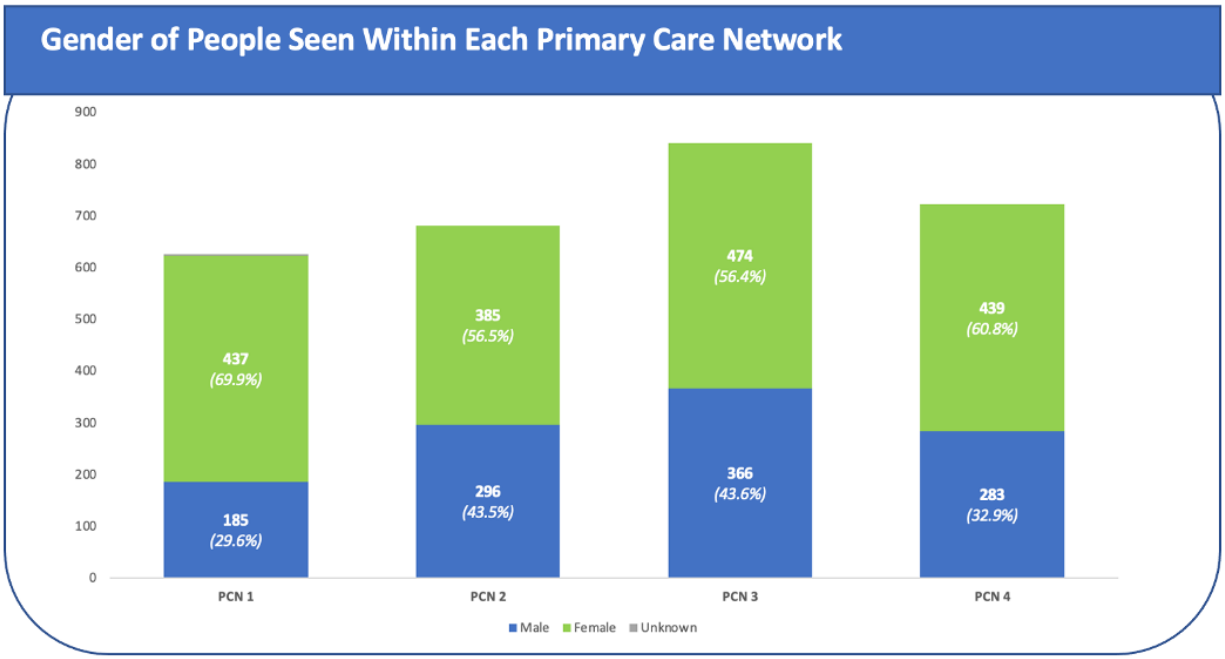


Figure 6: Age of service users by PCN (Jun 2020-May 2022)

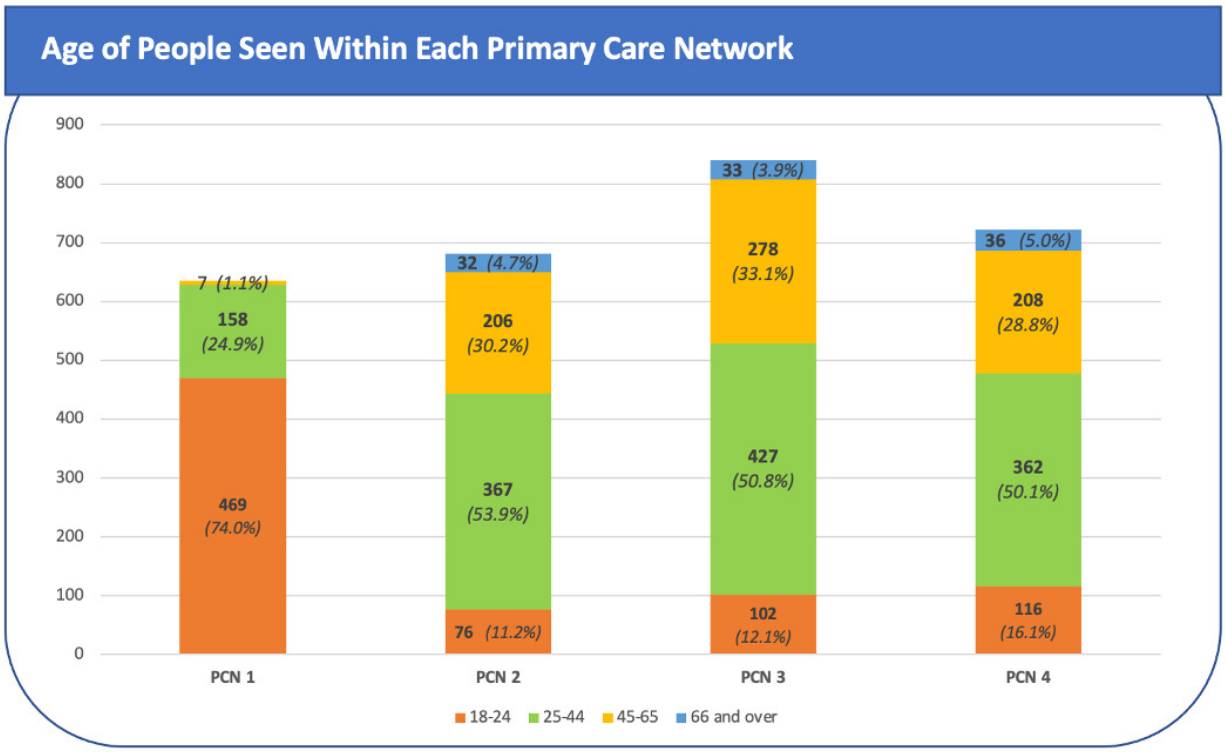
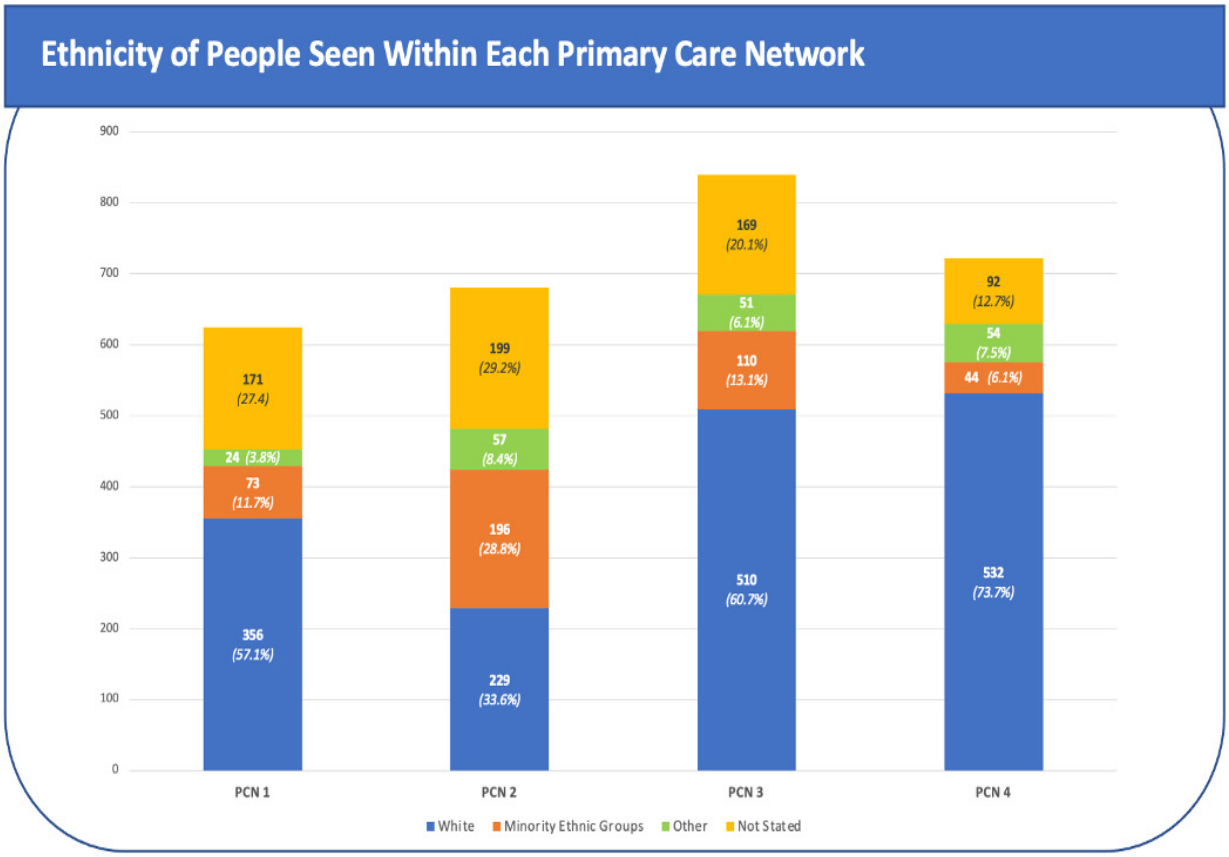


Figure 7: Ethnicity of service users by PCN (Jun 2020-May 2022)



b. Community Connector Activity

Throughout the project 278 people were seen by community connectors (Jun 2020 - Mar 2022), including 120 males and 158 females **(see Table 2: Breakdown of Community Connector activity)**.

Table 2: Breakdown of Community Connector activity

Age	Number of people seen
18-29	78
30-39	65
40-49	51
50-59	40
60+	36

In addition, 305 referrals were made to VCSE organisations over the same period, who offered a diverse array of support as described in **Table 2: Breakdown of VCSE activity.**

c. VCSE Activity

Table 3: Breakdown of VCSE activity

Provider	Staff involved	WTE	Referrals	Male	Female	Type of support provided
VCSE1	1	0.4	135	60	75	18 Debt Advice, 95 social welfare advice, 7 other advice
VCSE2	2	0.8	53	26	27	46 holistic needs assessment, 47 full benefits check, housing support 26, caring support 11, physical health support 51, fuel poverty 22
VCSE3	2	1.6	49	17	32	40 volunteering opportunities, garden self-care group 31, social groups 49, walk and talk sessions 29
VCSE4	2	1.6	15	11	4	Exercise sessions, debt support, personal development planning
VCSE5	2	1.6	44	24	18	28 health training/social prescriber, 11 community garden, 25 walk to talk, 39 1:1 personal development sessions
VCSE6	2	1.5	9	3	6	Training/education, volunteering/employment support, hobbies/interest groups, activities to support physical health
Total			305	141	162	

B

Evaluation Methodology and Methods

B. Evaluation Methodology and Methods

1. Research Approach and Methodology

This report presents the findings of an evaluation of the Sheffield Primary and Community Mental Health Transformation Programme, commissioned in January 2021 and conducted by the evaluation team based in the University of Sheffield between March 2021 and July 2022.

The evaluation was designed as a formative process evaluation, based on the following principles;

- The co-production of evaluation protocol with all programme partners,
- A process evaluation to focus on 'how' rather than 'why',
- An emphasis on rich and deep qualitative analysis,
- Emphasis on timely feedback and recommendations through rapid cycles of learning,
- Both a retrospective and prospective orientation, with a view to informing the wider roll-out of the service.

The evaluation therefore had three aims;

1. To **identify lessons learned** in the implementation of the Sheffield Primary and Community Mental Health Transformation Programme, covering as a minimum the following themes[12]:
    1. leadership
    2. governance
    3. infrastructure
    4. workforce
    5. impact (including accessibility, acceptability, and stakeholder experience)
    6. sustainability (including wider roll-out),
2. To ensure **actionable learning is shared with partners in a timely manner** throughout the evaluation period through briefings and interactive events, including lessons learned report and final report,
3. To generate **recommendations on the sustainable use of current dashboard and new software** in Sheffield, incorporating process flow mapping[13].

2. Methods

Data was generated through various methods, including:

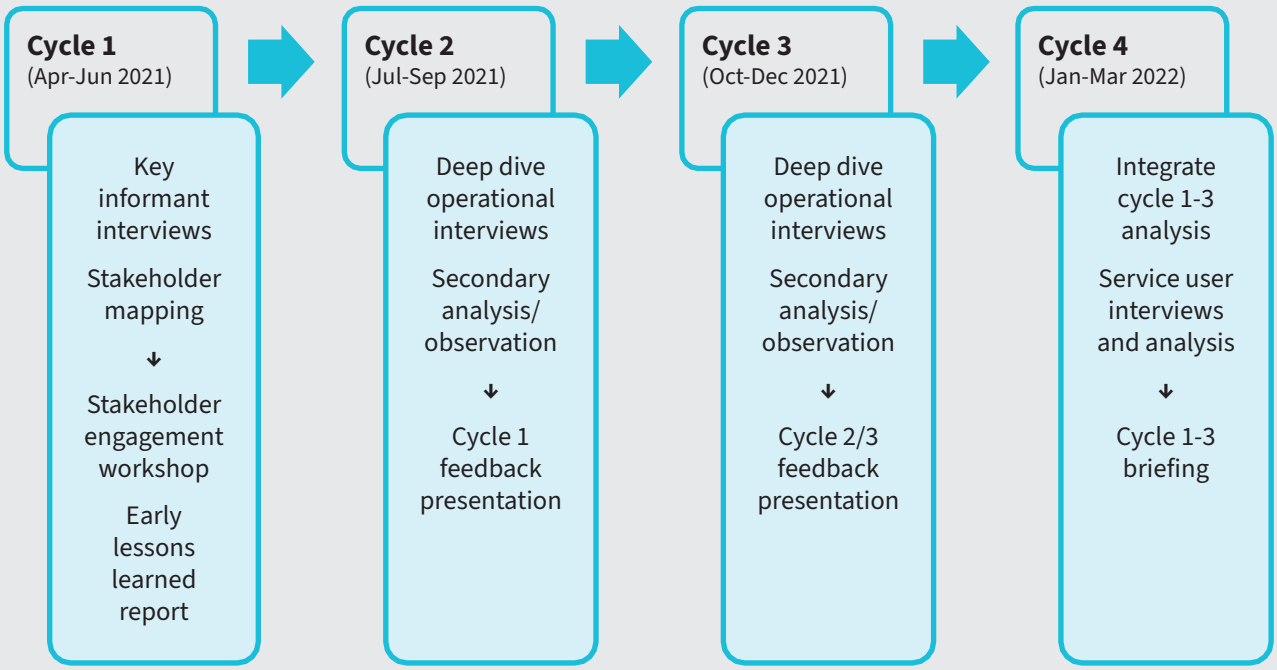
1. Semi-structured individual or group interviews with all Programme staff plus wider leadership in health, care and VCSE organisations involved with or affected by the Programme (referred to as "key informants"),
2. Semi structured interviews with service users,
3. Observation of relevant staff meetings,
4. Secondary analysis of relevant documentation, summary activity and outcome data as collected by partners.

This formative process and how findings were reported iteratively to the programme leadership team is represented in Figure 8: Evaluation Timeline and Deliverables.

12. Themes 1-4 highlighted as key enablers in the Community Mental Health Framework for Adults and Older Adults

13. The process flow mapping was not conducted, as a dashboard solution developed in Somerset was presented to South Yorkshire and Bassetlaw Transformation Board and taken forward for consideration.

Figure 8: Evaluation Timeline and Deliverables



a. Interviews:

In total, we interviewed 73 individuals across 52 interviews lasting between 30 and 75 minutes; this total is comprised of 46 individual interviews and 6 group interviews.

We organised the interviews into three groups.

Key informants/stakeholders:

First, in Cycle 1, we interviewed 20 "key informants". We defined key informants as staff in leadership roles across primary care, secondary care, healthcare commissioning, local council and VCSE organisations who were not directly involved with the operational delivery of the Programme but were either involved in a leadership capacity or were indirectly involved or affected by the Programme. Thus all key informants could be expected to be familiar with the Programme but to bring different perspectives to it. These interviewees were selected by a combination of purposive and snowball sampling; some were nominated by the Programme leads, others were approached later on the recommendation of other key informants due to specialist knowledge of a certain aspect, or their representation of a certain stakeholder/partner. **See Table 4: Key informant interviewees, by employing organisation** for a breakdown of key informants by organisation.

Table 4: Key informant interviewees, by employing organisation (Cycle 1)

Key Informant Organisation	Number interviewed
Primary Care Sheffield (PCS)	3
NHS Sheffield CCG (CCG)	4
Sheffield Health and Social Care (SHSC)	8
Sheffield City Council (SCC)	2
Sheffield Mind (SM)	1
Other	2
TOTAL	**20**

Programme Staff

In Cycle 2 and 3, we interviewed all clinical and VCSE staff involved in an operational capacity in the Programme, including patient-facing and team leads, across all four PCNs. No sampling techniques were employed as all Programme staff took part in the interviews; 42 staff in total. **See Table 5: Operational interviewees, by employing organisation and by role** for a breakdown of interviewees by site and by role.

Table 5: Operational interviewees, by employing organisation and by role (Cycle 2/3)

Site (PCN)	Number interviewed
PCN1	8
PCN2	10
PCN3	8
PCN4	8
Across all PCNs	8
TOTAL	**42**

Operational interviewees by role	Number interviewed
GP	5
VCSE	5
MHP	6
Psychologist/Psychotherapist	6
Trainee CAP	10
OT/Pharmacist	2
Community Connector	5
Health Coach	3
TOTAL	**42**

The operational interviews were semi-structured and followed an interview schedule informed by the evaluation aims defined above, covering context, achievements of Programme, enablers, barriers and challenges, and roll-out and sustainability. They were conducted by either 1 or 2 interviewees via Google Meet.

The 21 operational interviews included 15 individual interviews of between 30-60 minutes, either with sole practitioners or clinical leads, and 6 group interviews of around 90 minutes. Group interviews were employed when there were multiple practitioners performing the same role across different sites and were used to maximise representation of staff and minimise demands on their time. In total, 27 staff took part in the 6 group interviews which covered the psychologists/psychotherapists, mental health practitioners, community connectors, health coaches, and CAPs (split into two groups to keep group size manageable).

Service Users

In Cycle 4 we interviewed 10 service users using purposive sampling. Service users were nominated and approached by clinical leads across the four PCNs to ensure no vulnerable individuals are put forward based on clinical professional judgement. Participants were selected if they were 18 or over, and had meaningful experience of the programme, defined as having attended 2 or more sessions. With the aid of clinical leads, we sought to ensure that participants had experience of a range of services through the programme and aimed to maximise diversity across the sample in terms of gender, ethnicity, and age. We also asked clinical leads to ensure that service users invited had a range of views and were not "cherry-picked" for their positivity towards the programme. **See Table 6: Demographic information on service user interviewees** for demographic information on the service users interviewed:

Table 6: Demographic information on service user interviewees

Site (PCN)	Number interviewed
PCN1	1
PCN2	3
PCN3	2
PCN4	4
TOTAL	**10**

Sex	Number
Male	3
Female	7
TOTAL	**10**

Age	Number
21-30	3
31-40	2
41-50	2
51-60	2
61+	1
TOTAL	**10**

Ethnicity	Number
White British	9
Asian other	1
TOTAL	**10**

Service user interviews were carried out by telephone or using Google Meet, according to the service user's preference, by one interviewer experienced in patient and service user interviewing. Translators were available for service users who were not confident in communicating in English, however, these were not needed.

Informed consent was collected for all participants. The Information Sheet, Consent form and Interview Schedule for service users was reviewed by an Experts by Experience panel and a Patient Participation Group, and changes made accordingly, to ensure these materials were appropriate.

Individual and group interviews were recorded and then transcribed by approved University of Sheffield transcription services, before being anonymised and stored on secure University servers. Summary notes were made throughout the interviews, which were also stored on secure University servers.

b. Observation and Documentary Analysis

Researchers attended the monthly Programme Board and on invitation, team meetings, with the agreement of the partners. Field notes were generated and anonymised. These notes were not included in the coding, being handwritten, but were reviewed at regular intervals and thus informed the interviews indirectly.

Relevant documentation was provided by the partners. Activity data have been identified in discussion with partners and cited in the previous section **(A: Background and Context to Programme)**, to describe the scale and timeline of Programme activity and to provide demographic information on service users across the four PCNs.

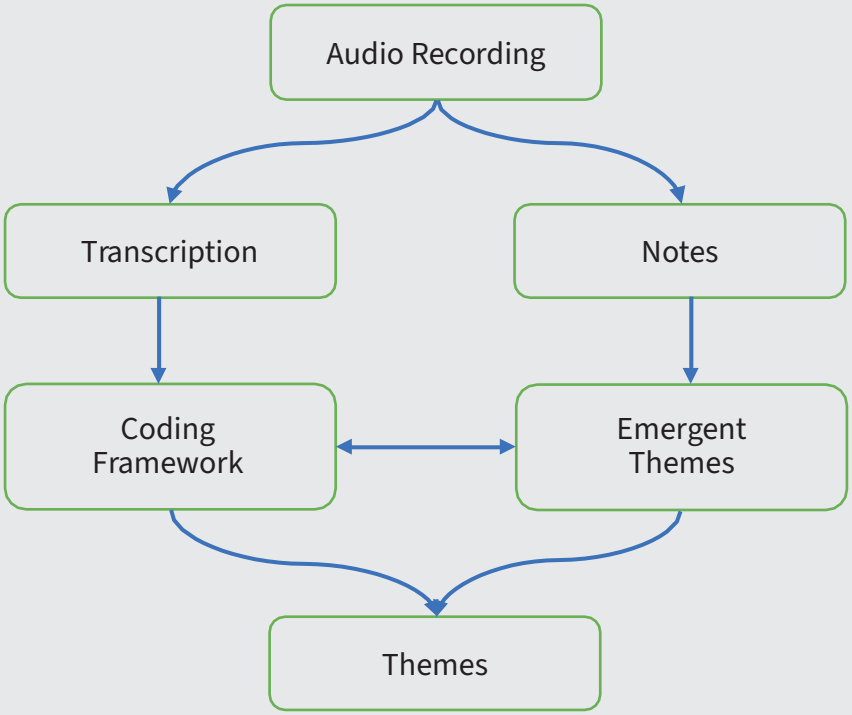
c. Data Analysis

An initial coding framework was developed by the evaluation team, based on summary notes of interviews, and informed by the evaluation framework. Inductive thematic analysis was then carried out on interview transcripts using NVIVO qualitative analysis software, which further developed the Framework. See **Figure 9: Data Generation and Analysis Process** for a simplified representation of the data generation and analysis process.

