Report to Healthier Communities & Adult Social Care Scrutiny Committee 14th November 2018

Subject: Prevention – Single Item Agenda

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Introduction:

Prevention has been a key theme running through many of the issues the Healthier Communities and Adult Social Care Scrutiny Committee has considered this year. We've heard lots about the importance of working in a more preventive way and the aim of this single item agenda meeting is to give the Scrutiny Committee an opportunity to engage with the prevention agenda in detail.

The purpose of the session is to give the Committee:

- an overview of the Council's strategic approach to prevention
- an understanding of how this is working in practice through some of the prevention projects going on across the city
- an opportunity to hear from a range of individuals and organisation about their experiences and views on prevention.

In addition, members of the Committee have had an opportunity to visit prevention projects in advance of the meeting, to experience first-hand the kind of work that is going on.

Following the discussion, the Committee may wish to make recommendations to decision makers, or identify any issues for further investigation.

Type of item:

Reviewing of existing policy	**x**
Informing the development of new policy	**x**

The Scrutiny Committee is being asked to:
Consider and discuss our approach to prevention and prevention activity and identify any areas where further investigation is required, or any comments and recommendations to put to decision makers.

Prevention – Single Item Agenda

1. Format of the Meeting

1.1 The meeting will focus on Q&A and discussion and although there will be brief powerpoint presentations to introduce the issues and provide context. An outline of the session is provided below. Please note timings are approximate:

Strategic Overview (4pm-4.45pm)

How are the Council and Partners approaching prevention?

- Greg Fell, Director of Public Health
- Nicola Shearstone, Head of Commissioning for Prevention and Early Help, Sheffield City Council
- Nicki Doherty, Director of Delivery, Care Outside of Hospital, NHS Sheffield CCG

What's happening on the Ground? (4.45pm-5.45pm)

Understanding the kind of work going on across the City, and how services are working in a preventive way. Understanding what's working well, what could be improved.

An introduction to Social Prescribing
Emma Dickinson, Commissioning Manager, SCC

People Keeping Well
Emma Dickinson, Commissioning Manager SCC
Bluebell Smith, Health and Wellbeing Lead, Voluntary Action Sheffield

Dementia Friendly
Kath Horner, Sheffield Dementia Action Alliance

Housing+
Bev Mullooly, Head of Neighbourhood Services, SCC

Community Support Workers and Lunch Clubs
Elaine Goddard, Health Improvement Principal, SCC

Mental Health
Jim Millns, Deputy Director of Mental Health Transformation, NHS Sheffield CCG

Access and Prevention
Sara Storey, Head of Access and Prevention, SCC

View from the Voluntary and Community Sector (5.45pm – 6.15pm) An opportunity to hear from organisations working in Sheffield on their views and experiences of prevention work – what's working well, and how we could improve. Maddy Desforges, Chief Executive, Voluntary Action Sheffield Debbie Matthews, Chief Executive, Manor Castle Development Trust Matt Dean, Chief Executive, Zest Ian Drayton, Partnership Manager, SOAR
Conclusions and Recommendations (6.15pm-6.45pm)

2. Background information

2.1 To help inform the discussion, there are some background documents and case studies attached that provide additional context on some of the work that you'll be hearing about:

What is Social Prescribing?

People Keeping Well Briefing Note

Housing Plus Update and Case Study

Lunch Clubs Briefing Note and Annual Report

Community Support Worker Case Study – It's the little things that can have the big impact.

Access and Prevention:

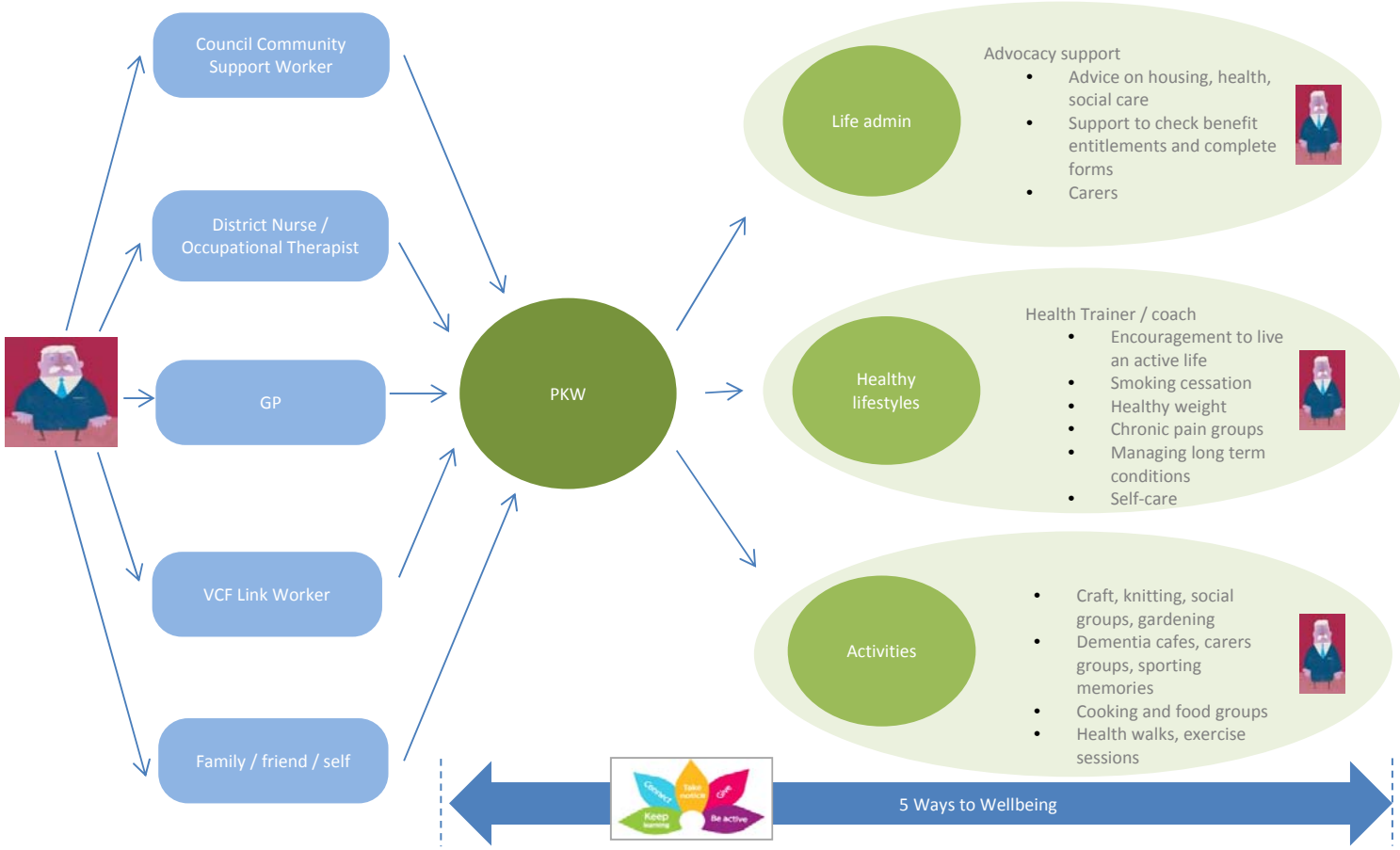
- Update on increasing the shift to Prevention
- First Local
- Focussed Reablement Report
- Home First Summary
- Too long a lie in Summary

3. Recommendation

3.1 Consider and discuss our approach to prevention and prevention activity and identify any areas where further investigation is required, or any comments and recommendations to put to decision makers.

What is Social Prescribing?