Themes were generated by identifying underlying commonalities between all participants (key informants, programme staff and service users) and organising them in a way which relates to the original research questions. The aim was to incorporate the full range of viewpoints, including positive and negative experiences, to generate a balanced understanding of each theme. In order to present these themes within the report, we describe the themes and use verbatim quotes to illustrate the views expressed. Due to the limits of space, we select those quotes which best represent the range of views expressed and through commentary explain where these views were widely held, or where they were largely held by particular groups of interviewees.

Ethical approval: This study was a service evaluation and did not require NHS ethics approval or research governance. However, ethical approval was sought from the University Ethics Committee and granted by the University of Sheffield, on 19 July 2021 (ref. 039619). An amendment to the ethics to enable interviews with service users was approved on 14 Mar 2022 (ref. 045370).

Figure 9: Data Generation and Analysis Process



3. Anonymisation of Interviewees

In the Evaluation Findings **(section D below)**, it is important that interviewee anonymity is protected but also that information is provided to ensure that the meaning of statements can be understood. We have therefore adopted the following protocol to refer to organisations and interviewees;

- All organisations are represented by pseudonyms with the exception of the key partners; Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield, and Sheffield Mind. The four PCNs are also represented by pseudonyms (PCN1, 2, 3, and 4).
- Key informants interviewed are referred to by code (KI1-KI20) and by their employer (SHSC, PCS, CCG, SCC, or SM – see Table 2 for abbreviations)
- Operational interviewees are referred to by code (P1-P15) and either by their profession (e.g. GP) or more broadly by sector (e.g. VCSE).
- There are three exceptions to this rule.
    - First, the team leads, where identifying their profession would compromise anonymity (as there is only one team lead for each professional group) – they are therefore only described as "team leads".
    - The second exception is where a PCN is named or referred to in a quote, where naming the professional and their PCN would also compromise anonymity.
    - The third exception relates to participants in group interviews who are referred to collectively by professional group, as we did not seek to identify individuals in group interviews; hence MHPGI for the mental health professionals; PsychGI for the psychologists and psychotherapists; CCGI for the community connectors; HCGI for the health coaches; and CAP1GI or CAP2GI for the two CAP group interviews.
- The service user interviews are simply referred to by code to ensure anonymity (SU1-SU11).

C

Summary of Cycle 1 Evaluation Findings

C. Summary of Cycle 1 Evaluation Findings

In Cycle 1, a rapid 'Lessons Learned' report was produced to capture learning and to offer rapid, interim feedback to inform the development of the Programme. The content of this report is summarised briefly here. All of the themes identified in this report are explored at length in the **D. Evaluation Findings** section which follows.

1. Cycle 1 Methods

Fourteen key informant interviews were conducted from March-May 2021 and were analysed for this report. Six further key informants were later interviewed, hence 20 in total.

Efforts were taken to ensure the different partners in the Programme were represented here, with interviewees from Primary Care Sheffield, Sheffield CCG, Sheffield Health and Social Care NHS Foundation Trust, Sheffield City Council, Sheffield Mind and other regional and national partners involved in the Programme.

Interviewees were all in strategic or leadership roles and noted that the depth of their knowledge of the Programme varied depending on their role and degree of involvement. Those involved at the oversight level had less awareness of the challenges and barriers faced, for instance, compared to those with more direct leadership responsibilities, and some due to their position had a greater focus on the position of the Programme in the wider system. None were involved in patient/service user-facing roles in the Programme.

The average interview length was 55 minutes although interviews ranged from 11 minutes to 101 minutes in duration. All interviews were recorded and transcribed (with one exception due to technical issues). Extensive notes were also taken in all interviews.

The interview schedule was structured around 5 key themes;

1. Role and involvement in the Programme
2. Perceived achievements of Programme to date
3. Perceptions of main challenges or barriers encountered by Programme
4. Enablers and lessons learned
5. Perceptions of challenges going forward as wider roll-out is initiated.

2. Cycle 1 Findings

The Lessons Learned report captured a widespread perception that setting up the service and delivering care through the COVID-19 pandemic was a remarkable achievement, that the Programme was demonstrating that there was a substantial undermet need in SMI, and that on a broader level, the Programme was not only delivering on its objectives but also demonstrating the potential of more collaborative and integrated working across health, care and other services.

The achievements to date were ascribed to;

1. the widespread recognition of a problem with current mental health provision,
2. the focus afforded by a dedicated Programme,
3. the strength of the core Programme team and clinical leads,
4. the composition and quality of the strategic leadership and programme management,
5. the openness and commitment to learning through the Programme.

Three key issues were identified in the Cycle 1 Lessons Learned report.

1. Undermet need and implications for workload management

   It was noted that the size and nature of undermet need was unclear until the service was set up. While it was understood that there was a high level of need, many felt it was found to be greater and more complex than anticipated. This presented an immediate challenge of large caseloads and a need to decide how to allocate work fairly between different frontline staff. This generated reflections on the nature of service that could be offered at scale after a wider rollout.

2. Differences between partners and other stakeholders

   Differences were noted between the different partners in the Programme, in particular between primary and secondary care, between NHS and non-NHS providers, and between public sector providers and VCSE providers. These differences were cultural but also institutional and built into working practices (IT systems, salary, etc). These differences were sometimes obscured by good working relationships within the Programme, and there was a need to surface and address these issues in order to ensure effective and coordinated delivery.

3. Networking and engagement with wider system

   Some interviewees raised the question of the visibility of the Programme at a strategic level, particularly outside primary care i.e. in the City Council and within Sheffield Health and Social Care NHS Foundation Trust, and also within the emergent Integrated Care System for South Yorkshire and Bassetlaw.

   Engagement with these organisations would be essential if the Programme were to form a part of the strategy for mental health at a city and regional level, which would require understanding the priorities, pressures and strategies of each organisation and a concerted effort to communicate with each about the Programme.

   These findings were presented in a report to the Programme Committee in September 2021.

D

Evaluation Findings

D. Evaluation Findings

The findings below are organised around 5 sections: Context, Achievements, Challenges and Barriers, Enablers, and Roll-out and Sustainability. Each section is then structured around a number of subthemes.

1. Contextual Factors

a. Undermet need

Throughout the interviews and group interviews, when discussing the Programme and its goals, the dominant sentiment was surprise at the volume of demand which was not being addressed by either specialist secondary care or through IAPT, and the complexity of needs encountered exemplified by the following quotes;

> I think the programme has demonstrated the amount of need and the unmet need that was there, a lot more complexity, I think, than what was ever imagined (P14, team lead)

> Just the vast quantity of people with kind of mental health issues that have been bounced around services and not really settled anywhere because don't quite fit the criteria for IAPT or secondary care… but have quite significant mental health difficulties that's really impacting functioning (P13, team lead)

Many suggested greater resource was needed to address this demand;

> The sheer volume of people that we have cared for and are caring for, it is overwhelming and it's too much and we need more staffing, there's no two ways about it. (MHPGI)

For others, however, the range and complexity of mental health needs provoked a more challenging question, demanding a greater understanding of the nature of mental health need;

> Oh, my god, we've got more resource! It's great that this is here, it's great that this resource is here, but "what would be enough?" I guess is the question, because we still don't, genuinely don't understand the need. (P12, team lead)

Some felt that they were seeking to support people with needs which were too complex for primary care;

> The intention of the service and what we're actually working with and doing and delivering are poles apart. We're working with patients with a level of complexity that sits them within secondary care (MHPGI)

But others felt that while needs were often complex, most cases were not too complex to receive support in primary care;

> People would need so much support in order to go through therapy because their lives aren't stable enough that it's just unachievable for patients, whereas actually what's happening is people are learning to live. A lot of it is past abuse, childhood trauma is key, living in poverty, criminology, drug and alcohol use, it's a lot of early parental death. You know, these are not issues that therapy is going to take away, these are issues that are lifelong that you live with, which is where social prescribing and having community and context and understanding flare-ups in sadness and low mood is really key (P02, GP)

More broadly, the challenge of introducing new arrangements for the provision of mental health care was described succinctly by one interviewee as "like trying to knit a jumper whilst you're wearing it" (KI16, SHSC). Doing so at a time of intense and unremitting demand was seen as extremely challenging;

> How do you continue to think about service development integration when you've got huge waiting lists? So you're having to deal with the past as well as the future. (KI20, SHSC)

b. Service issues and institutional differences

There was a general perception among staff that the provision of health and care services across the city was "disjointed" (CAP2GI) or "fragmented" (PsychGI). This perception was echoed by service users, one of whom described her experience of mental services prior to the programme as "spotty" (SU03). While it was recognised that this was not specific to Sheffield or to mental health services, some felt this particularly affected the relationship between primary and secondary care;

> Historically there's very much been a 'them and us' sort of primary care and secondary care feeling - not, you know, no blame on either side, but I think part of that is just to do with the way things have been contracted and commissioned, because… the way contracting works is it creates silos (KI16, SHSC)

Some however perceived a gradual improvement as different parts of the health and care sector shifted to a greater recognition of collective responsibility;

> It's getting there. It's been really frustrating, but it feels like finally there's starting to become a realisation that, oh, this is about a system, it's not about the "them and us". (KI16, SHSC)

It was emphasised that patients were not interested in the reasons for this fragmentation, but simply wanted cohesive care, support and treatment at the point of delivery;

> There just needs to be more cohesion. As far as the patients are concerned, we're a mental health service. They don't care if we're primary or secondary care, they've got a need that needs to be satisfied. And pressure of caseloads and things like that is not an excuse not to give somebody care. (MHPGI)

The most palpable example of this kind of disconnect or tension between primary care and other mental health services related to the process by which service users were referred either to IAPT or to specialist support from the Health and Social Care Trust. Both were seen to maintain strict criteria for acceptance of referrals, perceived by some both within SHSC and outside as being a form of demand management;

> Systems that were set in place which really worked because systems are overwhelmed, to keep people out rather than have people in. Because if you've got a waiting list of 200 people, everyone's very besieged and so almost unconsciously, you're working to try and manage the flow rather than hear the desperation. Because the system can't function to work with desperation anymore (KI20, SHSC)

> They're not saying no because there aren't needs. They're saying no because they've got a thousand people on a waiting list for EWS and it's now 12 months for a routine assessment with SPA. It's not the right reasons to be saying no. (P11, team lead)

While thresholds and referral criteria clearly play an important role in ensuring that people receive appropriate care, there was a more general sense of frustration with this process, and this exacerbated divisions and tensions between primary and secondary care. Service users we interviewed also reported their frustrations with the services previously available, describing waiting times for appointments and their struggles with the time-limited nature of the services, offering a limited number of sessions. Our interviewees said that the service they were referred to previously often did not meet their needs, and some had experiences that they felt worsened their mental health. This resulted in a reluctance to seek help when needed: as one explained, "I'd lost all faith in services" (SU09). Patients' past experiences with mental health services impacted their response to the programme. While for some, the programme represented a continuation of good care, for others, they entered into the programme with low expectations. For those whose experiences in the programme had been positive, there was a fear that this care could come to an end before they were ready:

> I'm always [thinking because of] previous experiences with others that I'm not… I'm going to be left with nothing (SU07)

This system-wide pressure was aggravated at SHSC by a number of challenges faced by SHSC. This included bedding-in a recent significant restructuring and an extensive "Back to Good" programme in response to a 2020 Care Quality Commission (CQC) rating of some of SHSC's core services as Inadequate, as well as the mental health and workforce impact of COVID 19. .

There was wide recognition that the challenges faced in recent years placed even greater pressure on operations and had potential implications for capacity to engage in the Programme;

> I think (the CQC rating) increases the sense of threat for staff, and anxiety, at a time where you're trying to do this organisational change (…) That really does impact on how willing people are to take the risk to do something different. (KI19, SHSC)

It was felt by some that engagement may be happening within SHSC at executive level but not at managerial or clinical teams;

> The exec team within SHSC (…) they get it, but it's that middle management, and then the clinical teams, that it's not, it's not being fed down through, and they're the ones that are in charge of the recommendations for change and a new service model. (KI16, SHSC)

Nonetheless, most of the senior leadership across different organisations were clear that a systems view was vital, and the Programme could not be seen in isolation as the new Community Mental Health Framework implied change for all parts of mental health provision in the city and region;

> For us it is about a system approach, a warm handover as opposed to 'this is our service in isolation, this is your service, and here is how they pass through that gate'. So it is quite challenging having those conversations, and especially within those three services that I mentioned (…) they are reviewing their service models currently, so they are also in a period of change and flux (KI16, SHSC)

c. Variation between sites

As noted above, the four sites selected for the Programme were chosen on the basis of health inequalities and population diversity. The rationale was agreed across system partners in line with the expectation of a PCN based service described in the Framework. However, key differences were noted between each Primary Care Network in terms of local population, profile of mental health need, and infrastructure, including GP and VCSE provision, which will be discussed below.

Demographic differences and varying inequalities between local populations were widely discussed, primarily relating to age, social class and ethnicity. While three of the PCNs primarily served deprived communities, one **(PCN1)** focused largely (but not exclusively) upon students, who were significantly younger and generally not from deprived backgrounds. For many in **PCN1** this was the first experience with adult mental health services, although some had experience of CAMHS in other areas.

Differences also were observed between the other networks. **PCN2** was described as very ethnically diverse with multiple separate communities, a large number of non-English speakers and a significant community of asylum seekers. PCN3 and PCN4 were described by interviewees as far less ethnically diverse, with high levels of deprivation and unemployment, in particular PCN3 where most of the area was in the most deprived decile of population in the 2019 Index of Multiple Deprivation (IMD2019).

Interviewees explained in detail the ways in which the composition of the local population, culturally and demographically, informed the profile of mental health need in each network.

> **PCN1:** We actually see a lot of students coming through who perhaps have perhaps neurodivergence, So, they kind of also tend to have diagnoses of autism and ADHD
>
> **PCN1**: I would say the majority of the people that we see in **PCN1** as well tend to be people from the LGBT community who are perhaps struggling with their identity.
>
> **PCN2:** It has got the highest rate of severe mental illness in the city. There's a lot of trauma, you know. We've got a lot of people who've come from various other countries and, you know, lots of history of war and persecution and torture and that sort of thing in the area. And even those who haven't, there's a lot of childhood trauma
>
> **PCN3/PCN4:** (compared to **PCN2**): My area is predominantly white but also the issues might be different as well, like drug and alcohol issues.
>
> **PCN4:** It's a kind of white working class with quite a bit of deprivation, unemployment and mental health issues that often attach to that group of patients.

The precise demographics of the various communities, and associated presentation of mental health problems, has implications for the kinds of services which can or should be provided in each area. So cultural issues or differences may affect uptake of certain services, for instance, or limit the impact of particular offerings;

> A lot of cultural differences in the area as well, which mean that it can sometimes be quite hard to link people in with activity in their local area. We often hear from people that they don't want to go to a specific group or activity where mental health may be mentioned. (P15, team lead)
>
> There wasn't a community to connect people to (…) especially for the demographic that I have which is young white men who don't want to be part of a yoga class or a knitting group (CCGI)

This cultural and demographic diversity then presents particular and distinctive challenges to the staff working in each area, but also underlines the value of network or neighbourhood services;

> And yeah, I think it's also having the time to learn about all of those different presentations and what the evidence base would be for all of those. So I think it kind of comes back down to time and training as well. (…) the evidence base that we don't necessarily have for certain groups of people (…) like X mentioned earlier about the Roma Slovak community, we're kind of trying to learn what works, but we're not really sure yet. (PsychGI)

Finally, it was noted that the sites may have very different degrees of engagement with VCSE organisations. At one end of the spectrum, staff in both primary care and VCSE in **PCN2** described a strong relationship between general practice and a local voluntary organisation. The VCSE were valued in part because they had an understanding of the local needs of the communities they worked with;

> There's quite strong community sector partners in **PCN2**. So, we've got [names local voluntary organisations] and, you know, so a lot of those groups which are great and really important to the community. So, so it's been really important to us to use those. (GP)

Some interviewees explained that the approach adopted by the Programme to directly fund VCSE staff, in the form of community connectors, was vital to move beyond arms-length referrals to VCSE toward a more equal partnership and integration of VCSE into health and care;

> What we've done is we've developed a model over time that's changed, that's predicated around the GP surgeries in PCN2. And that's about building relationships and it's about increasing referrals. And then when the new contracts came in and they could fund workers themselves, that's when it went from a relationship about communication and just referrals, to actually contractual relationship. So that's why we're much more embedded, and that's why this transformation programme is a big deal for us, because it's integrated working. (VCSE)

In contrast, other areas were perceived as having limited VCSE provision which in turn limited the kind of contribution that Community Connectors could make to the Programme;

> There's not an awful lot of voluntary sector or other activity in that area… so I think it has been quite challenging for some of those clients to really know what there is to engage with. (P15, team lead)

d. Impact of COVID

Interviewees described a range of challenges caused by the COVID-19 pandemic, both directly and indirectly. An immediate difficulty was presented as the pandemic hit while the Programme was in the midst of recruiting staff and engaging with local partners, which impacted on the recruitment process;

> COVID slightly scuppered the implementation. (...) So the intention had always been to start hitting the ground running with all the staff. (...) we'd managed to appoint four mental health practitioners before COVID, but COVID stopped anything else (...) We started off with mental health practitioners and some psychology support, but certainly not the whole full gamut of what we'd hoped. (P01, GP)

Similarly, the challenges of lockdown, social distancing and the pressure on general practices meant that it was particularly challenging to engage with GP practices;

> I think we would've been more integrated in GP practices if it weren't for COVID (PsychGI)
>
> I don't really have that much of a relationship with the GPs themselves. And that is an issue I think generally. But also, I totally respect that, you know, we approached this programme in the middle of a pandemic and the GPs are ridiculously busy (CCGI)

The pandemic had also impacted on related activities across the NHS, such as team building and training, in terms of availability or a need to use alternative modes of delivery;

> I think that a lot of the NHS teams, not just my organisation but more broadly, have been starved of training and input over the last two years while we've been working with COVID. (KI19, SHSC)
>
> We did a lot of training and obviously with COVID and stuff, a lot of it was remote (HCGI)

How care was delivered was directly impacted, as face-to-face activities such as assessments or consultations were shifted to telephone or conducted online.

> The idea was that we'd be integrating into community hubs, bases, venues. COVID then threw a big spanner in those works I believe, because of social distancing, venues closed (P14, team lead)

Some service users preferred to wait until it was possible to meet face-to-face, and the mode of delivery had implications for the quality of care which could be provided;

> You definitely miss a lot of things on the phone, but I think that goes wider than even just our service. I saw a patient last week face-to-face and definitely it's much easier to build that rapport and you're just…that's how you would normally assess a patient, quite holistically… from what they're saying, but also there's a lot of non-verbal stuff that you would pick up, even if it's just how someone dresses or how they…even how they smell (...) I know that may sound a little bit…But you might smell that somebody smells of alcohol or cannabis, for example, and it's all forming sort of part of your assessment (P13, team lead)

Some roles which were more reliant on face-to-face interaction were particularly affected, although some staff pointed to some positives in the shift to telephone consultations, in terms of accessibility and staff efficiency;

> With COVID I think it's forced us as therapists to be more flexible in what we offer. And obviously there's still things that govern that, but certainly there's people that I've done initial appointments via telephone, which is not anything I would ever do before, and for some people that has been the difference, I believe, almost in them engaging. (...) So I think that's been a real success, I think it has made us a lot more accessible. (PsychGI)

> I can certainly do more, my time's more efficient, yeah, I can't imagine what it would be like now face-to-face and how I'd deal with being in 22 GP practices. (P13, team lead)

Other staff were less affected by this; for example, some VCSE providers had already established workarounds to keep in touch with their clients under social distancing;

> At my organisation even for the first lockdown we were seamless. We carried on keeping in touch, doing online meetings with staff and with some clients, doing doorstep chats, doing walk and talks, so with all of our clients (P10, VCSE)

The work of the community connectors was particularly affected. As their focus was on linking people with community activities, the cancellation of such activities during lockdowns or groups moving online-only due to social distancing restrictions severely curtailed options;

> The biggest challenge with the Connector service is the fact that we've not been able to properly test the service because of COVID. So, the service started beginning of October last year, but I would say it's only really been in these last few months that the team have been able to kind of sort of do their roles in earnest (P15, team lead)

In practice, this led to many community connectors working instead in support worker/peer support functions, in an attempt to offer some service to their clients;

> One of the difficulties that we found was that the connectors fell slightly more into a support worker role instead where…you know, so we were seeing a lot of people that needed support with benefits and housing and financial situation sometimes because of the impact of COVID on their work and life. So, I think they fell slightly more into that role where they were kind of supporting people around filling in those applications and that side of things (P15, team lead)

An unintended consequence of this, one team lead argued, was to identify a pressing need for advocacy-based support among the people the Programme was helping;

> I think it has highlighted that there is a massive need in terms of that more advocacy-based support role for people. It's not really part of the connectors role to be doing those applications. I know a lot of the nurses in the team find themselves doing those kinds of things as well because there genuinely isn't anyone else to do it (team lead)

Fundamentally, though, this has limited the opportunity for learning about the community connectors through practical experience;

> Our biggest difficulty has just been COVID and we've not been able to test how this is going to work in a non-COVID world. So, we don't yet know kind of what those other difficulties we might face will be (P15, team lead)

In a more general sense, the pandemic represents a complicating factor when seeking to identify lessons from the early implementation, which left some interviewees noting that it would be difficult to neatly establish the impact of the Programme due to the timing of its implementation;

> It's so tricky to know what COVID has complicated and what would have been tricky even if it wasn't COVID (P12, team lead)

> I guess, again, the pandemic impact, it's difficult to pull out what's positively and negatively impacting on that, kind of, referral rate. (KI15, CCG)

Summary: Contextual Factors

- We found a widespread perception that there was a high level of undermet mental health need in all four sites, from both the professional and service user perspective.
- This degree of need provided strong motivation for the kind of provision offered by the Programme, but gauging and responding to this demand resulted in significant pressure on the Programme.
- This pressure was also experienced by the local mental health Trust, and over time these system pressures had led to tensions between primary and secondary care.
- In this context, the prioritisation of PCNs with the highest mental health need by the Programme was logical.
- Interviewees also emphasised the significant variation between the sites in terms of demographics, resulting in different profiles of mental health need in each PCN, and noted that sites also varied in terms of the strength of engagement with VCSE organisations.
- The COVID-19 pandemic had a significant impact at the start of the Programme and throughout on the design, management, and delivery of care through the Programme.

2. Achievements

a. Good patient care

There was a powerful sense across all groups involved in the Programme, and particularly among those in patient-facing roles, that they were making a real difference to those receiving care. This generated a very strong sense of pride in the achievements of the Programme:

> I think we're making a massive difference and I feel very proud to work for the service (CAP1GI)

> I can honestly say, I don't think I've ever been in a qualified nurse role where I've felt like I've had such an impact on people's lives and actually felt, like, wanted as a nurse. (MHPGI)

This was on the whole reflected in the service user interviews. Out of 10 patients interviewed, only 1 described a bad experience, and for 7 of the 9 service users describing good and integrated care, this was in contrast to their previous experiences within mental health services. However, this should be understood in the context that those with positive experiences may have been more likely to be willing to be interviewed.

Those who described good experiences had received support from a range of staff disciplines, including from the VCSE sector, and described these in very positive terms such as "really good" (SU06) and "they couldn't have done any more" (SU05). They described being treated with dignity and respect;

> I've never been treated so good (SU09).

For such patients the impact of the programme was transformational. They described lives that had been completely changed, and futures that looked much more hopeful:

> It's made such a difference in my life (SU09)

One patient used the analogy of being in a darkened room, and the MHP drawing back the curtain to let in the light: "they really have completely changed my perspective of life" (SU03).

These views expressed by the patients support the views of those delivering care, that good care had been provided and for several that their experience of mental health care was different and better through the Programme. They particularly valued the flexibility and responsiveness of staff, as discussed in Findings: 4a below).

Exploring the reasons for this sense of achievement, for some this reflects the sense of offering care where it was not available before;

> I think every single patient we've seen is an achievement because that person may have just been sat not having any service. (CAP1GI)

Specifically, several described having overcome deep scepticism among people who had lost faith in the health and care system;

> I've built up some really good relationships with people that have really struggled with mental health services previously that are now… you know, the anecdotal evidence I'm getting from them is that their perception has changed now that they're able to access mental health care at a GP practice. (MHPGI)

To support this, various interviewees attested to positive feedback received directly from service users, which they linked to the specific approach adopted within the Programme.

> And I just think that the way that we approach people and the culture that we've adopted within, especially the psychology part of the team, that's something that my clients have commented on to me and says that "I've been through CAMHS, I've talked to my GP of them, this and that, but this is the first time that I've really felt a service has properly listened to what I want and what I need". (CAP1GI)

b. Understanding and addressing undermet need

Given the size, complexity and unquantified level of undermet mental health need (discussed in **Findings: 1a** above), even before the impact of COVID, a key achievement for many was the progress made in identifying and better understanding this need.

> What I think the primary care transformation group have picked up has been unmet need, or where people are falling through the gaps and they just think 'oh, had enough of SHSC, they can't provide for me, they're not giving me what I need', so people have been circling around primary care that have got a serious mental illness (KI19, SHSC)

Many involved in the programme felt they were addressing a marginalised and often invisible community;

> Patients who really are marginalised, and for years with every (service) reconfiguration in Sheffield have just been further marginalised, you know, the people who are not mentally ill enough for SHSC. (MHPGI)

Several argued that the effectiveness in reaching this community could be explained by the location of care within general practice,

> What we've done is tapped into huge amounts of need that would never have breached the doors of mental health services, but because we're in GP practices, and because people trust their GPs and they're used to going there for any sort of health need, and GPs have said, "well do you know, actually, we do have someone that you can probably talk to about that now", whereas before they might have said, "oh, no, I'm not going to the City Centre or whatever, I'm not seeing strangers who are going to ask me loads of questions", is we've tapped into a huge amount of unmet need in people who probably were really, really struggling, and who just never shouted up. (P11, team lead)

However, some felt the Programme had gone further and was reaching people in need who were alienated from the GP practices also;

> A lot of patients that we've seen, they don't come into GPs, they won't ring the GP, they won't come in if they need to. (HCGI)

Many pointed to the flexibility and proactivity of the service to explain this success;

> People are saying there are certain groups of people who have been quite difficult to engage that we're able to work with a little bit differently, so maybe we've got better engagement from some groups of people. (CAP2GI)

This was supported by the service users interviewed, who described a wide variety of support provided, which had enabled service users to engage in ways that were sustainable for them. For example, SU03 went on local walks with her MHP, until she felt able to engage outside of her own locality:

> I met up with him a few times and we'd just walk in the local area so I was getting used to going out (SU03).

The issue of flexibility will be examined in more detail in **Findings 4 (Enablers)**.

The consequence of this approach, however, is that it is likely to identify a large amount of need previously unrecognised by NHS services, much of this at an early stage when people with mental health problems may not yet have been seen by mental health services. The management of demand for early intervention then generates its own difficulties, a point explored below under **Findings 3 (Challenges and Barriers)**.

c. Local responsiveness and under-served communities

As noted above **(Findings: 1c)**, there are significant differences between the four sites, resulting in different profiles of mental health need which require different resources, as "one shoe doesn't fit all" (P14, team lead). Another interviewee expanded on this;

> The good thing about working locally is, you obviously can focus on the particular concerns in each area, can't you, (…) and, hopefully, the team that can be built around that can be tailored to that need. (MHPGI)

Thus for many, a key achievement lay in the capacity of the Programme to be flexible, develop local understandings and adapt care to fit local needs;

> We've managed to reach those pockets, and I guess that some of that is the point of this isn't it, is bringing care into people's communities, rather than expecting people to travel to points of care (P11, team lead)

In particular, the uptake of care through the Programme among minority ethnic groups was seen to be significantly higher;

> In our area there's quite a dramatic increase in the percentage of people from non-white British backgrounds who are now accessing mental health support (MHPGI)

The explanation for this, for several interviewees, was the localism of provision. Key to this was the positioning of services within local communities, reflecting the practical and personal barriers many people may face to travelling to central services;

> The nature of our location is that accessing city-wide services is difficult for patients actually, some of them never go anywhere, very limited. (…) it's costly to travel, isn't it, their IT access isn't brilliant, (they are) really reliant on local services. (P2, GP)

> The majority of people (are) on benefits, so there is a financial element as well. So not many people can afford to go somewhere outside the local area to access services because of the bus fare and all these things. (CCGI)

The provision of care through GP practices was also highlighted as

> There is still a lot of stigma around mental health, particularly in certain cultures and certain areas of the city, so in a sense (people) may be happy to come into a GP practice because it's just a GP practice rather than (…) a primary care mental health base that they're going into (P13, team lead)

Moreover, the strong links to local primary care, as well as to VCSE providers with their community connections, was seen to play a key role in enhancing provision to people from minority ethnic backgrounds;

> There's a greater proportion of people from BAME backgrounds who are coming through the primary care transformation. I think it's because they're out there, they're connected with primary care, they're linked properly with local communities. (KI19, SHSC)

The specific factors which supported this will be examined in more detail below under **Findings: 4a below**.

d. Addressing GP needs or pressures

As noted above **(Findings: 1b)**, current system challenges resulted in a situation where many GPs did not have confidence that traditional MH referrals to secondary care or to IAPT would be successful. This led to a reluctance to refer many serious cases, despite lack of expertise or resources to deal with SMI in general practice;

> I wonder whether there is an element of our referral patterns having shifted to, because of the kind of lack of ability to get people into secondary care services. My understanding before we started was that 50 per cent of referrals to secondary care were rejected from SHSC. So, you know, once you've had that for a little while you sort of stop trying unless there's very extreme need. (P01, GP)

All of the GPs interviewed therefore described the value of a referral route which could break this cycle;

> One person in particular, a patient who I had regular contact with... (with) very difficult consultations. I was struggling to help him really and at the end of each consultation, it was very prolonged and I felt we'd not really got anywhere. So, for a GP, that workload has been taken off me (…) And it looks like they've been making progress with him, which has saved me a lot of time and energy when I didn't really feel I was making any improvement to his mental health anyway. (P03, GP)

> For the past 18 months, we haven't referred any patients directly into SPA, even though a lot of them have got significant mental health problems, the first port of call would be through to the (Programme) (...) I guess, that does mean we're managing more in primary care, aren't we? (P04, GP)

Many members of the Programme Team mentioned experiencing very positive feedback from GPs and practice managers on their contribution, both in providing care directly with patients and indirectly as an informal source of advice on diagnosis or medication;

> GPs will grab me, knock on the door, I've just seen this person, what do you think? And it can be a ten-minute conversation, like 'right, blah, blah, blah, that sounds like IAPT, try them with IAPT, if IAPT say no for whatever reason, come back to me'. And that would have saved a referral to SPA, Lord knows how many weeks or months waiting for SPA to say no (P11, team lead)

The last two quotes indicate a potential impact on secondary and specialist health services as referrals are redirected from SPA to Programme teams and inappropriate referrals are prevented.

Several noted with pride that the team had been nominated by local GPs for a British Medical Journal award. It was noted how unusual it was for a new initiative to receive such widespread support given pressures and tensions in the system;

> I think SHSC have been tarred with a brush of 'well as soon as you try and get to mental health it's just a nightmare, you can't get any patients anywhere, they just bounce through the system'. You know, we try and send them to IAPT and they say "well they drink two drinks a night so therefore they're an alcoholic, they don't fit in IAPT" so they bounce them back. So for this service as a mental health service with SHSC involved to be seen in such a positive manner I think is a huge achievement for them. (KI18, PCS)

e. Interdisciplinary or interorganisational working

Supporting all of these achievements was a general sense that the Programme had been successful at breaking down boundaries. Given concerns about the fragmented state of care (**Findings: 1b** above), it was notable that the majority of interviewees spoke of the progress made in building strong relationships between different roles and role holders across the Programme.

For example, the Mental Health Practitioners described in some detail the range of close relationships they maintained with other members of the team;

> Ad hoc supervision with psychologists, they're part of our fortnightly MDTs. We have really close relationships, they'll text, they'll ring us if they need a bit of advice about a situation that feels too complex for them. We have tasked our community connectors with attending the local social prescribing monthly meeting, which I started attending when we started but, obviously, sharing and delegating, that went to the community connectors. So yeah, there's a lot of work that goes on, kind of, direct joint work, indirect supervision, talking through different cases and the more, kind of, direct attending groups and referring people into those services, and it goes both ways. So yeah, quite a lot of joined up work, which is good, it's great. (MHPGI)

Similarly, the psychologist and psychotherapists discussed a "unique relationship" they were building with the voluntary sector, as well as much stronger direct relationships with GPs than experienced in secondary care, with one participant stating;

> Rather than it just being tokenism, it's actively very robust in terms of actually wraparound care and kind of making sure that it's very integrated. (PsychGI)

These sentiments were echoed across most of the professional groups involved in the Programme, with the community connectors being the key exception (discussed in **3: Challenges and Barriers** below). One of the CAPs stressed the range of connections and the philosophy of care this engendered;

> There's nobody I haven't worked with jointly within **PCN3**. I've done a piece of work jointly with everyone. And I think I get it now; that's the stuff around scaffolding: if there's something I can't provide, if I can't provide it, they're going to drop out, but then another professional will step in simultaneously and do a joint piece of work. (CAP2GI)

In term of process, one GP underlined the importance of the multidisciplinary team meetings (MDTs) in forging and supporting this interdisciplinary and collaborative approach, with benefits for staff as well as patients;

> The regular meeting at the MDT and again reinforcing that. And feeling like everybody involved in that discussion actually has a seat around the table and is valuable. That it isn't like a hierarchy of who's the boss who makes the decisions; it feels like actually everybody there is putting the patient at the centre. So I think that's good. Not only good, I think for the patient, but I think also good for us as team members, because it feels like the sole responsibility for decision making doesn't stay or rest with one person in terms of risk and things (P05, GP)

One MHP differentiated, however, between sites where there was genuine collaborative work with GPs and others where there was a more distant process by which patients are referred on by GPs;

> Where they've got the Programme Teams, I think GPs feel like they've made a referral into that team, and they step back, and the GPs don't have much accountability for that patient's care anymore, and they, for them, feel like they've handed it over whereas for me (…), really embedded into that network, there isn't that sense, GPs won't just say, "oh it's up to you now to sort all this out". They're asking me for an assessment or, and a bit of an opinion, to triage something, and so it's a shared accountability where we were individual practitioners, and it doesn't happen in the other networks (P11, team lead)

Many also spoke positively of experiences of successful collaboration across organisational boundaries in different parts of the sector, including local voluntary organisations and other parts of local government;

> Relationship building, I'm very proud of the… you know, we put a lot of effort into forging and maintaining the complex relationships with the PCN, the wider VCSE sector. (MHPGI)

> I volunteered to be the bridging person between an employment service and our service. And that might mean things like sharing statistical information, number of referrals, frequency of dropouts with each other. (CAP2GI)

Experiences of this approach led some to describe this collaborative provision as central to mental health services in the future, with the involvement of VCSE organisations critical;

> I think that is the future in terms of working with secondary mental health services, by the way, having those kinds of meetings and having a shared understanding. (MHPGI)

The voluntary sector organisations that we work with have worked in the public health realm, that's what they do, working with local communities and inequalities around health and wellbeing. So, they are experts in that field and in their community. So, if we want to have a community-based programme, there's just no way that we can do that without them. (P15, team lead)

Summary: Achievements

- We found widespread and deep pride in the achievements of the Programme across all staff involved in delivery, reflecting a strong conviction that the Programme had extended the reach of mental health services and had a palpable impact.
- Many felt that the success in helping under-served groups was facilitated by the flexible approaches adopted through the Programme, a view echoed by the majority of services users interviewed who particularly valued the flexibility and responsiveness in the care they received.
- Furthermore, Programme staff and GPs described in detail how the service had provided valuable support to GPs, directly and indirectly.
- The Programme also described success in building strong collaborative bonds across professional and organisational boundaries, although this appeared to vary somewhat between the sites.

3. Challenges and Barriers

a. Divergent Understandings of the Mission and Scope of the Programme

Given the novelty of the Programme and the dispersed partners involved, it is perhaps to be anticipated that there may be differing or even contradictory conceptions of what the Programme was intended to be and what it aimed to achieve. As one team lead explained;

> I hold my hands up, it could be totally me that sort of misunderstood it, but I think, talking to X, she had a slightly different idea of what it would look like as well, so I don't think it is just me that's stitched the information together incorrectly, I think we've all been given slightly different versions of what was going to happen, which has just made it a really difficult thing on the ground to try and manage (P11, team lead)

At a deeper level, there were inevitably different views on what the Programme might mean;

> Is this an opportunity or threat? I just see that kind of dissonance between different bits of (the partners) and how they think of it. (KI15, CCG)

The challenge presented by this ambiguity appeared to be the risk of raising expectations that could not be met. Similar terms were used by various interviewees to define the principles of the programme, described as follows by one GP;

> It was supposed to be a service that (...) didn't turn anybody away and no wrong front door, you could access services and not be discharged all the time (P02, GP)

This definition is clearly broader than the remit of the Community Mental Health Framework **(see A. Background and Context)** but it was repeated sufficiently frequently in interviews to indicate it had become a widespread shorthand for the Programme in Sheffield. Several of the clinical staff noted the difficulty this posed for managing expectations;

> Our criteria very much was the gap between IAPT and secondary mental health services (…) And we're never going to be able to fill that gap, so I think managing expectations (...) I feel it's really disingenuous to go in promising things that you can't deliver (P12, team lead)

> The big difficulty is managing expectation and to a degree while there is no wrong door, also normalising things with GPs… I think sometimes (…) they come to us for our advice and often what they want is (for us) to take it away and solve it. And that's what we're doing and it's not our remit (…) And initially it came to the point where we suddenly became almost the de facto bin for all things mental health. (MHPGI)

It seemed some staff found it difficult to set boundaries on the scope of their work, a situation not helped by the degree of ambiguity in Programme definition. Communication difficulties between different parts of the Programme, and particularly with some general practices, meant that an operational level it was sometimes difficult to clarify what the Programme was and what it offered;

> We still get the odd clinician saying, "Oh I don't really know how to refer to you, who do you work with?" We've had engagement events, we've had drop-in Q&As, we hold a regular MDT meeting... So there's lots of comms that get sent out all the time and we're actively working with hundreds of people, so I don't understand that. (MHPGI)

Certain groups described this as a much more significant barrier; the health coaches and community connectors in particular found it very difficult to secure time with practice managers or GPs to explain what they offer. While the CAPs found engagement with GPs variable, they also found it particularly challenging to explain their role and that of the Programme when interacting with secondary care. These barriers to communication are likely to have led to enduring misconceptions about the Programme.

Fundamentally, though, there was an appeal by many for greater clarity on scope and for this to be communicated clearly outside of the Programme;

> What I'm asking for is to tell people what the doors are and what they aren't, what the remit is. Because if you throw the net out too far, you're going to catch too many people (CAP2GI)

b. Vertical Communication issues

In a similar vein. several team members raised questions or expressed concerns about the degree of vertical communication;

> I feel like there's a bit of a disconnection between higher up managers and us on the ground clinicians. Things change and decisions are made and sometimes it feels like we're the last people to find out about that. (CAP2GI)

Several interviewees described being uncertain about the roles and responsibilities of Programme leadership;

> Who are the managers, what are the job titles, what are their responsibilities? And I suppose I feel like we've still not got that, and almost like it would be easily solved but it's not really been addressed (CAP2GI)

Some recognised that this lack of clarity was linked to the fact that some key individuals left and were replaced, but nonetheless emphasised the need to clearly identify lines of communication;

> I think it would be helpful if there was a clearer understanding of who is in charge or who to go to with those kinds of queries. Clinical queries, fine, but it's the system queries that seems that names have changed, somebody might be involved in that actually it's shifted to somebody else, and you never quite know about that. Which can be frustrating. (P05, GP)

While this situation is far from unique within the NHS and other large organisations, there were certain implications of this for the Programme in Sheffield, relating not only to cascading information down the chain but also to upward communication and more reciprocal engagement between staff and leadership;

> We've already got some really helpful ideas around this that may actually be a better fit. So maybe, moving forwards, having more opportunity for that information sharing, bottom up, top down, I think would be really helpful. (PsychGI)

The danger of a failure to clearly consult and engage was articulated by one lead, who stressed the importance of capturing the expertise and proactive commitment of the team members;

> They're a great team, they're really, really committed and enthusiastic, but they're also incredibly intelligent and knowledgeable (…) We've recruited the sort of people that aren't just going to come in, do a job and go home. They're committed to the service, to the patients, and they want to make it work, and if we don't keep them up to speed with everything that's going on, we'll lose them, and if we don't listen to them as well, we'll lose them. (KI16)

There were perceptions among some of the VCSE sector leadership of a lack of consultation in the design of the Programme, and a desire for more involvement in the operation of the service;

> We've had these discussions, but nothing is ever, ever really being done about it, because they've designed it up there and they haven't worked out how it's delivered there, and it's two different things. And because they haven't communicated with us in the middle, that's why it's totally the wrong way round (P06, VCSE)

Some interviewees in general practice and commissioning suggested there was a lack of clinical input at senior levels, and perhaps unfamiliarity with the reality of the situation in general practice;

> It felt like the decision makers were non-clinical and therefore, perhaps couldn't or wouldn't or it wasn't possible to understand the actual nuances of how it feels on the ground. So sometimes it felt like, and still does feel like rules are made for rules sake and it's hard to see actually how that fits into the real life dealing with people who are struggling. So it felt like decision makers were management and with less clinical input than I think perhaps would be helpful. (P05, GP)

c. Limited engagement with VCSE

Despite the achievements in establishing inter-organisational working (described in **Findings: 2e** above), some interviewees attested to ongoing challenges and problems communicating and coordinating work between different organisations, particularly relating to the degree of engagement with the VCSE providers.