'Social prescribing – can be referred to as community referral, it is a means of council, health, other organisations (or self – referrals) linking people to a range of local, non-clinical services to improve health and wellbeing'



Social Determinants of Health

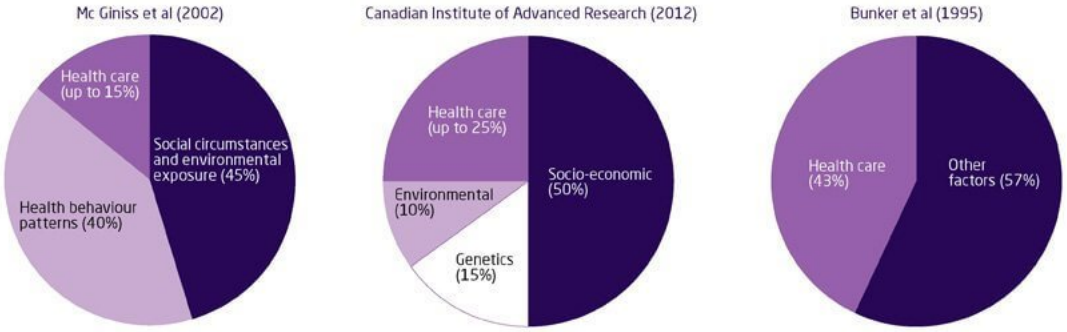
https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

(Diagrams are from the Kings Fund Broader determinants of health)

Health is dependent on genes, lifestyles, environment and health care. Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment

Healthcare at the most contributes to only 40% of people's health and lifestyle and social factors have a much greater impact on health

Several studies have estimated how the broader determinants of health impact on our health. The three pie charts below depict the main findings of three research papers



People Keeping Well – Stories

Names changed

Story 1:

John is in his fifties and has mental health issues. He was referred to the social prescribing service at Zest by his GP, for support for his health and welfare. On meeting, he was very agitated and had tried to arrange an earlier appointment as he was suffering from severe anxiety due to his debt worries. The conversation revealed that the Council believed he had been overpaid in Housing and Council Tax benefits which totalled a debt of approximately £3,200. He had been advised that he must start paying £400 per month, an amount he could not afford. His anxiety means he is uncomfortable around other people. The Link Worker arranged an early appointment with Langsett Advice Centre on his behalf. The Advisor went through his paperwork discovered that there was a miscalculation and he owed £200, but was also owed £1995 in back-dated ESA. The Advisor is working to get the £200 written off and is due a credit of £1995 and will also be receiving increased benefits. He is now able to pay off a small debt to his neighbour and feels like a weight has been lifted from his shoulders.

Story 2:

Mary is a single parent in her 40s, with an 11 year old son. She pushed a note through the door of the Terminus Initiative one freezing cold Monday morning in January explaining, like many people, following the heavy snow and plunging temperatures she had a frozen condenser pipe and had no central heating in her flat. She had had little joy from her landlord and had to resort to an electric heater in the freezing conditions which had eaten all her fuel credit. She had no savings and could not pay a £10 unexpected extra payment; consequently she and her son had spent the weekend with no heating. The Grace Foodbank had referred her to the Terminus who provided a small top up for her electricity and gas.

Story 3:

Bob is a 64 and left his job because of family bereavement. He was not taking antidepressants but acknowledged, with the GP, that he does need help. He was referred to the Health Trainer because he was lonely after death of his wife and mother within a year. After the initial conversation, Bob was referred to the Food Growing group. This group uses an outdoor space which has been landscaped and now grows organic fruit and vegetables. Since attending the group once a week, his confidence has grown. He now takes a leading role in woodwork, making and fixing furniture and equipment for the site. He supports not only other volunteers, but also a team of young offenders who use the site through a partnership with the probation service. It is clear to see how his confidence has grown, he feels a sense of purpose and not lonely anymore

People Keeping Well – the impact of group sessions

Visit: Bounce and Burn (mini-trampoline exercise session)

PKW Partner: Manor & Castle Development Trust (MCDT)

What happened:

The large hall was set out with 26 mini-trampolines. Many of the 21 attendees (men and women from a range of backgrounds) arrived early and were chatting to each other, or even starting to warm up and gently bounce on the small circular trampolines. Three newcomers were given an introduction, demonstration and safety instructions, which included 'smile!' The first part of the session to music included bouncing, marching, side steps, kicks etc on the trampolines, with accompanying arm movements. It is low-impact so participants can keep going for longer than if they were on the floor. This energetic section was followed by a section using the trampolines to do push-ups and planks, and then lying on the trampolines to do sit-ups.