This was seen to reflect the wider challenges that Third Sector providers generally face working with PCNs, with several VCSE representatives expressed frustration at the extent of engagement;

> We try our best to have strategic relationships, but it is very challenging, it's like skinning an onion working with PCNs, you know, you might have a good relationship with the clinical director or management lead, or a partner GP – because the communication structures are not the best – so it's a constant struggle trying to keep them engaged, try to tell them what you're doing (P06, VCSE)

Others discussed the broader difficulty of communicating what VCSE organisations can offer to general practice;

> I sat and I wrote just about everything, just bullet points, everything that they can refer into. And (the practice nurse) said "I just don't know, I didn't know this was happening." And yet they've got posters on the wall, we've sent infographics out to every member of staff in the GPs surgery! (P09, VCSE)

These communication difficulties also affected the Programme despite good person-to-person relationships in many places, pointing to underlying structural issues;

> I think there's still a little bit of distance between voluntary sector and primary care… but that's not coming from voluntary sector. Like they so desperately want to be more involved with primary care and be seen as that equal partner. But when it comes to kind of… you know, even things like data sharing and what information they're able to access and, therefore, which meetings they're able to sit in because we might be talking about patients (…) It is the more structural barriers that tend to be the reason for that, that disconnect between primary care and the voluntary sector in terms of what they're able to access and feel like they're actually able to feed into in terms of that decision making. I would say in terms of the relationships with the staff in primary care. definitely within the team we see really good relationships (P15, team lead)

A key example of such structural barriers were the contrasting policies and approaches in different areas about whether, or how, to involve VCSE organisations in multi-disciplinary team (MDT) meetings in general practice. While in some practices full involvement was routine, this was not consistently the case;

> In **PCN2** (…) they have an MDT meeting, mental health. It took us ages to get a seat round that table, so the worker who leads our [social cafe] there, funded through the transformation programme (…) trying to get to that mental health network was a nightmare (…) We (VCSE) couldn't get in to make that transformation because we couldn't get into that MDT (VCSE)

> (In **PCN3**) It's only recently we've been allowed to go to the multidisciplinary meetings and we don't understand why that wasn't set up at the beginning of the project (…) we were queried and questioned about data protection and about sharing of information (…) which I challenged. Early days, people wouldn't even say the first name of the person and I said, "I can't do this". (VCSE)

The result in practice was that some VCSE staff complained that they had received few referrals, despite appointing staff to deal with clients referred through the programme, which underlined the importance of involvement and communication to understand how VCSE could shape their offering;

> I think having a better understanding of the demand, in terms of the numbers and kind of what we might expect to see in terms of the clients, you know, what kind of needs people might be coming with, or what kind of level of illness or wellness as well, if you like, and the kind of diagnoses we've not even got into that yet. We're kind of just desperate for them to send us any clients and then we'll work out what we can do with them, and if, you know, they're in our scope even. (P09, VCSE)

Another VCSE partner felt that in part, the communication difficulties and the limits on engagement reflected the model adopted in the Programme of having one lead charity acting as a partner. This meant that communications between smaller, local VCSE providers were often indirect, as they were mediated through Sheffield Mind who had limited capacity to coordinate with multiple providers;

> You are very much reliant on Sheffield Mind understanding what we do and being able to share that. And I suppose if there are challenges it's how they are escalated (…) our usual relationships are we have funding from 'x' source, and we will have a direct relationship with them (P08, VCSE)

This may have reflected the pragmatic decision taken on commissioning VCSE organisations in the Programme, in view of the understanding that smaller or more organic VCSE organisations may struggle to conform with the administrative and bureaucratic demands of CCG commissioning processes;

> The CCG's way of commissioning was very much around how well an application was written rather than necessarily what the offer itself was. (…) So, we ended up offering the contracts to the bigger voluntary sector organisations in the area (…) which are great and they all do fantastic work. But it did mean that some of the smaller organisations, (…) who offer like allotment-based groups and specifically work with people with sort of mental health issues, they missed out on the funding because their bid just wasn't quite as technical, I guess as some of the other ones. (P15, team lead)

However, several VCSE providers argued that direct representation in the governance structure at board level was important, despite the valuable system contribution of Sheffield Mind;

> You want a (VCSE) provider there, not as a tokenistic, but they need a proper remit to say, from our perspective this is what's working, this isn't, this is what can change. So okay, it might be an operational input rather than a strategic input, but that operational is just as important as strategy, because how do you know it's working if you don't get a provider sat round the table? (P05, VCSE)

d. Coordination of services and staff

Co-location, estates and physical infrastructure

Many staff interviewed spoke at length about their difficulties securing space to work with patients in general practices, and the broader challenges and sense of isolation created by the lack of a base or a shared hub. Clearly lockdowns, social distancing and the use of GP premises to deliver the vaccination programme affected the availability of space for the Programme. While staff noted the impact of COVID, the persistence of this issue caused great frustration for all staff, but perhaps most acutely among the psychology team and the CAPs.

> Going back to the (physical) base thing, you know, I've never felt so isolated in a job I don't think. And also, I've never worked with such complexity and trauma. So that kind of worries me when you have those two things together (PsychGI)

> I think we might need to get some tents and just take them with us (MHPGI)

While space was made available to staff struggling to work from home in response to this concern, staff felt that the issue of estates provision, compounding long-term lack of investment in primary care estates, had a profound impact on staff wellbeing as well as on the service they could provide.

On a practical level, staff discussed the challenges of lacking dedicated space: the time taken to negotiate a room to see a patient or for a meeting, describing experiences of working on laptops in GP waiting rooms, the reluctance of some practice staff to allow access to printers and basic stationery. Others described the difficulty of conducting challenging consultations online and on occasion not seeing patients because space could not be found.

> We're all over the place trying to run around and sort the bits out. Then we might say to an admin and a GP, can you just print me this letter out, I've put it on the system, and they look at you as if you're an alien in the building that, why would I do that for you? (P14, team lead)

This impacted on patients, as seen in our service user interviews. One patient described how he received letters for appointments after they had happened, resulting in him being discharged from the service for non-attendance. Despite being happy with the service she received overall, when asked how the service could be improved SU07 mentioned: "the whole part of being able to probably maybe contact them a lot more easier" (SU07). While staff described their efforts to protect service users from the organisational challenges of the programme, the service user we interviewed who had a negative experience of the programme saw his experience as a result of organisational problems, seeing the programme as having "no backbone, no organisation or joined up thinking" (SU02).

Beyond this general frustration and the inefficiency caused, this situation was also experienced as demeaning to many staff, underlining a sense of separation from "proper" primary care and reinforcing an outsider status, perhaps implying a broader lack of esteem;

> It's a visual representation of how mental health is the poorer cousin of physical health because I've got like the broom cupboard (MHPGI)

More fundamentally, staff discussed the sense of intrusion caused when they were required to work from their own home conducting virtual consultations with patients;

> I can't really speak about this in any more clear terms, but it's really difficult having stories about abuse in your house. The worst things that people can do to each other, to their kids. (KI20, SHSC)

> The main thing is psychological safety for staff, so being able to separate the level of trauma and the complexity of the work that we do from your own home, or even doing that alone in a GP practice. You know, this kind of work isn't designed for us to just do and then be left with on our own. (PsychGI)

The strength of feeling about estates provision is partly explained by this sense of intrusion and the need to separate challenging therapeutic work from home life, to protect personal well- being.

This also related to the collegial support within teams, both at an emotional level and in sharing knowledge, insight and good practice between new staff, some still in training, in what were often new roles in an emergent service. The lack of a common hub, or else co-location with other parts of the healthcare system, was seen to have impeded this collegial support and the generation of a shared understanding and set of practices. This has implications not only for staff wellbeing and system functionality, but also the critical issue of recruitment and retention;

> People have said to me quite openly, if I'd have known that we weren't going to have a base then I wouldn't have come for the job. (P12, team lead)

> It's really made me very seriously think about getting another job, because it's made me realise how much I value colleagues around me when I'm doing the heaviness of the work that we're doing at the moment, which we just don't have. (PsychGI)

Interviewees emphasised that location was critical, as the Programme delivery needed meeting or consultation space to be locally situated and thus accessible to service users;

> It's not that we're trying to put someone on a desk for five days a week, it's not that, but it is something about we do need some clinical rooms because there are some people that need to be seen face to face. And if we start making them move across the city, then actually we're not centring around the PCN and we're breaking away from what we actually wanted to do in the first place (KI18, PCS).

Some felt this to be an intractable, nationwide issue and expressed pessimism that this could ever be resolved. Others offered potential solutions, including a consideration of greater use of VCSE premises, or exploring the possibility of working with other public services and city council property.

Organisational infrastructure

A related issue raised across different groups was the lack of infrastructure in the early stages of the Programme, in terms of staffing for operational and clinical management as well as a lack of established processes and standard operating procedures.

> Putting clinicians on their own into networks without an MDT around them is pretty, well, risky on lots of different levels and I don't think it's particularly fair. (PsychGI)

The pressure resulting from the COVID pandemic, discussed in **section A: Background and Context** and in **Findings: 1d**, clearly affected the set-up significantly. Some interviewees also felt this reflected the early priority given to appointing clinical roles to deliver the service;

> The focus, rightly, had been clinical practitioners. The difficulty with that is there was nobody doing anything on the operational side, so there was no one sorting out where they sat, there was no one sorting out how they'd get their IT, the processes behind all that; because it's not a clinician's forte (KI18, PCS)

> …you've got strategy is good, the operational is good (but) that sponge and that jam in the middle of that cake, which is your middle management, it's not existing really (P06, VCSE)

Most staff groups recognised that this had been gradually addressed through the appointment of staff to operational management and administrative roles, and the development of procedures and responsibilities, such as the identification of a duty on-call manager, or a number for patients to use to cancel appointments.

> I think the passing of time rectified a lot of things really, and things were changed along the way and little iterative changes were made. And uncertainty I think, is to be expected in a new service. (CAP1GI)

In the early stages, however, this gap generated practical difficulties for each professional group. The newer roles, such as the health coaches and CAPs, described delays taking up duties, for instance as staff waited for Hepatitis B vaccinations, or due to more general uncertainty;

> I think having ten new trainees is all like "what are we doing?" was very confusing for all of us but also, I think our supervisors and things realised that there was less clarity than they maybe thought (CAP1GI)

Other groups suggested that, while some degree of space was beneficial in allowing professionals to define their own roles **(see Findings: 4a)**, a vacuum could also create tensions and negative behaviours;

> Because we went in and hit the ground running before structures were set up, it's left individual clinicians to argue "what should we be doing?" And that could be a beautiful discussion where people come together and two minds meet, or it can be bullying. (PsychGI)

Systems and process barriers

Many staff raised issues around the flow of patients into and through the mental health system as a whole, in particular with referrals to and from IAPT and SPA, reflecting a recognition that the Programme formed part of a larger, complex system of care, support and treatment. Reflecting the divergent views of the Programme **(see Findings: 3a)** it was noted that even terms such as "referral", which were taken-for-granted in secondary care, may need to be challenged through the Programme;

> It's really difficult, because we're kind of trying to change a whole system and culture through one service (KI16, SHSC)

Therefore addressing the challenge of appropriate referrals to the Programme implied also considering impacts on referrals to IAPT and to secondary and specialist mental health services.

> We've got an inordinate amount of people that fit our broad criteria, but (in the Programme) we are trying to work to a primary care model [without] inclusion or exclusion criteria, everyone is available, you know, everyone is accepted (KI16, SHSC)

This seems to have been reflected in the service user's experiences of being referred into the programme. Most seem to have been referred in by their GP, but many were unclear on the exact mechanism of referral or had been bounced back from IAPT. One patient described her referral process as: "a bit of a hoo-haa" (SU10), though for others, it has been smoother.

Many staff perceived a problem with the presentation of the service as 'no wrong door' (or to be precise "a single right door for all" **(Section A3: Programme Implementation)**, despite often agreeing with this aim in principle;

> The ethos of no wrong door and having very few exclusion criteria has meant that we've become very overwhelmed very quickly and our area, our PCN, is currently closed to referrals because of how saturated we've become. (MHPGI)

> We had this phrase, 'no wrong door' and it sounds very ambitious and very moral, it's what we all kind of live for I guess in a way as therapists, we want to help everyone we can. But (…) sometimes you think to yourself why are they getting referred to us? (…) In essence the GP is saving time by sending the referral to mental health nurse or our team, even though they know they're not for us. But no wrong door is interpreted as, 'oh we'll take it and do something with that person'. And I think that going forward is dangerous. (CAP2GI)

Several also pointed to the system effects of offering mental health care through the Programme without the strict thresholds or referral criteria applied by other providers in the system;

> It's like water, water has to go somewhere, and it will find a way to get somewhere; and clients are the same, GPs will find a way to get somebody to the system so they can move on with the other stuff. And we are those people there those clients are fed to; so they need to look at it and manage expectations and be really clear about stuff. (P06, VCSE)

For some, the cross-referral of service users would be an example of the system working as it should, with step-up and step-down care to more or less specialist/ intensive services. However, some felt referrals from the Programme to IAPT or SPA remained difficult, while perceiving that referrals from IAPT or SPA into the Programme had been made easier.

This linked to a broader concern expressed, that other services might see the Programme as a way to reduce their own waiting lists.

> Our pool of patients is getting bigger and bigger and bigger as the other services tighten more and more with regards to what they accept and won't accept (MHPGI)

Among some VCSE providers, the opposite problem was raised; that lack of clarity about referral criteria to VCSE was leading to very small numbers of referrals from general practice, suggesting a mismatch between provision and need, or lack of familiarity with VCSE capability (as noted in **Findings: 3c** above).

> I can't believe there isn't enough demand for mental health support that we shouldn't be massively busy. So, surely there've got to be clients there that we can support and that we're equipped to support, you know, at our level of expertise, our scope of expertise, surely. So, there's something amiss with the model somewhere. (P09, VCSE)

The question of appropriate referrals again relates to a wider question of balancing focus with appropriate flexibility, which will be addressed in more detail under **Findings: 4a** below.

e. Work Allocation and Staffing

Challenges relating to staffing raised in interviews centre very much upon caseload issues, reflecting in large part the fundamental challenge presented by the scale of undermet need (as discussed in 1A and 2B). Several interviewees described extremely high caseloads and patient contacts and this was perceived to be particularly acute for the MHPs, described as the "workhorses" of the system;

> The nurses are under far too much pressure and it's not okay, it's not sustainable and it's not something that's going to keep them in the job a long time. The heart's there and in the right place but the workload is just completely unreasonable (CAP2GI)

> We were seeing a ridiculous amount of patients in one day. (…) And so now we're kind of around ten and 12, which in itself is a massive amount of new assessments in one day, whereas before, I mean, I know I was touching 20–22 at times, maybe even 25 (MHPGI)

In some respects, this reflected the high commitment to their patients by MHPs;

> We've all got clients on our caseloads that really should not be on our caseloads, but because no-one else is going to see them, so having us is better than having nothing. (MHPGI)

> We're all working at over capacity because we do not want patients to have to wait for any longer than they possibly can. (MHPGI)

Other groups also described experiences of intensity of caseload; the psychologists and psychotherapists discussed pressure to increase their clinical contacts alongside other responsibilities for supervision of CAPs and indirect service development, and the CAPs, while protected as trainees, expressed concern at the impact of moving to five-day working once qualified.

Associated with the volume of work is, in many cases, the intensity and the impact of the content of the work with many patients, leading to a risk of burnout;

> And I think that takes its toll (…) their days are so intense and tough, because, you know, that's all they're hearing, you know. Torture and abuse and all the rest of it, case after case after case without a break. (P01, GP)

Apart from the direct consequences on staff, wide consequences of this including growing waiting lists for the Programme, resulting in temporary suspension of referrals in some instances, risking replicating issues elsewhere in the MH system;

> I think in some respects what we've done is moved the holding from the GP and all we've done is just transfer the problem and given it to the mental health practitioners to hold (KI16, SHSC)

Exploring the nature of the caseload, some interviewees suggested there was a need to differentiate between active and inactive cases more clearly, and also to focus explicitly on the discharge criteria;

> If you speak to any of them, they're like "well, I've got 400 people on my caseload", and it's like, you can't possibly have 400 people on. You might have 400 people on a list that need to see you, but you can't be actively working with 400 people, and that's not safe. (KI16, SHSC)

More fundamentally, some suggested a need to clarify the distinction between the primary and secondary care approaches to caseloads, reflecting different fundamental understandings of the Programme (as noted in **Findings: 3a**) contrasting the referral-treatment-discharge model of secondary care to the general practice approach to patient lists and "discharge";

> I think that's been a big part of the, one of the challenges that we've had is the secondary care mind-set versus the primary care mind-set. Because we are used to not discharging. We are used to just supporting no matter what, and people coming and going over periods of time and needing more support at some point, and then dropping off for a while and then coming back. And that's how we're used to working. And actually, you know, do you have this service having referrals and discharges? Because obviously there's a limit to what they can do, in more of the secondary care model, or are they part of primary care and it is in the same way that people will come and go, but they never get discharged? (P01, GP)

In addition to the question of individual caseload, recruiting and retaining staff is key to ensuring a sustainable service can be provided. In this regard, one challenge raised by staff was the difference in conditions of employment between different partners in the service.

> Some of us are employed by PCS, some people are employed by SHSC. We have different conditions, so holidays, rights to pay, carer's leave for those of us who have children, and families indeed, that you might need carer's leave for. That again, for me is a huge, you know, why am I going to continue to work here if I don't have the same conditions as my colleague who's sitting next to me. (MHPGI)

Differences related to specific employment policies, as described above, as well as availability of funding for training and development, and less tangible issues but equally important issues such as differences in employer attitudes towards sick leave due to stress. Temporal flexibility, in terms of working hours, was also highly valued by staff;

> I really appreciate the management because they allowed me to work my hours over three days. And I think that's one of the really, really wonderful strands to this organisation that they have been really receptive to what people are asking in that respect (PsychGI)

The other key concern raised which was seen to have a particular impact on the attractiveness of the roles, and the willingness of staff to remain in post, was the ability of staff, in particular the MHPs, to benefit from training and development opportunities.

> I just think the training offer is quite poor in comparison to what I've had previously (elsewhere in the NHS). I feel that it's not (a) priority (…) training is really important, and about not having to spend all your own free time doing work so that you can clinically deliver a really effective treatment and you're up to speed with everything. (PsychGI)

> (Some) business cases and requests for training (…) haven't come to fruition. I know that's a wider issue, but I think in terms of staff retention, professional development, enjoyment of a job and actually developing rather than just feeling like absolute assessment treadmills, that we just get strapped into our hamster wheels each day and off we go, and we finish and start it all again the next day. (MHPGI)

Summary: Challenges and Barriers

- found that there were multiple and sometimes inconsistent views of what the Programme was, which partly reflected the process by which the focus was gradually refined.
- Nonetheless, as this ambiguity persisted, there was a risk of scope creep and of unrealistic expectations being placed on the Programme.
- Some described issues with vertical communications and with communication and engagement with VCSE partners.
- The ability of the Programme to build internal coherence limited by a lack of estates provision and the inability of staff to co-locate, and gaps in administrative infrastructure led to less efficiency overall as clinical staff dealt with administrative tasks themselves.
- The estates and administrative issues also led to demotivation as some staff felt this reflected a lack of value placed on the Programme.
- While staff generally absorbed these challenges and maintained good patient care, one interviewee's description of his negative experiences with the programme demonstrated the potential of these issues to impact upon patient care.
- More broadly, staff highlighted challenges engaging with secondary mental health care and IAPT, suggesting work was needed to position the Programme more clearly within the wider system.
- Finally, staff discussed concerns about caseloads and the need to balance workload more equitably across the team, and the need for attention to be paid to certain HR issues, such as equity in employment conditions and availability of training and development opportunities.

4. Enablers

a. Flexibility

Staff across the different roles and professional groups spoke very positively of the value of flexibility in how care was organised and delivered. Flexibility here related to various aspects of the service; firstly, there was a major focus on flexibility in access criteria, with many arguing this was critical to engaging many marginalised communities;

> I think it's the flexibility of criteria to access the service, I think it means we don't exclude them. But I wouldn't say it's just around the Slovak community, I think we work with a lot of people from black and minority ethnic groups, including we've worked with quite a lot of asylum seekers and refugees up in **PCN2**, which I know would really struggle to access the kind of pre-existing provision that was in the city. (PsychGI)

> We don't have these same kinds of boundaries, we are more inventive with re-engaging people. We're not, you know, one strike and you're out or, you know, you miss one telephone call and that's it, you can't possibly have a life outside of the mental health care that we're delivering to you (MHPGI)

The service users interviewed also suggested that flexibility was valuable to them, for example, in knowing how to reconnect with the service in future if they needed to, or being able to get in contact in an emergency. This was described by multiple interviewees as a "safety net", which gave them reassurance without them necessarily needing to use it.

Staff also appreciated perceived flexibility in the time and space allowed to work with patients,

> Sometimes it's been… I've imposed care upon people, whereas here it's very… it's not transactional, you know, it's very relational the support that I give with my clients. We're not time-limited, you know, we've not got one eye on discharge, we don't use the D-word [discharge]. (MHPGI)

> I think we've been able to do such valuable work because we've had the space to do it. (HCGI)

> It was well received, and I think that's because we had time to spend with clients. So, we're never kind of cutting anybody short, if you like. And because we always see clients when and where suits them, we're really flexible like that (P09, VCSE)

Service users also valued the continuity of care that this has enabled. SU10 described how having regular appointments with an MHP over a long period of time meant that the MHP had a lot of contextual knowledge, and could easily identify if she needed extra help, rather than her having to "reach out" which she often wouldn't do if she was struggling more than usual.

At the heart of this was a perceived encouragement of creativity and innovation across the Programme, and a degree of trust in professionals to understand and adapt to local need;

> As senior clinicians we've had a lot of autonomy in shaping and saying that this is what the need is, this is… And we've had a lot of trust, I believe, that we can go and create what the service offer is for the patients that we're then working with… I've had the scope to do that and the support from the management team to do that, I think. (P14, team member)

> We've been granted the autonomy to shape services to an extent, which has always kept me going. (PsychGI)

This flexibility was described by all the VCSE partners interviewed as central to their approach, as their work was often responsive and adaptable, ranging from connecting clients to boxing clubs to help accessing food banks;

> Everything that we do, is in response to our service users. And we will try new things, and we'll soon be told if they're not right. You know, so you go right, okay, then, what do you think? How should…how can we change it? What would be better? And so… and that's how we have kind of operated all along (P07, VCSE)

The value of this approach to patients was evident in our service user interviews. Patients described being given choices and feeling like they were in control of their own care: "My priorities were valued" (SU03). They described how they were not pressured into taking steps for which they were not prepared and being given a range of options from which to choose: "he gave me an opportunity and gave me a choice" (SU04).

Staff also provided concrete examples of the benefits of taking "positive risks" in therapy;

> We're running a group at the moment that is informed by practice-based evidence and (…) what does it really mean truly to belong. And we're running a group at the moment. We've got a service user that's been part of services for 35 years and she said, "I've been attending groups all my life and this is the most meaningful group I've had – it feels authentic, it feels compassionate, it's something that really feels as if it's got such a significant value to me." (…) We're getting some really, really interesting and, you know, really meaningful feedback in the fact that we've been able to be creative about the way that we operate within that group structure (PsychGI)

Flexibility and ability to think innovatively about therapies, as well as the links to broader social care and community activities, was seen as important to ensure the service addressed the needs of the local population;

> To have something different in each network I think is really important (P02)

While flexibility was generally described positively, some of the psychologists and psychotherapists warned against too much flexibility. They highlighted the need to balance flexibility and structure in terms of interventions; allowing space for innovation but seeking to ensure innovations were evidence-based, with processes to share effective innovations to ensure system learning;

> I just think sometimes we're almost being so flexible and responsive we're kind of forgetting some of the stuff that we would bring, which is the evidence-based and tried-and-tested therapeutic interventions. (PsychGI)

> I think when there's too much space and openness to something it can fill people with anxiety at times. And I think we work with really complex individuals, like the clients, fantastic but complex individuals. And I think that if there isn't a structure to hang something on that feels very complex, that can lead to feeling really quite overwhelmed. So I think it's important that you have the space for creativity, but I feel like there's been an absence of structure (PsychGI)

b. Commitment to Mission and Programme

Throughout the interviews, we encountered powerful statements of commitment to the principles of the Programme. It was notable how widely and deeply held were these commitments among front-line staff, articulated with passion across all of the focus groups. For instance;

> I love the role, it's very varied and challenging but fulfilling at the same time. (MHPFG)

> We're all very, very passionate, and I think that's why the service has worked so well so quick because we got a really strong team from the beginning that are still really, really passionate. (MHPFG)

> People genuinely are thinking, this is how I want to work, if it could be the model that we hope it could be and genuinely strong MDT working, thinking about linking with community services as well, I think that's a huge thing for people, I think it's a big pull. (P12, team lead)

Drilling into the source of this deep commitment, it was possible to identify two complementary elements; a wide recognition of the limitations of the existing system and therefore a problem to be addressed (as discussed in **Findings: 1a Undermet Need**), and conviction that the philosophy and approach embodied in the programme had the potential to make a real difference in addressing this problem or gap.

Many spoke of how the philosophy of the Programme aligned with their own values and beliefs about how mental health provision should work, often keeping them in role despite the challenges discussed;

> I have carried on with it because I love the definition of a service, I really personally agree with and professionally agree with it, that there's just nothing there for people who don't just have mild, moderate anxiety and depression or who are at risk of suicide, there's nothing in between. And I've personally been in that gap, so I really agree with it. (CAP1GI)

> I just think the ethos of the service is really aligned with my own values and that's something that… yeah, when I applied for the job that's what motivated me (…) And it still keeps me there, like the hope that… I really want to see where the service is going to get to and I don't want to miss out. I think that's the other thing, I think I'd get like proper FOMO [Fear of Missing Out] if I ended up going to another service and thinking, oh I could've just seen where it had gone. Like, I really do hold that excitement and hope for the programme really and I want to be a part of that. (PsychGI)

It was also notable that the recognition of the problem with existing provision was shared by the different groups, from GPs to VCSE leads to professional staff who had worked in other mental health services;

> We wanted to be first wave because we were the most deprived network in the city, and I wanted to make sure that it was a service that met the needs of the patients in our network. (PO2, GP)

> I'd heard about the… is it the Community Mental Health Framework, the paper? So I'd come across that because I think everyone in IAPT at the time was like, "Oh my God it's the answers to our prayers!" (CAP1GI)

Equally important, then, is the conviction among most of those interviewed that the Programme has the potential to do something new or different, which would make a difference to the mental health care received, often by the most marginalised in society;

> I could see that if that was real, that (it) would work, because we've been doing it for years, or trying to (P10, VCSE)

> There's a lot of potential to be helping the patients because the patients that we will be working with are hard to reach and not very… They don't go to the doctors, they don't leave the house or anything. (HCGI)

In addition, staff talked about the rewarding (if challenging) nature of the work, comparing it positively with experiences in other mental health services and the innate excitement of building something new;

> You had this huge thing to deliver, to make a difference in people's lives, and that was still a privilege at the beginning, if that makes sense. That was, being involved in that was exciting. And I think staff felt empowered and wanted to do it. (KI20, SHSC)

> The work is much more rewarding than secondary, in that you get to see people getting better (MHPGI)

> What motivates me is the service users and I do feel like the service makes sense and I feel like the service makes a difference. I think for me my wellbeing is mostly tied to feeling valued and I certainly do feel very valued by the service users (PsychGI)

c. Core Team Qualities

Many interviewees who were not involved directly in the leadership, management and delivery of the Programme) spoke of the distinctive quality of the core team i.e. those recruited into that team in team lead and patient-facing roles, with a particular focus on the values of staff;

> It's very exciting. I think we've brought together a group of people who were interested in working in a different way. (KI19, SHSC)

> I remember being on the recruitment panel (…) So you start there, who do you get, who do you recruit and you recruit according to really a set of values. And it starts really at the beginning. And then those people, hopefully if you've recruited well, enact those values (KI20, SHSC)

Service users emphasised the importance of the personal attributes of the staff in the programme they had contact with, describing a high level of trust: "right from the very beginning I trusted him" (SU10), and feeling connected with those providing the service: "it's professional, but there's more of a connection" (SU07). The MHPs were particularly praised for their personal qualities: "it's not what he does, it's who he is" (SU04).

Within the teams themselves, many mentioned the strength of peer support and the importance of this support;

> I have to have wholeheartedly hold up my hand and say that could've crushed me, not being allowed to do it, and these guys were so supportive and I will be forever grateful for the respect you gave me, like, that meant a huge amount. (PsychGI)

Similarly, the CAPs spoke positively of the value of collegial support within teams, identifying particular activities such as a WhatsApp group which enhanced communication and a sense of belonging;

> …just like having a chat on WhatsApp and if someone says like, I'm struggling with this specific thing of if a supervisor is not available, like I've had a difficult session, anyone free for a chat, there's always, like, jump in to help someone out. And it does feel that we're very much a group of CAPs. (CAP1GI)

The Health Coaches mentioned shadowing each other as critical to developing confidence to practice independently;

> I feel confident doing either together or separate, now that we've had a bit of time doing it together, but I think it will work well, say if we do do it separate and then (…) if there's any more health coaches come in, they can shadow either one of us and then there's still two of us anywhere for a period of time. (HCGI)

The quality of collegial support was explicitly referred to by several interviewees as the thing which "keeps people in place".

Outside of the core team, some interviewees emphasised the qualities of the Programme leadership team, in terms of both capabilities, the organisations they represented and their networks;

> There's been something about how that team of people putting, implementing it have been across secondary care and primary care and representation for Sheffield Mind and the community services as well to make sure that all of, there is sort of fair representation across the board. (P01, GP)

> Having a leadership group that was connected and had long standing relationships outside of the primary care framework, was important. So you had SHSC relationships that were well formed at the top. So you had a leadership group that were going to get the job done but were also connected to the people who needed to be connected. (KI20, SHSC)

Many also emphasised the importance of good communication other groups, and GPs in particular, identifying strong GP connections as one of the key benefits of the Programme as currently set up;

> …having that real, like, direct communication and link with GPs, so even if we're not offering direct support to the person or we need to kind of, like, discharge from our care, we can always have that direct conversation with the GP. And it feels a lot more connected to GPs than, yeah, when I've been in secondary care (PsychGI)

It was also noted, however, that experiences of GP engagement varied between roles, and also by PCN/ GP practice and individual practitioner;

> In terms of GP talk, like again each area's different. I haven't really had many discussions with GPs at all, to be honest. Most of the discussions I have are with the MDT that I work in and the mental health nurse practitioner (…) acts as, I guess, like a firewall really to take on any sort of enquiries and will filter them down through triage into the wider MDT. (CCGI)

> A number of the GPs tend to have a special interest in mental health. I really notice the difference when I've spoken to GPs who have that interest whereas those who don't (CAP2GI).

Summary: Enablers

- We found several specific enabling factors to have made a difference.
- Flexibility was seen to be one of the great strengths of the service, with several dimensions including flexibility in access, in how time and space were used when working with service users, and in the degree of creativity in treatments which were possible and encouraged, an approach which was already quite normal among the VCSE providers.
- The depth of commitment to the Programme, reflecting both the acute awareness of undermet need and belief in the Programme to make a difference, was a powerful motivating factor.
- The Programme further benefited from the quality of staff recruited, their 'fit' with the ethos of the Programme and their willingness to support each other.
- This extended to the leadership team also, where some felt the composition, including the representation of GPs, was critical.

5. Roll-out and Sustainability

Through our interviews, respondents shared a number of reflections on the future of the Programme as it transitions from a Programme to a stable and ongoing service, in terms of how it might be rolled-out across the city and region and how it might be made sustainable in the longer term. From the service users' perspective, most emphasised the urgent need for the wider roll out and greater accessibility of the service. Many staff made concrete suggestions about how to deal with or avoid such dangers, which we have attempted to collate below.

a. Work Design and Sustainability

To some degree, the longer-term sustainability of this service as a human system depends primarily upon having sufficient staff, with appropriate expertise and competency, able to deliver care as specified. This is challenged by failure to recruit or retain the right staff, or the inability of staff to cope with impossible workloads, both of which were discussed in some detail in **Findings: 3e**. This discussion will not be repeated in detail here, other than to flag up the key themes of this section; supportive leadership, staff involvement and engagement, a balance of structure and space to innovate, and opportunities for continuing professional development.

Additional themes raised in interviews which were seen to be important to ensure the teams could be sustained related to Role Clarity, Team Composition and the integration of ARRS roles.

Role Clarity

Similarly, many argued that more work was needed to clarify some roles, in particular the MHP and the CAP role, and to communicate this to stakeholders, from GPs and practice managers to others involved in mental health services.

> (The MHP role) has morphed into being essentially anything and everything – mental health advisers for GPs. I'm frequently referred to as a therapist or a counsellor or a psychologist. (MHPGI)

A key area of uncertainty related to the CAP role, reflecting in part the novelty of the role. The role was a new Health Education England role being tested by Sheffield, but with a commitment to recurrently fund the roles beyond the apprenticeship;

> The new trainee clinical associate psychologists and that, they're going to be a really, really valued profession once we're really up and running. But that's been a real challenge, again, a huge part of the workforce, there were ten people who were apprentices on a new, completely new programme trying to understand what it is, who they can work with, what are the parameters, what's the suitability? (P12, team lead)

Both the CAPs and the psychology team who supervise the CAPs discussed ways in which the CAP role could be better managed, through better communication with university about the clinical work of CAPs, and with the services about their capabilities, as well as more time allocated for the supervision of CAPs, which many felt to have been underestimated.

Team Composition

Looking forward toward a sustainable team, interviewees discussed various additional roles which they felt would improve the service, such as a family therapist, a support worker, a care coordinator, or a first-contact mental health worker in general practice. Some also underlined the danger of neglecting administrative roles;

> I think the senior, senior team have had to really fight to make sure that we've had roles that aren't clinical. So it's, like, the sense of, we can't, everybody can't do everything (P12, team lead)

> The importance of having an admin team is massive. Because we've only just got that in place and it's been so hard to not have them (CAP2GI)

Others argued that what would be needed were more of the existing roles, with many citing a need for more MHPs, and some citing need for more psychology and MH pharmacist support. Some staff, describing the importance of broader specialist input, reinforced the importance of embedding the primary care services within specialised pathways and SHSC;

> Everybody hates this concept whenever I've suggested it before, because it sounds like secondary services, but having secondary central teams of psychology, but who maybe had developed specific pathways, so trauma informed pathway, PTSD, OCD, whatever it is, that everybody can then sort of refer into, but still making that really clear that this is still a primary care offer, and that there are other services for more complex things, feels like it might be fairer (P11, team lead)

Link to Additional Roles Reimbursement Scheme (ARRS) staff

Relatedly, team members described their sense of responsibility for staff recruited through the Additional Roles Reimbursement Scheme (ARRS) to mental health roles in parts of the city which were not involved in the first phase of the Programme. While other ARRS roles already existed in general practice, mental health ARRS roles are new positions, jointly funded by PCNs and mental health providers but with limited guidance in terms of job descriptions.

Staff emphasised the importance of ensuring that ARRS roles were also supported, despite being separate to the Programme.;

> I think these new people are going into these roles completely on their own, like X really put it really well, canaries, lowering them very slowly. And I just feel like they're going to get battered actually and I feel like they're not very well protected at all. And it's our role to protect them but given what you've already heard about our workload and being the work horses, it's difficult to put all of our energy into that as well. (MHPGI)

It was felt to be important that lessons learned through the Programme were also used to inform the implementation of these ARRS roles;

> What worries me is that we're not learning from that initial period where the nurses were accepting all these referrals and now, we're asking the ARRS to go and do the exact same thing. And it feels really… I feel really guilty when I'm supervising one of my satellite workers and I'm like, "I'm over here in my MDT and, you know, I'm doing fine but you crack on". And it just feels wrong. (MHPGI)

b. Sustainability at scale

Given this likely need to scale the investment across a broader area, and a perception that existing resources may need to be spread more thinly as a consequence, several interviewees reflected on the need to tailor provision and staffing to match needs in each area.

> We're either going to end up in two situations, that we've spread ourselves too thinly that we can't really do anything, or we've got inequality of service across the city. So we've got the four that we've rolled out to with this gold standard, lovely multidisciplinary team, and then we've got other people, other networks (..) that have got slightly less because, well, we haven't actually quite got as much money, or you've got less mental health needs, so therefore you're not going to get as much (KI16, SHSC)

This was linked by some to the argument that each area or PCN did not need the same provision in terms of staffing team composition, but rather "equitable" provision, reflecting discussions above in **Findings: 2c** regarding local need;

> Different communities are different and have different levels of need, you know. Not feeling the need to have equal provision but having equitable provision. So, you know, actually provision that goes to need rather than just, well everybody has to have exactly the same because that's there (...) That is something I feel the programme has at the heart of what they do, is an understanding that actually, health inequalities means that different areas will need different levels of service. (P01, GP)

Several drew on their experience to explain the detailed work necessary to effectively determine provision which matched need but also took into account other local services, including social provision and VCSE offerings in each area;

> They're so different, the PCNs, honestly, that I work in… It's getting to know the area that you work in and who else is working there, what else are they doing. So that might be (...) social prescribers, it might be initiatives that are up and running in various areas of the city that might be supporting mental health, it's GPs with specialist interest in mental health… So it's trying to network and find out. But you've got to go and do that for each individual area. (P13, team lead)

It was noted by many that financial sustainability for a wider roll-out relied on the service being able to measure not only activity but impact. Several felt that it would be challenging to capture impact in a way which would be meaningful but would also hold weight with commissioners and partner organisations. After describing the rich contribution made by the Programme and the VCSE partners, one interviewee asked;

> How do you convey everything that I've said in the last hour? How do you actually convey that into little boxes with numbers? (P08, VCSE)

While some felt that evidence of impact would be found in Patient Reported Outcome Measures such as ReQoL (to be replaced with DIALOG[14]) or other measures such as prescription rates of psychotropic medication, other interviewees discussed the expectation that the impact would be seen in terms of referrals to SPA;

> If the conversion rates end up where you've got just as many people going to SPA having been through primary care, then something's not quite right there (KI15, CCG)

While some noted that this impact may only be felt over the longer term, others were clear that impact evaluation based on referrals to specialist services would not be an appropriate or valid measure of success;

> There is a tendency to want to measure referrals into secondary care, and is this making a difference by reducing your referrals in secondary care? But a lot of the people that we're dealing, or they are dealing with, actually we wouldn't necessarily have referred to second care (P01, GP)

Nonetheless, all recognised that strategic decision would depend on the generation of robust data, and that financial uncertainty in itself was an obstacle to success. The financial uncertainty was a particularly acute concern for the VCSE partners in Sheffield who were keen to argue that even a moderate VCSE investment could have a substantial impact;

> Just a little bit of investment in an individual has such a massive impact, not just on the individual but on the community that they live in, their neighbours, and everybody. But it's only a tiny bit of investment, really, but it needs to be quality. It can't be just cheap as chips, it has to be quality investment. And it has to be an equal playing field. (P10, VCSE)

The long-term sustainability of the Programme as a service depended on the ability of VCSE partners to plan and commit over a meaningful period, in line with the other partners involved, which was in turn reliant on a model of commissioning which could provide stability beyond a 12-month cycle.

> One of the biggest issues we find is sustainable funding for these groups (...) if these groups don't have sustainable funding, it's really difficult for us to plan how we work with them. And what they're doing is, they get funding for a year and then they're having to reapply and they're spending six months working and six months desperately trying to find money to keep going. (P01, GP)

Summary: Roll-out and Sustainability

- Reflections on roll-out and sustainability focused on two themes.
- The first was the appropriate design of work. This covered important but arguably universal HR and OD concerns such as supportive leadership, staff involvement and engagement, and opportunities for continuing professional development.
- More specific to the national policy framework and local workforce plans, there was a need for greater role clarity (particularly for MHPs and CAPs).
- Specific to the local Programme and roll out was the need to ensure the right composition of teams at a neighbourhood level (reflecting local need and potentially including new roles) and the need to align the service more effectively alongside new ARRS roles in PCNs.
- The second theme related more to sustainability at scale, ensuring sufficient capacity and sufficient funding, again tailored to local need at a PCN level.
- Many recognised the importance of focusing at an early stage on capturing meaningful data and evidence in order to justify investment in mental health provision of this kind.

14 https://www.elft.nhs.uk/dialog

E

Discussion

E. Discussion

Below we draw together key themes which cut across the different Findings sections set out above. It is important to note that some of these issues were initially raised in the Cycle 1 Lessons Learned report (summarised in **Section C: Summary of Cycle 1 Evaluation Findings** above). We are aware therefore that some are issues which the Programme team have already begun to address, which was the intention of the rapid cycle learning approach adopted in the evaluation.

Lessons learned through evaluations frequently focus on what needs to change, or what else needs to be done. The most valuable place to start, however, is by recognising what has gone well in implementation, and thus what elements of the Programme should be preserved and nurtured, alongside what may need to be changed or developed. The summary of Achievements above identifies several successful elements which should be preserved as far as possible in the wider roll-out of the Framework in the area. Two in particular are highlighted here, which we identified as key strengths of the Sheffield Programme.

1. Success in reaching marginalised groups and tailoring care to local need

There was a strong and widely held perception among those interviewed that better mental health care had been provided to many groups whose needs were not met by existing services. This is reflected in the activity data (**see Section A: Background and Context)** which indicates that 20% of service users were from minority ethnic backgrounds (data is not routinely collected on the economic or social status of service users). How the Programme managed to meet the needs of people with serious mental illness is explained by staff and supported by many of the experiences described by the service users interviewed **(see Findings: 2c; 4a)**.

A key advantage of the Programme was that many felt the provision of care was more effectively tailored to the needs of local populations **(Findings: 1c; 2b)**. This was thanks in part to the involvement of general practices, who knew their patients well, and of local VCSE providers, set up to reflect the local populations and address their specific concerns (Findings: 2c).