The difference it has made

- "I've been depressed for a long time; it's under control now but exercise makes it better"
- "I came back to exercising even after having a hysterectomy"
- "I don't speak very good English but I have been in Sheffield for 6 years so now this will help me"
- "I used to come when I wasn't working. Now I bring a client with me who has autism. It's good because we can each have a trampoline and but my client (who doesn't speak) can do their own thing yet be part of a big group"
- "I live nearby and I like that it's *my* local community here – local people doing something positive"
- "It's something different"
- "I really enjoy it"
- "I was really just coming today to watch so I got myself a cup of tea, but I've ended up joining in!"
- "It's one of the best kind of exercises – it's good for the joints"
- "This is *my* day – for the rest of the week I help my elderly mum and babysit for others"
- "I've lost 2 dress sizes"
- "My mum and dad died within 8 months of each other and I was all alone. I was then under the Doctor for my mental health. After becoming a Health Champion and coming to these groups I now have constant support from the friends I've made – having a support network makes a world of difference"
- "I was sceptical at first, but I've lost inches"
- "It's 4 bus stops for me to get here. I used to come on the bus but now I walk here and walk back – even if I have to crawl back!"
- "You can tell the difference every week – if I don't come I feel very lethargic"
- "I'd be very upset if I couldn't come"
- "Doing fitness has got me out of my shell and helped me with my depression"

Visit: Craft Group

PKW Partner: Darnall Wellbeing

What happened: The group meets in a community room at Darnall Primary Care Centre. It is mostly volunteer-led and was started through Health Champions. Attendees pay £1 each week which goes towards materials and refreshments. A variety of craft resources were available on the table, but most of the participants had brought their own craft that week as it was a 'do your own' week.

Crafts included on the day of the visit included knitting beanie hats for premature babies at the Children's Hospital, using gel pens on a mindfulness colouring book, sketching, knitting gloves, cross stitch and knitting a curtain-tie for a friend. Examples of other recent crafts had also been brought – knitted twiddle-muffs for people with dementia, knitted poppies for the British Legion, matching knitted bears for stillborn babies and their parents, dreamcatchers, mittens for a Handsworth children's group, a fluffy toy and a large patchwork knitted blanket to which everyone (who could knit!) had contributed since the start of the group. There was a friendly and convivial atmosphere in the room, with plenty of laughter and jokes.

The difference it has made:

- "It's a safe place to unburden to a friend in confidence, even in a busy room"
- "It's good for the 'young elderly' who aren't totally past it or ready for the reminiscence groups"
- "Lots of the attendees have been carers so are in the same position and can share experiences"
- "It's good that groups like this exist to take into account people's change in circumstances"
- "Mentally the company is good"
- "It's about speaking to others as well as doing something useful"
- "I've learnt new skills"
- "People here have lost their husbands so they like to get out and socialise as well as do craft"
- "I like that the volunteer teaches people to knit, even if some are not very good at it"

Visit: Eat Well Course

PKW Partner: Manor and Castle Development Trust

What happened: 5 people completed a 6 week course at the Arbourthorne Centre. A few others were ill for the final session. The session included goal-setting, charting activity levels, a discussion around emotional eating, a weekly weigh-in, a quiz on healthy eating and signposting to other services. The second half of the session was a practical cooking lesson. The group followed recipes to make Green Tai Chicken Curry with wholegrain rice, and banana and raisin flapjacks (with honey rather than golden syrup). These included many ingredients that the participants had never tried before. Collectively the group had lost 20lbs and 44 inches over the 6 week course.