The physical localisation of services also played a major role here. Several interviewees including service users noted the significant barriers they faced which limited their access to centralised specialist services, beyond the challenges of the referral process. These included practical challenges such as physically accessing care in a central location, discomfort moving outside local communities and the stigma of engaging with specialist mental health care **(Findings: 2c)**. By contrast, local provision of care (linked to the familiar GP practice or other community facilities) was experienced as more accessible, less threatening and distant, and was not seen to risk the same social stigma in their communities. The impact of these barriers was most severe for vulnerable people or those in more deprived communities, with very acute need of mental health support (**Findings: 2c**: see also **point 4** below on the need for appropriate estates provision at a local level).

Effective reach at a local level also requires appropriate provision of estates for meetings and consultations within each PCN area **(Findings: 3d)**. Ideally this would enable some co-location for local teams, with accessible and sufficient administrative support. The Programme leadership have been aware of estates and administration issues and progress has been made here as the evaluation has continued. However, the clear importance of these issues for local responsiveness, efficient functioning of the service and indeed for staff morale justifies their reiteration here.

Beyond local knowledge and location, this success in reaching marginalised groups also relied on the flexibility in care delivery. Staff in patient-facing roles were afforded more autonomy in deciding how to engage service users and to tailor care to meet individual needs. This issue of flexibility/variability is addressed below **(point 6)**.

2. Effective engagement with general practice

A second key strength of the Programme is the extent to which the Programme successfully managed to engage with general practice. This is not a given, as the experience of other Framework pilots nationally suggests[15]. The success of the Sheffield Programme in this regard reflects the formation of the Programme as a partnership, with a leadership team and Programme board with effective representation of both secondary mental health trust and primary care providers **(Section C; Findings 2b)**, and the efforts made to engage with the concerns of general practice **(Findings 2d)**.

One consequence of this partnership is that the Programme was implemented with a clear understanding of the needs of patients with mental health needs being treated in primary care and was designed with these in mind. This was no doubt facilitated by the selection of PCNs with particular high levels of need in the area of mental health. Nonetheless, this is particularly important given the scepticism which may have developed among GPs who have struggled to successfully refer patients to specialist mental health services in the past, and who therefore may be distrustful when approached by new initiatives driven by specialist mental health trusts **(Findings: 1b)**. Engagement is likely to be weaker in other PCNs not involved in the early implementation and is likely to require focused attention to communicate lessons learned and to support wider roll-out.

While it is important that this engagement and confidence among general practice should be maintained through wider roll-out, perhaps the inevitable corollary is that the perceived 'ownership' of the initiative by secondary mental health services may be diluted **(Findings 2a; 3d)**. There is therefore a need to ensure that other partners, in particular the mental health trust but also the VCSE sector and the city council, feel equally represented and not only engaged but involved as the Programme becomes embedded as an ongoing service in the wider health and care system **(Findings: 3c)** see also **point 4** below).

Beyond these strengths, there were other aspects to the Programme in Sheffield and its implementation which were more double-sided; strengths or achievements of the Programme which also presented potential limitations or challenges, or where solutions may generate new challenges. These more complex issues are discussed below.

3. Challenges of managing scale of demand

One of the most consistent themes raised by interviewees was the scale and complexity of mental health need being managed within general practice **(Findings: 1a)**. A key achievement of the Programme, as noted, was the success in identifying this need and finding innovative ways to meet the need drawing on clinical and non-clinical staff, including VCSE providers of care and support.

However, the scale of demand and its complexity also presented a major challenge, which at times required exceptional degrees of effort and commitment from the staff to maintain a safe and effective level of care **(Findings: 2e)**. Some staff noted that the burden of this caseload did not fall evenly across the team. We do not have activity data to assess these claims, but collaborative working may be undermined by a perception of inequity. This is clearly an issue which requires transparency and careful management, recognising that it may take time for newer roles to become familiar and normalised within a primary care setting.

It was also clear that the scale and complexity of need varied by neighbourhood **(Findings: 1c)**, reflecting various factors including demographics and deprivation. The prevalence of particular conditions similarly varies between PCNs; for example, some areas with higher numbers of asylum-seekers observed much higher levels of trauma, while others encountered more widespread anxiety and depression. Reflecting local need, then, and informed by local clinical priorities, the composition of teams may be expected to vary by PCN. Detailed understanding of local need, drawing on the expertise of the full range of partners in each PCN, is therefore needed to ensure that team composition reflects the profile of demand.

15. Kings Fund Transforming community mental health services: Lessons from early implementer sites May 2021

There is also a challenge of ensuring adequate capacity and capability to carry caseloads as rates of referral and discharge fluctuate **(Finding: 3e)**. The formal model of referral-diagnosis-treatment-discharge familiar in secondary and specialist healthcare did not fit neatly with the 'patient list' model, which is the basis of general practice, as the former assumed high-intensity treatment and the latter, more episodic and intermittent periods of more or less intensive care. Arguably, the chronic nature of some aspects of SMI demands a fluid process of stepping-up and stepping-down of care intensity, rather than a time-consuming and difficult process of referral or re-referral. As well as absorbing staff time, it is noted that the "cliff edge" of discharge may generate anxiety among service users and thus exacerbate conditions. Uncertainty about the model of care adopted here **(Findings: 3a)** is a barrier to smooth cooperation between mental health services, and is also likely to prevent the effective measurement of activity, caseload and team capacity **(Findings: 5b)**.

4. Integration with secondary and specialist mental health services

The Programme benefited in several ways from its status as a discrete project, with dedicated and effective project management support and a clear mission which could be maintained despite the competing pressures of the COVID-19 pandemic **(Section C: Findings: 1d)**. This project focus inevitably also generates a degree of separation between the Programme and existing systems and services, however **(Findings: 3d)**. The challenge for all successful policy pilots is therefore to (re-) embed themselves at some point within the wider system if they are to transition from a standalone pilot to form part of 'business as usual' in public services.

The process of embedding the Programme in the wider health and care system also requires the service going forward to be clearly positioned within or around other standard system processes, such as patient pathways and the referral procedures of other services such as SPA and IAPT. As the Programme aims to 'fill a gap' for people with needs too severe for IAPT but who do not meet thresholds for secondary care **(see Section A: Background and Context)**, there is a need to clarify eligibility criteria for the Programme in the context of criteria applied in other mental health services, ideally avoiding gaps and also overlaps **(Findings: 5b)**. Equally, attention needs to be paid to the escalation/de-escalation process between the different services and the referral of people 'up' to more intensive care and also 'down' to less intensive or specialist care.

Both issues will require coordinated action with specialist mental health providers, to ensure consistency with policies of other providers and pathways and to ensure the system implications of these decisions are considered (**Findings: 3d**; see also **point 3 above**).

Clarification of policies and processes **(Findings: 5a)** are also likely to result in some tension with one of the key advantages of the Programme: the degree of flexibility afforded to staff in tailoring care to local needs. This is considered under **point 6 below**.

Secondly, embedding the Programme at scale as a service within the broader health and care system will require strategic engagement at a senior level, involving different parts of the health and care system including not only primary and secondary care providers but also system integrators such as the ICS. This was raised as a priority in the Cycle 1 Lessons Learned report **(see Section C)** but bears repeating here as the South Yorkshire and Bassetlaw ICS is now staffed and formally operational from 1 July 2022, which was not the case when the earlier report was produced.

5. Importance of local community assets and VCSE

As noted, a particular focus of the Framework is to ensure greater use of community assets and VCSE providers in local communities **(Section A: Background and Context)**. There was evidence throughout this Programme of the distinctive contribution that VCSE organisations could make to the lives of people living with SMI, and also a clear sense that VCSE providers felt they had more to contribute **(Findings: 2e)**.

The Programme also provided insight into the challenges of integrating VCSE meaningfully in the design, organisation and delivery of community mental health services. Firstly, interviewees in some VCSE providers would have liked greater involvement in the design of the Programme, recognising that it was set up in a very short timeframe and consultation processes were affected by pandemic pressures on the health and care system **(Findings: 3c)**. A related challenge is to engage meaningfully with the diversity of VCSE organisations, some of whom are large while others are small and have limited capacity or experience to engage with commissioners or complex policy initiatives. The work of Rethink Mental Illness in supporting the development of a VCSE provider collaborative in the area (described in **Section A: Background and Context**) is therefore invaluable, to

ensure the full range of VCSE organisations are visible, represented, and supported to engage in important initiatives such as this.

Beyond this, engaging VCSE in the organisation of mental health care, rather than merely the delivery of care, requires the representation of VCSE organisations in key oversight as well as operational meetings **(Findings: 3c)**. This may pose challenges to smaller and even larger VCSE organisations with limited or zero managerial capacity, and arguably needs consideration as part of the funding of VCSE here. The formation of a VCSE provider collaborative is likely to facilitate strategic engagement here.

We also observed variation between sites in terms of how far VCSE or other non-clinical staff were able to participate in MDT meetings **(Findings: 3c)**. While this is likely to remain a decision for practices to make, with a view on their responsibilities to patients, where VCSE were not able to be involved in such meetings directly they felt there was a clear limit on their ability to identify cases where they could provide care, or tailor care to meet need.

Finally, involving VCSE providers in the delivery of care is often limited by a lack of awareness across primary care of what providers offer. VCSE interviewees described the difficulty of communicating their offering to general practice, even at a local level **(Findings: 3c)**. Clearly, awareness of a VCSE provider is only the first step and it will take time for GPs and other staff to have experience of successful care delivered by voluntary organisations, and to know for whom this care would be suitable. The development of social prescribing infrastructure may play a key role here. However, a key first step is to improve communication paths between VCSE and healthcare providers and commissioners. Again, the Rethink Mental Illness work is likely to make a positive contribution here.

6. Importance of flexibility and innovation in delivery

Both Programme staff and services users attested to the importance of flexibility in the delivery of care, as discussed above. Several aspects to flexibility were described, which related to how patients accessed the service, how staff worked with and adapted to patients, and SHSC placed in staff to develop innovative solutions to meet individual need. Staff explained how this trust and autonomy led to greater job satisfaction and encouraged them to commit to the Programme, and the service users interviewed explained how they felt their views and choices were better valued as a result of this flexibility, and this gave them a sense of autonomy in their treatment and recovery **(Findings: 4a)**. Given the importance of this flexibility to both staff and service users, there is a strong sense that this should be preserved.

This however presents challenges to the need for consistency and parity across the service. Flexibility in clinical care delivery also may conflict with the parallel need for treatment to be evidence-based. As noted by clinical staff, due to their size and marginal status, there may not be an existing evidence base for some groups (for example, the Slovakian Roma community) and staff may need to innovate with existing models to develop appropriate care (and in so doing, start to build an evidence base for treatment).

The issue of consistency and parity is not only a clinical matter but also managerial, as parity of provision should be built into the design and mission of the service, particularly as it expands. There is therefore a need to ensure that the form, nature and importance of this 'flexibility' should be articulated and this statement used to ensure policy and practice continue to support and defend an appropriate degree of flexibility.

The issue of evidence-based care is primarily a clinical matter, raised mainly by the psychologists, psychotherapists and mental health professionals, with a view to also ensuring successful innovations are rapidly shared across the service. The correct balance is therefore a matter for clinical and professional judgement but there is a need to dedicate time to reflect on this. This may form part of the reflexive continual professional development described as a priority by these groups (see **Section E**: Findings and **point 7** below). Systems and processes will also be needed to change clinical practice in a structured manner over time.

7. Challenge of sustainability at scale

Given the limited financial and human resources available within the healthcare system, there was an acute awareness among all those interviewed of the need to make the service sustainable at greater scale. Four aspects of sustainability were highlighted; financial viability, staff recruitment and retention, integration within the wider health and care system, and the need to ensure appropriate evidence of impact was captured **(Findings: 5b)**.

Financial viability: As the evaluation has not conducted an economic evaluation or analysed budgetary records, it is not appropriate to advise here in detail on funding or necessary/minimal staff resourcing. We would however underline the need for provision tailored to local need at a PCN level, and to reiterate that given variation in need, as noted, equitable provision at scale would not imply equal provision **(Findings: 1c)**. The service will be facilitated by parallel and separately-funded initiatives such as the ARRS roles; however, the challenge of aligning services alongside any ARRS mental health provision at PCN level may be complex **(Findings: 5a)**. Targeted work at PCN level and between PCNs (potentially supported by the ICS) on job description and scope of work is critical, to avoid duplication or gaps in provision, and to ensure ARRS roles are connected to other Primary and Community Mental Health teams for knowledge sharing and peer support.

Recruitment and retention: The ability of the service to retain staff and to attract qualified and experienced staff is also critical given widespread and well-documented shortages of healthcare staff, particularly in the field of mental health. The perception of the Programme as something new which responds to a pressing need has been an important factor in recruitment and retention, but this factor may dissipate as the service becomes a standard component of mental health care. Many staff explained their commitment to the ethos and mission of the Programme and the impact this had on their willingness and ability to invest in their role **(Findings: 4a)**. Demotivating factors were highlighted as having the opposite effect and leading staff to consider leaving; these included a lack of a physical home base, difficulty in securing appropriate consultation space when meeting service users, and obstacles to continuing professional development **(Findings: 3d)**. As far as possible, standardisation of employment conditions for staff in similar roles would be desirable, recognising that this is limited by the policies and practices of different employing organisations. Finally, but most importantly, work to ensure that the caseload for staff is manageable and perceived to be equitable across the team is essential **(Findings: 3e)**. Without this, recruitment and retention will prove challenging, particularly as the Community Mental Health Framework is implemented across other areas and regions and will seek to recruit from the same pool **(Findings: 5a)**.

Integration in wider system: This has been covered at some length above under **points 1, 4 and 5**, but to briefly reiterate; important progress has been made in engaging general practice, which is vital for this kind of provision, although degree of engagement with VCSE varies in some areas and this requires attention through comms and engagement, ideally driven by PCN leadership **(Findings: 5b)**. Work remains to be done to raise awareness of the Programme within SHSC at all levels. This should focus not only on how the Primary and Community Mental Health Team in Sheffield can improve the reach and impact of mental health care as a whole, but also on how it can support SHSC in achieving its own goals - for example, by reducing inappropriate referrals to SPA and IAPT, by building local knowledge of mental health demand across the city, and by offering a step-down option for SPA and a step-up option for IAPT. For this to be effective, there needs to be careful consideration of the collective, systemic impact of the service and to ensure 'warm handovers' are feasible in practice as users move between services. This would entail a substantial commitment given documented challenges and tensions between different parts of the mental health care system **(see Findings: 1b)** but is critical work to build on the achievements and to develop a sustainable mental health system for the city as a whole.

Evidencing impact: Finally, interviewees made a number of valuable and pragmatic points about the inevitable need for strong evidence not only of activity but of the impact of the services, and also the danger of looking for impact in the wrong places **(Findings: 5b)**. An important warning was that given the effectiveness of the Programme in identifying mental health need at an earlier stage and reaching marginalised groups who may never have received care due to a range of barriers, the immediate impact on referrals to SPA, for example, may be limited - although this may become apparent in the longer term. Impact on Patient Reported Experience Measures or Patient Reported Outcome Measures are more appropriate measures of impact, as well as prescription rates for psychotropic medication or antidepressants. Beyond this, work to ensure the validity and reliability of patient data and also budgetary data is vital, and potentially a more rigorous economic evaluation of impact at an appropriate point in time.

F

Recommendations

F. Recommendations

Recommendations below are presented in an order which reflects the structure of the Discussion section, rather than in order or importance. The Discussion section is identified in column 2 (point), but the importance of each is defined in column 3.

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
1. Estates								
1.1 Ensure the service delivers care within neighbourhoods and in convenient locations for service users.	1	High						
1.2 In each PCN, a set of options should be developed for estates provision, addressing space for clinical consultations and other meetings, and for a physical base or hub for the service teams.	1	High						
1.3 The impact of the service on primary care estate should be considered at ICS level where capital investment in estates is considered.	1	Medium						
1.4 Given pressures on estates in general practice, alternative spaces should be considered, such as council premises and Third Sector buildings.	1	High						
2. Administrative support								
2.1 A plan should be developed stipulating necessary administrative support for service teams at a PCN level.	1	High						
2.2 This plan should be developed in discussion with GP practices or other premises used, recognising pressures on existing GP administration and the peripatetic nature of work for staff within service teams.	1	Medium						
3. Communications								
3.1 A targeted briefing should be composed for delivery to GP practices and VCSE organisations in remaining PCNs across the city of Sheffield and, if appropriate, more widely to summarise and communicate lessons learned from Programme.	2	High						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
4. Mental Health Needs Analysis and Mapping at PCN level								
4.1 Analysis should be commissioned at PCN level to establish the level and nature of mental health need in each locality.	3	High						
4.2 This analysis should draw on data and expertise from primary care, secondary care, the city council and the Third Sector.	3	Medium						
4.3 The analysis should also be informed by the experience of the Programme and the insights of Programme team leads, including VCSE providers.	3	High						
5. Team Composition								
5.1 Using the Needs Analysis (Recommendation 4), further work is required to ascertain the appropriate and affordable design of service provision required to deliver an equitable level of care in each PCN.	3	High						
5.2 This work would also need to take into account any changes in secondary care provision as well as emergent contribution of any ARRS mental roles.	3	Medium						
6. Caseload Review								
6.1 An assessment should be undertaken to review caseload distribution across teams, with senior clinical input, to confirm appropriate and manageable workloads for each group within the teams.	3	High						
6.2 This review should determine and articulate an agreed approach to caseload management, recognising the different expectations of primary and secondary care.	3	Medium						
6.3 This review should inform a training intervention to address conflicting assumptions across teams about expectations of caseload and associated issues of risk and staff capacity.	3	Medium						
6.4 This review may also form the basis for explicit policy as regards safe and sustainable caseloads.	3	Medium						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
7. Engagement with Secondary Mental Health Services								
7.1 A strategy for clear and direct engagement with SHSC at senior level to articulate formation and impact of the Programme, presented in the light of national policy and CMHF expectations, and to share lessons learned through the Programme.	4	High						
7.2 This will involve the creation of a focused briefing clarifying the mission, focus and achievements of the Programme which should be delivered to relevant senior boards in other parts of the health and care provider system, including acute trusts, social care providers and, critically, the secondary mental health care provider.	4	High						
7.3 This communication should focus on the impact of the Programme and the expected contribution the service can make to the goals and objectives of secondary mental health services.	4	High						
8. Organisational Development								
8.1 An OD (Organisational Development) initiative should be considered, ideally delivered collaboratively with SHSC, to build mutual understanding between primary and secondary care mental health providers (and should include ARRS mental health workers who are not part of Primary and Community Mental Health teams).	4	High						
8.2 This intervention should aim to explore cultural differences and risks of miscommunication across mental health services, to support clinicians and managers to work collaboratively across primary and secondary care.	4	High						
8.3 This intervention could be extended to incorporate other partners, in particular VCSE organisations and local authority staff and support whole-system collaboration and integration.	4	Medium						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
9. System Integration								
9.1 Collaborative discussions should be initiated with SHSC also required at a system level (between primary and secondary care as well as commissioners) to agree processes and criteria for service users to transition to/from more specialist/ intensive care and to/from lower intensity IAPT care.	4	High						
9.2 This discussion may also encompass work to clarify eligibility criteria for the service, which should be consistent with those applied by other MH providers.	4	Medium						
10. Governance and Multi-Partner Engagement								
10.1 The design of the board or oversight committees for the future service should ensure representation from all partners, including the secondary mental health provider, local council, general practice and VCSE organisations.	4	High						
10.2 In particular, the board/committee design should ensure that the range of VCSE providers have input into the design and operation of Primary and Community Mental Health services; engaging with VCSE provider alliance may facilitate a wide range of engagement, including smaller VCSE organisations.	5	High						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
11. VCSE and General Practice Liaison								
11.1 A targeted initiative should be undertaken to improve communication between VCSE organisations and GP practices, potentially supported at scale by the establishment of a VCSE provider alliance.	5	High						
11.2 This work may take place at scale, to share evidence of effective support provided through VCSE organisations, and at a PCN level to strengthen two-way communication between local VCSE providers and general practices.	5	Medium						
11.3 Community Mental Health Teams and PCNs should consider ways in which to strengthen VCSE partnerships across primary care at a neighbourhood level, including opportunities for collaborative applications for funding, to enhance capacity to provide care, support and treatment through Third Sector providers.	5	Medium						
12. Facilitation of MDT Participation between Partners								
12.1 Guidance should be developed on the operation of MDT meetings to facilitate participation of different providers, both clinical and non-clinical.	5	High						
12.2 Respecting the clinical autonomy of GP practices, it would be helpful for GPs and GP leads to share experiences of MDT operations and evidence of positive impact of more inclusive practices.	5	Medium						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
13. Commitment to Flexibility, Innovation and Learning								
13.1 The service should develop a clear statement of principle on the issue of flexibility and innovation in service delivery, including a definition of the positive dimensions of flexibility that the service will embrace and encourage.	6	High						
13.2 Given the high value placed on flexibility and patient-centred care by both staff and services users, guidance should be developed to ensure staff have the confidence to explore adaptive, patient-centred care but do so safely and informed by evidence where available.	6	High						
13.3 To ensure lessons are learned and innovations are assessed and shared, processes should be established to facilitate rapid sharing and assessment of innovative practice between clinicians, with checks and balances to ensure safe care.	6	Medium						
13.4 This is likely to require a dedicated, clinician-led piece of work to develop guidance and to identify the processes by which innovation should be assessed and shared.	6	High						

Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
14. Recruitment and Retention of Staff								
14.1 Attention to certain key elements of the job offer is necessary to optimise ability to recruit and retain staff, in terms of both agreeing policy and communicating this to existing and prospective staff. These include;	7	High						
14.2 Clear articulation and communication of the ethos, mission, and expected impact of the service, in both recruitment and selection, and through in duction processes.	7	High						
14.3 Clarification of roles and responsibilities, particularly for new roles such as MHP and CAPs as well as relevant ARRS roles, to ensure a shared understanding of respective responsibilities and to support smooth collaboration across teams	7	Medium						
14.4 Work to ensure appropriate estates space for teams, potentially including a home-base to enable a degree of co-location and access to good quality spaces for meetings and consultations.	7	High						
14.5 Standardisation of employment conditions as far as possible given multiple employer organisations	7	Medium						
14.6 Clarification and articulation of provision of development and training opportunities.	7	Medium						

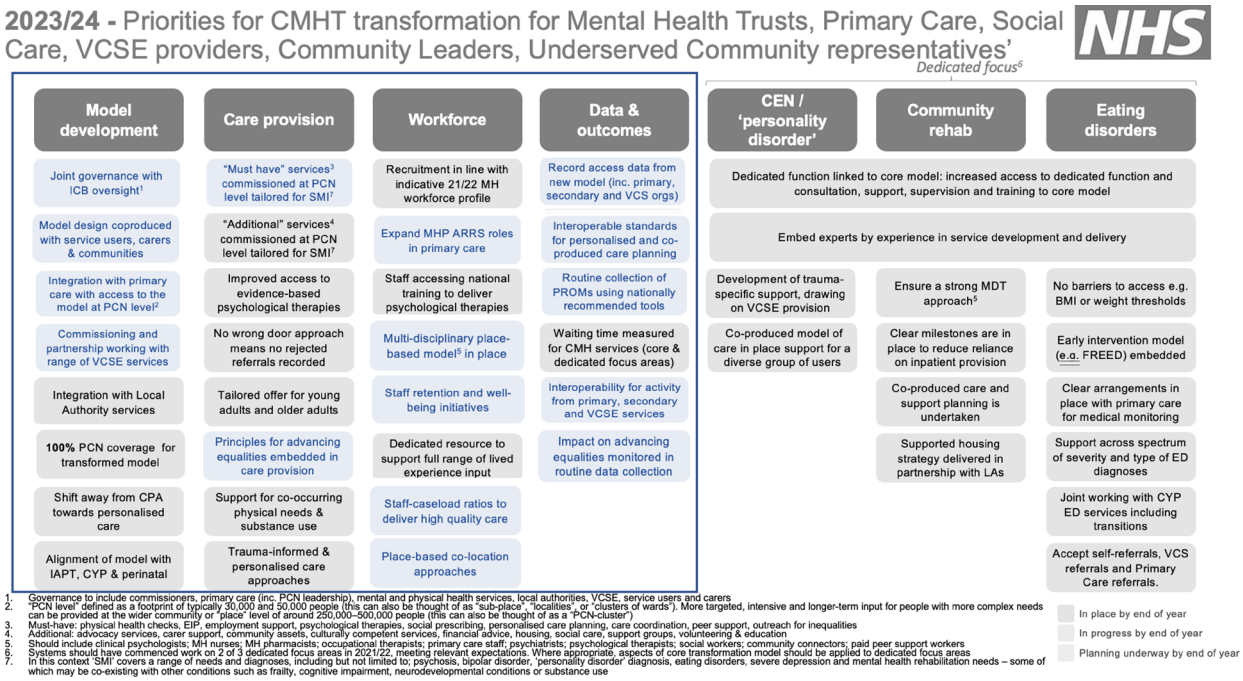
Recommendation	Source (Discussion)	Importance	Sheffield service/ rollout	PCN	Local providers/ commissioners	ICS	Clinical Networks	National
15. Measurement of impact								
15.1 A detailed project is needed to measure the impact of the Programme and current/ future Primary and Community Mental Health provision, potentially with an economic impact evaluation.	7	High						
15.2 To inform this work, a focused project would be necessary involving clinical leads, service leads, technical leads and commissioners to establish appropriate measures of impact, which may include patient reported measures and prescription rates for psychotropic medication or antidepressants.	7	High						
15.3 Equally, mechanisms should be put in place to routinely capture feedback from service users and from staff on a regular basis, and to demonstrate to users, staff and commissioners how the service learns from and acts upon this feedback.	7	High						
15.4 This work should however recognise the points made above about the scale of undermet need, the degree to which the Programme may have reached under-served groups, and the likely identification of need at an early stage through the Programme, all of which will affect the degree of impact measured.	7	Medium						
15.5 There would be substantial value in a broader commissioned piece of research drawing together learning on implementation and impact across the 12 CMHF early implementer sites at a national level.	7	Medium						
15.6 Similarly, given the number of new roles being introduced across mental health services, there is a need for a broader evaluation of the impact, challenges and benefits of these new roles implemented as part of the Community Mental Health Framework.	7	Medium						

The recommendations contained within the evaluation report were developed over the period March 2021-July 2022.

Independent to this evaluation, in March 2022, NHS England published a national roadmap for Community Mental Health Transformation. The roadmap spans the core community mental health offer, together with key focus areas of eating disorders, personality disorder and community rehabilitation.

The recommendations of this evaluation have therefore been mapped against the NHS England roadmap (**Figure 10: Priorities for CMHT Transformation,** below), to compare this evaluation's recommendations and the national strategy. Priorities which match this evaluation's Recommendations are highlighted in blue.

Figure 10: Priorities for CMHT Transformation



As can be seen, here is strong correlation between the recommendations in this evaluation and the NHS England roadmap which underlines the relevance of this evaluation to national guidance and support toolkits. The recommendations of this report are primarily focused upon the 'core community' offer as shown above.

Sheffield University Management School.

NHS Sheffield Clinical Commissioning Group

Learning from the Sheffield Primary and Community Mental Health Transformation Programme

The Community Mental Health Framework for Adults and Older Adults (CMHF) aims to deliver "integrated, personalised, place-based and well-coordinated care", by overcoming barriers between Mental health and physical health, betwen health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and between primary and secondary care.

The Sheffield Primary and Community Mental Health Transformation Programme is one of 12 early implementer sites testing the CMHF across England.

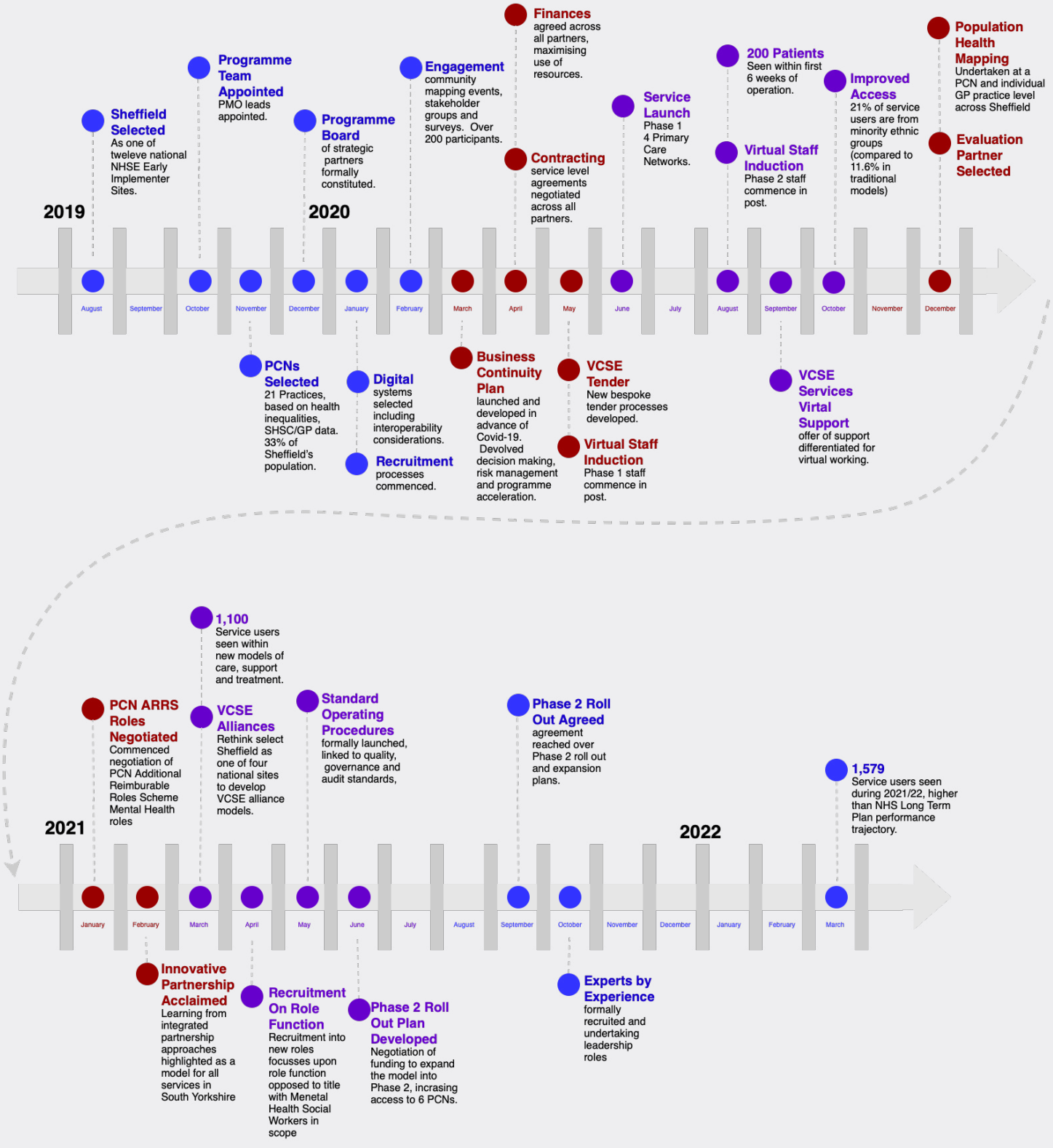
It was designed to offer care at neighbourhood level, built around new Primary Care Networks (PCNs), strengthening relationships with VCSE organisations, and addressing health inequalities across the city of Sheffield.

The Sheffield Programme was a partnership between NHS Sheffield Clinical Commissioning Group, Sheffield Health and Social Care NHS Foundation Trust (SHSC), Primary Care Sheffield (PCS), Sheffield City Council and Sheffield Mind, who commissioned 6 further VCSE partners. The Programme was delivered by 36 staff, some in new roles to be tested as part of workforce development. The leadership team included clinical leads and seconded representatives from other Programme partners.

The Sheffield Programme was initially tested across 4 PCNs in Sheffield, representing one third of the city's population and directly employed 36 staff. The PCNs sites were selected based on inequalities (socio-economic deprivation and ethnic minority populations) and degree of mental health need.

In total, 2,692 referrals were made into the Programme. The vast majority of the referrals were people of working age (18-65) with only 3.6% over 65; around 60% of people referred were female, and around 20% of those referred were of minority ethnic backgrounds.

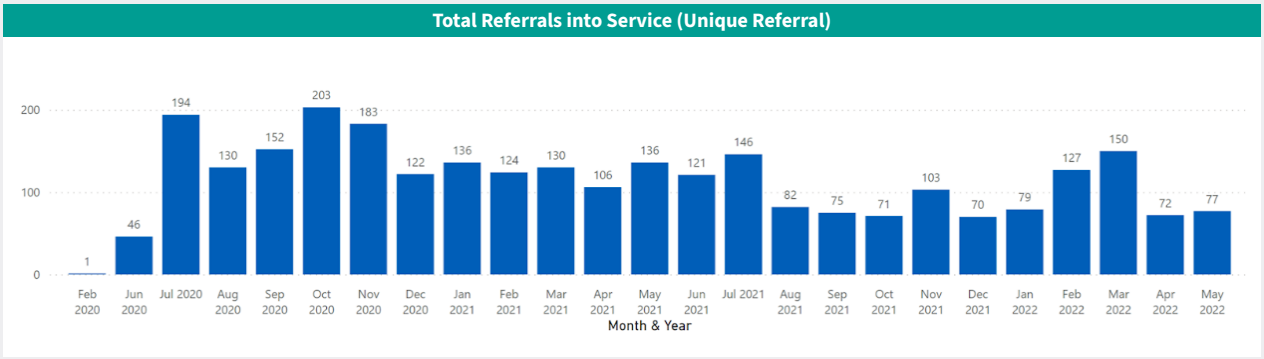
Programme Timeline 2019-2022



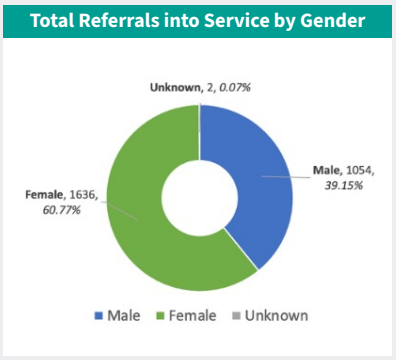
Key:

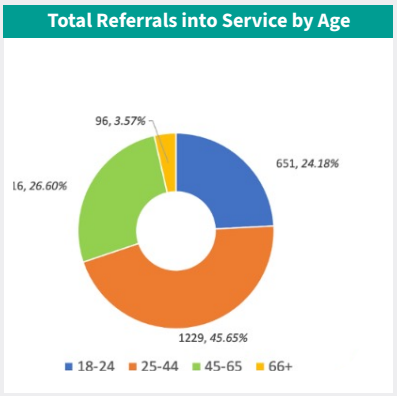
- Denotes non-Covid restrictions in effect
- Denotes times of UK National Covid lockdowns
- Denotes times where social distancing/tiering was in effect in relation to Covid

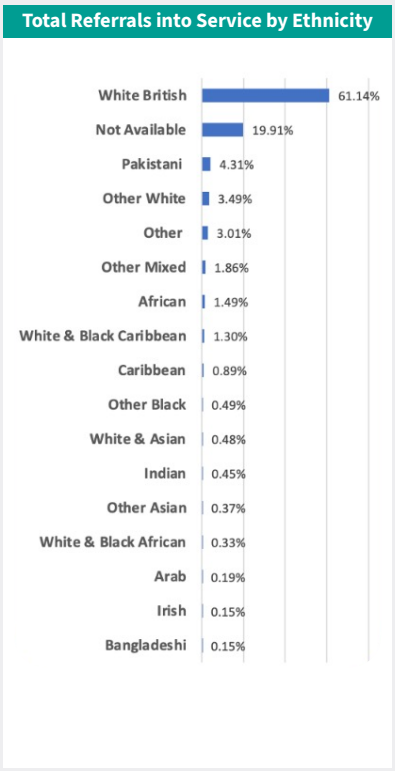
Referrals into Service by Month (16 Jun 2020-31 May 2022)



Total Referrals into Programme (by Gender, Age and Ethnicity) Jun 2020-May 2022







A team from the University of Sheffield were selected to evaluate the Sheffield Programme and spent 16 months studying the Programme. Their report focused on 7 key themes.

1. The Programme was successful in reaching marginalised groups and tailoring mental health care to match local need

We found the mental health care provided by the programme was tailored to local needs and was able to reach those in marginalised groups. This was enabled by three main factors: the programme being located within communities, the use of general practices and third sector organisations understanding of local needs, and the flexible way in which care was made accessible and delivered.

The good thing about working locally is, you obviously can focus on the particular concerns in each area, can't you, (…) and, hopefully, the team that can be built around that can be tailored to that need. (Team member)

There's a greater proportion of people from BAME backgrounds who are coming through the primary care transformation. I think it's because they're out there, they're connected with primary care, they're linked properly with local communities. (Trust lead)

2. The Programme benefitted from strong engagement with general practice

It was clear the Programme was strengthened by effective engagement with general practice. This meant the programme better reflected the mental health needs of patients and the pressures experienced in general practice seeking to support these patients.

What we've done is tapped into huge amounts of need that would never have breached the doors of mental health services, but because we're in GP practices,

and because people trust their GPs and they're used to going there for any sort of health need, and GPs have said, "well do you know, actually, we do have someone that you can probably talk to about that now", whereas before they might have said, "oh, no, I'm not going to the City Centre or whatever, I'm not seeing strangers who are going to ask me loads of questions", is we've tapped into a huge amount of unmet need in people who probably were really, really struggling, and who just never shouted up. (Team lead)

3. The Programme faced challenges managing the scale of demand

The scale and complexity of demand presented challenges. Balancing workload across teams was challenging, as was the need to ensure support reflected the local demographics in each PCN. The primary care model of 'GP patient lists' did not fit neatly with the refer-treat-discharge model of secondary care, which presented challenges in how caseloads were managed and how services users and staff understood referrals and discharges.

The nurses are under far too much pressure and it's not okay, it's not sustainable and it's not something that's going to keep them in the job a long time. The heart's there and in the right place but the workload is just completely unreasonable (Team member)

4. The Programme also faced some challenges integrating with secondary and specialist mental health services

The position of the programme separate to other services gave it greater focus. This also meant however that it could be more difficult positioning the Programme within secondary and specialist mental health services. For the programme to be better integrated, clarification and coordination of policies and processes with other providers, and engagement at a senior level is key.

There just needs to be more cohesion. As far as the patients are concerned, we're a mental health service. They don't care if we're primary or secondary care, they've got a need that needs to be satisfied. And pressure of caseloads and things like that is not an excuse not to give somebody care. (Team member)

5. The VCSE partners were Important to the Programme and had the potential to make a greater contribution in the future

The contribution of VCSE providers so far, and the potential for greater contribution, was widely recognised, although challenges and barriers to involvement were also identified. Some VCSE leads would prefer greater involvement in the design of Community Mental Health services and several felt that there was a need to strengthen relationships between VCSE providers and general practices.

It's only recently we've been allowed to go to the multidisciplinary meetings and we don't understand why that wasn't set up at the beginning of the project (…) we were queried and questioned about data protection and about sharing of information (…) which I challenged. Early days, people wouldn't even say the first name of the person and I said, "I can't do this". (Team member)

6. The effectiveness of the Programme relied on the flexibility and innovation of the staff in delivering care

Staff and service users felt strongly that flexibility in the delivery of care was vital in the Programme, with staff feeling empowered to develop innovative solutions to meet users needs, and service users feeling this flexibility valued their own autonomy and choices. Some staff felt this presented certain challenges to consistency of care and innovation should be balanced with evidence-based care.

And I just think that the way that we approach people and the culture that we've adopted within, especially the psychology part of the team, that's something that my clients have commented on to me and says that "I've been through CAMHS, I've talked to my GP of them, this and that, but this is the first time that I've really felt a service has properly listened to what I want and what I need". (Team member)

I think the programme is really, really helpful because not only have you got that support there, but you've got it when you need it, not like if you've got…wanted to see the GP and it's really hard to get appointments. (Service user)

7. All staff identified key challenges in rolling out the the service so that it could be sustainable at scale

As the service expands, sustainability was understood as likely to be a significant challenge. Four key areas were highlighted by staff: how to ensure the service was financially viable when rolled out; how to ensure good staff could be recruited and retained; how to embed the service within the wider health and care system; and how to get useful and appropriate evidence of the impact of the service.

For more information on the Programme, see the video at;
Youtube link: https://youtu.be/VCLcbHSMqWc

For more information on the evaluation, contact Prof. Damian Hodgson, evaluation lead at:
d.hodgson@sheffield.ac.uk

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of: Greg Fell

Date: 8th December 2022

Subject: Infant Mortality Strategy Refresh

Author of Report: Amanda Pickard

Summary:

Please note: This paper covers the topic of early child death including cot death. Whilst it contains no graphic or individual case detail, some readers may find the topic distressing.

The existing infant mortality strategy was written in 2014, shared with the CCG and STH and owned by SCC. We have continued to systematically reduce our infant mortality rates in Sheffield, exceeding the target set out in that strategy and bringing our rates below both the Yorkshire and Humber and England average.

However infant mortality is directly associated with poverty and the current cost-of-living crisis brings a direct threat to our positive progress.

This paper brings the situation to the Board's attention and sets out the approach we are taking to refreshing the strategy for the Board's consideration and opinion.

This approach includes reviewing the evidence relating to the 8 risk factors, engaging with partners, stakeholders and collating service users' feedback to inform a refreshed strategy.

Early recommendations are building on the trusted relationships families have with wider services and organisations, maximising opportunistic contacts to identify risks, and ensuring poverty becomes a theme that runs throughout our strategy as opposed to being a single risk factor in itself.

Questions for the Health and Wellbeing Board:

How can the Board help raise awareness of infant mortality strategy and help incorporate actions to address the risk factors in their sphere of influence.

We ask if the board can raise awareness of the risk to infant mortality progress in Sheffield due to the current cost-of-living and energy crisis.

Recommendations for the Health and Wellbeing Board:

To recognise the good progress on infant mortality since the inception of the last strategy

To acknowledge the risk to infant mortality progress in relation to the current cost-of-living crisis.

To raise awareness of infant mortality risk factors and incorporate actions to address these in their field of influence

To endorse the approach to the current Infant Mortality Strategy refresh

Background Papers:

2014 Infant Mortality Strategy available here

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

Ambition 1 - Every child achieves a level of development in their early year for the best start in life.

Ambition 4 - Everyone has access to a home that supports their health.

Who has contributed to this paper?

Amanda Pickard, Acting Public Health Principal SCC

Bethan Plant, Public Health Principal SCC

Julia Thompson, Public Health Principal SCC

Greg Fell, Director of Public Health SCC

Infant Mortality Strategy Refresh 2022

1.0 SUMMARY

1.1 The existing infant mortality strategy was written in 2014, owned by SCC and shared with the CCG and STH. It is broken down by 8 evidence-based themes relating to broadly preventable risk factors. Thanks to a whole-systems, multi-disciplinary approach we have consistently managed to reduce the infant mortality rate within Sheffield and are now below the England Yorkshire average.

1.2 Data on infant mortality rates show that we have also managed to reduce the inequality gap between the most affluent and most deprived groups in Sheffield since 2014.

1.3 Infant mortality is directly associated with poverty. The current situation with cost-of-living, the energy crisis and families moving into poverty for the first time means that the refresh of the strategy is needed in order to negate as far as possible any reverse in our positive progress to date.

1.4 The infant mortality strategy offers excellent value for money, focusing on partnership working, communication, training and awareness and has very little dedicated spend attached to it.

1.5 The approach to refreshing the strategy is to engage with stakeholders and understand families' experiences to identify improvements. We will also consult latest evidence and review our data.

1.6 Poverty needs to be a theme that runs throughout the strategy. We need to maximise contact points across SCC where trusted relationships with families have been established to impact on risk factors.

2.0 The Infant Mortality Strategy

2.1 Infant mortality is defined as the death of a baby between 24 weeks' gestation and under 1 year of age.

2.2 The current strategy for infant mortality was written in 2014 and was shared between the CCG, Sheffield Teaching Hospitals and owned by Sheffield City Council. Since this strategy was adopted, and particularly within the last 2 years, we have had a significant change in the context in which we (Sheffield City Council) are working and the climate in which our population is living with the effects of the cost-of-living crisis moving many of our families, pregnant people, and mothers into poverty.

2.3 Infant mortality is directly associated with poverty therefore the current context requires that the existing strategy is reviewed and updated to negate as far as possible any loss in progress Sheffield has made in this space.

2.4 Infant mortality rates are an important marker of the overall health of society and used as a key indicator by the UN and UNICEF as a proxy measure. Whilst largely

preventable, the risk factors are directly linked to poverty via maternal health and the wider social and environmental conditions. This means the most disadvantaged in society suffering the highest rates of infant death and subsequent impacts.

2.5 The impact of an infant death is devastating for parents, families, and the wider community. Coping with loss and bereavement significantly impacts on the individuals and family's health and wellbeing which in turn impacts on widening inequalities, and indirectly impacting economy and productivity.

Where are we now?

2.6 The current strategy has been successful in continuing to systematically reduce infant mortality rates since 2001 and accelerate those reductions to below the England average. We have exceeded the target set out in the 2014 strategy and this is with very little dedicated money attributed to the strategy.

2.7 In England infant mortality rates have fallen by 20%, from 4.9 per 1000 births in 2005 to 3.9 per 1000 births in 2020.

2.8 During the same period in Sheffield our infant mortality rate has fallen by 42% from 6.0 per 1000 live births to 3.5 per 1000 births, placing us below the England average rate. The most recent data currently equates to around 21 infant deaths per year in Sheffield.

2.9 We are now ranked 4th of 16 Local Authorities making up our CIPFA nearest neighbours and sit well below the Yorkshire and Humber average of 4.2 (2021) per 1000 births.

2.10 Infant death disproportionately affects the most disadvantaged in society, with most risk factors being linked directly or indirectly to deprivation. This gap in rates between the poorest and most affluent in Sheffield has also continued to narrow as our rates here have fallen but a significant inequality gap still remains.

2.11 Despite significant reductions in the past decade, rates in England (and Sheffield) remain high in comparison to many European counterparts and we still have much progress to make.

2.12 Whilst the England reduction in infant mortality rates have mostly stalled since 2014 in Sheffield we have continued to make progress in reducing our rates. We believe our continued progress is attributable to taking a multi-disciplinary and whole systems approach, like our recent tobacco strategies which have also seen good progress versus our 'nearest neighbours' and England rates.

2.13 The existing strategy is broken down by 8 themes that are recognised in evidence as key risk factors for infant mortality. This currently includes 1) maternal weight, 2) smoking in pregnancy, 3) safer sleep, 4) teenage conceptions, 5) housing and poverty, 6) consanguinity and genetic recessive conditions, 7) breast feeding and 8) early access to maternal care.

2.14 We have had notable success in several theme areas in the existing strategy, such as such as reductions in smoking in pregnancy which has fallen by 35% in 7 years, from

15.1% of mothers smoking at time of delivery (SATOD) in 2014 to 9.8% SATOD in 2021, just a touch above the England figure of 9.6%. The Yorkshire and Humber average rate still sits at 13.1%, again a testament to our whole systems and multidisciplinary approaches to both tobacco and infant mortality especially where little budget is attributed.

2.15 Breastfeeding is another area of notable success with Sheffield achieving 71.7% breast feeding initiation rates, higher than both the England (67.4%) and Yorkshire and Humber (56.4%) averages. Our maternity and health visiting services have also achieved UNICEF Breast Feeding Initiative Gold Status and intend to apply for Beacon Status soon.

2.16 Some themes need additional attention however particularly considering changes to services since COVID-19 and the imminent winter in combination with the energy and cost-of-living crisis. This includes safer sleep, poverty and housing, maternal weight, and teenage conception.

2.17 One example of how this worsening situation may impact directly on infant mortality rates is via safer sleep practices. As families reduce heating usage in their homes and make changes to keep warm there is a risk of parents increasing bedding, blankets and swaddling around their baby, or be tempted to sleep with their babies in their own beds to ensure warmth. These changes to sleeping practices significantly increase the risk of Sudden Infant Death Syndrome (SIDS), more commonly known as ‘cot death’.

2.18 This potential for a reversal in rates in a number of our risk factor areas means the urgency to refresh and double down our effort on infant mortality is pressing.

What is the approach for the infant mortality strategy refresh?

2.19 The overall approach to refreshing the strategy consists of reviewing the 8 themes according to;

- Recent national and academic evidence and should any additional risk factors be identified as a theme.

- Seeking professional’s and stakeholder’s views on current provision and services to highlight gaps or modification

- Seeking views of service users and target audiences to identify gaps and modification of existing services or missing services.

- Working collaboratively with partnerships and organisations who gather insight and learning eg.

- Healthwatch, Maternity Voices Partnership to inform services provision and training.

- Run multi-disciplinary stakeholder workshops on themes requiring more attention

- Review value for money of SCC commissioned projects and services relating to each them such as the community genetic literacy project.

- Review our data and intelligence in relation to each theme, aiming to fill gaps in knowledge and understanding. Examples include working with STH to improve data sharing on births to provide timely information on health inequities.

2.20 This approach is already yielding learning and early recommendations for the strategy. So far maternal weight, safer sleep and teenage conception along with early access to maternal care have been identified as areas for specific workshops and focused review.

2.21 Poverty also needs to be a theme that runs throughout the strategy as it's inherently linked to most risk factors identified within the strategy.

2.22 Access for some teenage conception services and support for teenage parents has also been identified as a particular issue. This also extends to young parents as many pre-existing services have now gone.

2.23 The additional funding for Start for Life/Family Hubs and the opportunity this offers to deliver more targeted prevention and early support particularly in deprived communities will be developed further as the programme of spend takes shape.

2.24 Additional work during the ante-natal and post-natal period to identify vulnerabilities during this early period working with parents to be and families to signpost them to community based support.

2.25 Very little spend is currently attached to infant mortality, outside of breast feeding, genetic recessive conditions and the volunteer Doula programme. We will review this spend to ensure best value for money in terms of impacts and outcomes.

2.26 A key finding developing is the role of contact points and trusted relationships that exist between mothers, families and SCC services. These contact points have the potential to impact on risk factors and we will recommend maximising training and awareness of infant mortality risk factors with multi-disciplinary contacts within the Council beyond those in a professional maternal and child health role such as midwifery and health visiting.

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

3.1 It should first be acknowledged that Sheffield has made great progress in reducing infant mortality rates with very limited budget as set out in the data presented above. However, a very real potential risk to that positive progress exists due to infant mortality being directly associated with poverty and the current situation for families and parents in terms of costs-of-living.

3.2 In order to make a difference we need to focus on areas of the 8 risk factors that have room for gains and improvements and will involve running more focused workshops on some of these factors and extending the range of partners involved in developing the strategy's action plans.

3.3 The approach to this is talking to stakeholders and assessing evidence to identify where improvements need and can be made. So far we intend to hold focused workshops on maternal weight, safer sleep and an additional area that will be identified, potentially poverty, early access to maternal care or teenage conception.

3.4 One early finding of this refresh approach is the importance of the trusted relationship over the professional relationship as well as opportunistic contacts with at-risk families, parents or babies. For example some women and families, and particularly those moving into poverty for the first time may feel stigma or shame about their circumstances and not reveal the full extent of problems to a professional such as a midwife or health visitor. They may however be more likely to disclose their situation to a nursery setting staff member, volunteer doula or community group or faith group leader.

3.5 Opportunities also exist with those staff and professionals who may be entering households for other reasons, such as housing officers, maintenance staff or wider organisations such as VCF, Police and Fire and Rescue.

3.6 Seeking opportunities to engage with, train and upskill these groups in infant mortality risk factors will bring additional opportunities to identify and intervene early with at-risk families or individuals.

4.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

4.1 As infant mortality is inherently associated with poverty is has a direct impact on health inequalities.

4.2 The refreshed strategy will recommend focusing on areas with the greatest gains to make. This will be a combination of areas with the greatest rates of infant mortality, communities and disadvantaged population groups experiencing the greatest risk factors and also be informed by wider SCC reactive poverty work taking place to forecast those communities most at risk of cost-of-living impacts.

5.0 QUESTIONS FOR THE BOARD

5.1 How can the board help raise awareness of infant mortality strategy and actions to address the risk factors in their sphere of influence.

5.2 We ask if the board can raise awareness of the risk to infant mortality progress in Sheffield due to the current cost-of-living and energy crisis.

5.3 How will the board take on some of the actions raised within this paper?

6.0 RECOMMENDATIONS

Our initial developing recommendations include the following;

- To produce a refreshed Infant Mortality Strategy for Spring 2023

- That the strategy remains anchored within and owned by SCC due to the role of wider determinants in infant mortality.
- Engage with the ICB and STH to adopt the strategy in relation to commissioned maternity services
- Engage with the ICB to identify system improvements which could help to reduce risks (eg better data sharing to identify vulnerable parents and respond to their needs) and other activity which will help to accelerate local progress work such as SY funded smoking in pregnancy incentive schemes.
- To build upon the success of the current model but plug gaps identified as part of the process.
- Set out intention for changes in commissioning according to value for money and influence those services commissioned by others.
- Poverty to be highlighted as thread that runs throughout the strategy
- Maximise training and awareness of infant mortality risk factors with multi-disciplinary contacts within the Council - trusted individuals and relationships beyond those in a professional role such as midwifery and health visiting, for example housing and welfare support teams.
- Engage with H&WB Board partner organisations to identify and maximise contact points and training opportunities for infant mortality risks. E.g. Police, early years settings, multi academy trusts, VCF etc.
- Implement and act on recommendations identified as part of multi-disciplinary stakeholder theme workshops
- Improve data including ethnicity data, births data and information received from the Child Death Overview Panel in order to further inform health inequities.
- Explore more options and approaches to maternal weight, safer sleep and other risk-factors with improvements to gain.

HWBB Forward Plan - Public Meetings

Month	Type	Topics	Topic Leads	Ambition	Time	Additional invitees and notes	Chair
30th March 2023	Public	Healthwatch Update	Judy Robinson		00:10		TBC
		Annual Report - look back and impact report			00:20		
		Physical Activity & Leisure			00:20		
		Health & Wellbeing Outcomes Framework	Sandie Buchan	HI	00:10		
		Climate Change and health conference report	Mark Whitworth/Victoria Penman	HI	00:20		
		Food Strategy	Jess Wilson	HI	00:20		
		Wellbeing data	Greg Fell				
		Violence Reduction Unit	Benn Kemp		00:20		
		BCF Update	Martin Smith		00:10		
		Forward Plan	Greg Fell		00:05		
					02:15		
29th June 2023	Public	Healthwatch Update	Judy Robinson		00:10	Potential for this meeting to be themed around mental health and wellbeing	TBC
		Health Protection	Ruth Granger		00:10		
		BCF Update	Joe Horobin		00:10		
		Forward Plan	Greg Fell		00:05		
					00:35		
28th September 2023	Public	Healthwatch Update	Judy Robinson		00:10		TBC
			Ruth Granger		00:10		
		BCF Update	Joe Horobin		00:10		
		Forward Plan	Greg Fell		00:05		
					00:35		
01/12/2023	Public	Healthwatch Update	Judy Robinson		00:10		TBC
		Health Protection	Ruth Granger		00:10		
		BCF Update	Joe Horobin		00:10		
		Forward Plan	Greg Fell		00:05		
					00:35		

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

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 29 September 2022

PRESENT: Councillor Angela Argenzio (SCC) (Chair)
Sandie Buchan (ICB)
Alexis Chappell (SCC)
Councillor Douglas Johnson (SCC)
Greg Fell (Sheffield City Council)
Judy Robinson (Healthwatch)
Sarah Jenkins (Sheffield Teaching Hospitals NHS Foundation Trust)
Kathryn Robertshaw (HCP)
David Warwicker
Joe Rennie (Sheffield Hallam University)
Helen Sims (Voluntary Action Sheffield)
Leigh Sorsbie (ICB)
Martin Smith (ICB)
Daniel Spicer (SCC)
Kay Kirk (SCC)
Fiona Martinez (SCC)

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from David Black, Ruth Brown, Andrew Jones, Emma Latimer, Dr Zak McMurray, Sharon Mays, Councillor Mick Rooney, Councillor Dawn Dale, James Henderson, Joe Horobin, Councillor George Lindars-Hammond and Rob Sykes,

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest made.

3. PUBLIC QUESTIONS

3.1 No public questions were received.

4. HEALTHWATCH UPDATE

4.1 Judy Robinson was in attendance to provide an update on Healthwatch.

4.2 She stated issues such as long covid, dentistry and accessibility due to an increase in digital systems within healthcare.

4.3 Greg Fell stated that he felt digital solutions did not necessarily lead to better outcomes.

5. RACE EQUALITY COMMISSION

5.1 Greg Fell briefing introduced the paper. He stated that the purpose of the paper

was to define the role of the board within the wider city strategy. Adele Robinson, Equalities Engagement Officer, stated she had been supporting the Race Equality Commission for four years. She said that racism impacted on the health and wellbeing of many communities. She stated that she felt whole city action was essential.

5.2 Judy Robinson stated she supported the ideas and findings of the report. She asked whether there was detail available around specific issues, such as the experience of black women accessing maternity services. Shahida Siddique, Chief Executive of Faith Star and commissioner on the Race Equality Commission, responded to the question. She stated that there had been aspects of research carried out around access to maternity services. She said there was work which needed to be done to join up these efforts.

5.3 Councillor Johnson asked whether work being carried out by different organisations was being reviewed as a whole. Shahida Siddique agreed that this work should be carried out, and she added that timelines and deadlines be given to this work.

5.4 Greg Fell suggested that a longer discussion take place on the item to create actions. He agreed to organise this event. Councillor Argenzio asked that a timeline be provided to ensure the work would be carried out. She suggested that a timeline also be created to increase diversity on the board. Dan Spicer stated this issue could be raised again during the discussion of the Terms of Reference.

6. LEARNING FROM COMMUNITY ENGAGEMENT DURING THE COVID-19 PANDEMIC

6.1 Greg Fell presented a report which reflected on the learning from community engagement during the COVID-19 pandemic. Dan Spicer provided context to the report for the board. He stated that trust and understanding between the public and health services had been addressed in the report.

6.2 Sarah Hepworth, Public Health Principal, gave a presentation on the work carried out. Colin Havard, Community Development Coordinator, stated that the aim was to move the project to an ongoing programme.

6.3 Shahida Siddique, Chief Executive spoke about initial responses to COVID within BAME communities.

6.4 Sandie Buchan encouraged a sustainable, longer-term model of engagement. Dan Spicer agreed that every public service had an interest in prioritising engagement.

6.5 Greg Fell stated that there were resourcing issues and ‘ways of working’ issues to address. He said the learning around covering areas which did not routinely access services could assist primary care.

6.6 Alexis Chappell thanked authors for the report and endorsed and supported the recommendations.

6.7 AGREED that the Health and Wellbeing Board:

- Agree that trusting relationships based on open engagement are a critical aspect of good public service delivery
- Note the impact and value of the engagement approaches developed through COVID, and agree that this should be sustained and developed for the future, with capacity identified to do this
- Sponsor a joint workshop with Sheffield City Partnership Board, and other partnerships that may be interested, to consider concrete next steps to learn from this and other work to improve engagement between public services and citizens in Sheffield
- Revisit the previously agreed commitment to recruiting an Engagement Coordinator, considering whether this could apply across partnerships in light of the outcome of that workshop
- Sponsor the development of a proposition to put to potential funding partners to consider the links between effective engagement and health inequalities

7. COMPASSIONATE CITY

7.1 Greg Fell gave a history of the Compassionate City report, which responded to ambition 9 of the Health and Wellbeing Board's ambitions. He stated this work began three years ago but added that it had been delayed by the COVID-19 pandemic. He said the governance was complex; however, he stayed a good deal of progress had taken place.

7.2 Dr Sam Kyerematenq, Medical Director at St Luke's Hospice and Nick Dayton, Programme Manager for Compassionate Sheffield provided an overview of the report.

7.3 AGREED that the Health and Wellbeing Board:

- asks the Sheffield Joint Commissioning Committee if they will take this work forward as part of Sheffield's programme of integrated commissioning.

8. HOUSING AND HEATH CONFERENCE REPORT

8.1 Greg Fell stated that this report directly linked to ambition 5 of the Health and Wellbeing Board's ambitions. He provided feedback from a half day workshop on Housing and Health, and stated that crossovers between health and housing had been noted during the workshop.

8.2 AGREED that the Health and Wellbeing Board:

- Note the report of the Housing, Health and Wellbeing Summit and endorse its recommendations for next steps

- Provide feedback on the approach and operation of the Summit to feed into future work
- Agree to establish a time-limited task and finish group to identify appropriate resource to drive progress in this area
- Agree to receive a report from this group setting out how a programme of work based on (not limited to) the recommendations in the summary report will be established

9. BOARD REVIEW AND TERMS OF REFERENCE UPDATE

9.1 Greg Fell presented the Board Review and Terms of Reference Update. He stated the Terms of Reference had been change. He added that the Board membership had been considered.

9.2 Dan Spicer referenced diversity within the board and stated that though it was recognised that some of the Board's membership was set diversity would be addressed through a specific recruitment to those posts which were not set.

9.3 AGREED that the Health and Wellbeing Board:

- Agree the proposed changes to the Health and Wellbeing Board Terms of Reference; and
- Agree to formally propose these changes to Full Council at the next available opportunity, for incorporation into the Council's Constitution.

10. JOINT HEALTH AND WELLBEING STRATEGY REVIEW

10.1 Professor Chris Gibbons presented the Joint Health and Wellbeing Strategy Review.

10.2 AGREED that the Health and Wellbeing Board:

- note the report alongside other, complementary work on the Board and its Terms of Reference

11. JOINT STRATEGIC NEEDS ASSESSMENT AND PHARMACEUTICAL NEEDS ASSESSMENT

11.1 Professor Gibbons provided a verbal update on the Joint Strategic Needs Assessment (JSNA) and Pharmaceutical Needs Assessment (PNA).

11.2 He stated that the JSNA was a live document. He stated that resource restraints had meant a community based PNA had not been carried out. He said that due to changes in the NHS structure future PNAs would be carried out differently.

12. INEGRATED CARE SYSTEM UPDATE

12.1 Greg Fell presented the Integrated Care System Update item. He stated that the South Yorkshire Integrated Care Partnership (ICP) had now been established and had met once. He stated that the Health and Wellbeing Board had been asked to nominate 5 members.

12.2 Councillor Argenzio asked that the Board consider who these members might be.

12.3 Councillor Argenzio agreed that this be confirmed by the Steering Group.

13. BETTER CARE FUND UPDATE

13.1 Greg Fell gave an update on the Better Care Fund and introduced Martin Smith – Manager of the Better Care Plan.

13.2 Martin Smith stated the Better Care Fund goals had been achieved and outlined the Fund's future goals.

14. FORWARD PLAN

14.1 Councillor Argenzio welcomed suggestions for the Health and Wellbeing Board Forward Plan.

15. MINUTES OF THE PREVIOUS MEETING

15.1 AGREED: that the minutes of the meeting held on the 23rd June 2022 were a true and accurate record.

16. DATE AND TIME OF NEXT MEETING

16.1 The next meeting of Sheffield Health and Wellbeing Board would be held on Thursday 8th December at 9.30am.

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