The difference it has made:

- "I'm getting there with portion sizes – I've asked for a new dinner set and I'm going to choose one with smaller plates. I'm getting my mother-in-law to buy it for me so that my husband can't complain!"
- "My GP doesn't need to increase my beta blockers for high blood pressure now, because of the progress I've made"
- "I wouldn't have learnt how to look at food labels without this course"
- "When I go walking I think where I am on the exercise scale and try to walk harder and with purpose"
- "I felt right energised after having a 'green monster' smoothie with spinach, pineapple and banana"
- "Last night I tried a 5% fat mince with peas, carrots and a potato/sweet potato mix. My son doesn't like sweet potato and asked why it was orange – I told him carrot juice had leaked into the potato mash and so he ate it!"
- "I've been making my own meals. I realised it doesn't have to take all day to cook"
- "Everyone should eat more vegetables"
- "I've not even run for a bus in the last 10 years but this week I did some jogging!"
- "I've not been to KFC or McDonalds at all this week"

Visit: Chair-based exercise at Spa View

PKW Partner: Woodhouse & District Community Forum

What happened: 13 people aged over 50 took part in this weekly session, which was accompanied by a range of music from the 1960's. Each person paid £2. The exercises worked from the feet up to the face, and included the use of balls, resistance bands and weights. The chair-based movements covered actions as diverse as ski-ing, canoeing, riding a bike, 'the Charlie Chaplin', playing the bagpipes and waving like the Queen! There was also a relaxation section, facial exercises and even a sing-along. At the end of the hour-long session the participants gathered together for refreshments and a chat.

The difference it has made:

- "I'm 84 and live on my own but I like to keep going and get out and about to this"
- "I definitely have more movement now"
- "We were missed when we didn't come last week – people asked where we were"
- "The instructor is very good – and he's almost our age! He makes it fun"
- "We have quite a few laughs"
- "It's not as easy as it looks. It feels like you've had a good workout"
- "It keeps you supple"
- "It has brought my blood pressure down"
- "You'd get fed up in the house – they're long days at the moment"
- "It's good for the body, soul and spirit"
- "I've got Labyrinthitis at the moment, but I thought coming here was better than sitting at home"

- "Yesterday evening I went to a show at City Hall with my daughter. My legs started to stiffen up so I did some of the feet and ankle exercises in my chair and it really helped with my circulation"
- "I often don't feel like coming but afterwards I'm always glad I've come"

Visit: Wednesday Shiregreen Social Group

PKW Partners: SOAR and Sanctuary Housing

What happened: The group meets weekly in Shiregreen Neighbourhood Centre – once a fortnight it is run by volunteers and on the alternate weeks it is run by a SOAR staff members with help from volunteers. The attendees were mostly retired but some were as young as 30. There were 9 men, 2 ladies and 6 volunteers who socialised around 2 large tables, and took part in activities such as dominos, cards, newspaper-reading, card-making hand massage and table-tennis. Those who come in the morning pay 50p for a cuppa and a piece of homemade cake (made by a volunteer). Those who stay for lunch (cooked on the premises by the volunteers) pay £1. There was a raffle to raise money for evenings out for the group, for example at bowling, the dogs, or the casino

The difference it has made to attendees:

- "It keeps me active"
- "I'd be lost without this group"
- "I'm a quiet person but this group makes me converse more"
- "It has brought me out of my shell"
- "I'm in my mid-80s and have lost most of my family but this keeps me going"
- "When you're retired you miss the chat and the ideas from colleagues of what to do and places to go and how people live their lives, so coming here helps"

The difference it has made to volunteers:

- "I've realised I used to be a selfish person, but this has opened my eyes and I want to help people"
- "I feel proud of encouraging people – that's an achievement for me"
- "Without this I wouldn't have anyone to talk to or have a routine"
- "It has given me confidence"
- "I was destroyed, but now I'm not"
- "It's like a second network, people are there if they need help; as volunteers we're linked on Facebook, we go on trips together, we support at other groups"
- "It has been a lifesaver"
- "I've made loads of new friends"
- "It gives me purpose – my condition washes me out so it would be easier to stay in bed and not go out"
- "I was isolated after an accident at work and had lost confidence – without this group I'd have gone rapidly downhill"
- "I was unable to work for 16 years due to a number of health conditions, but I can do this"

Briefing Note

What is 'People Keeping Well'?

'People Keeping Well in their Community' is community-based prevention activity that can help to prevent and delay people needing to access health and social care services. It is one of Sheffield's approaches to Social Prescribing.

It's about resolving social issues and connecting people to **'things that matter to them'** locally which will reduce the risk and/or decline of poor health and wellbeing, so that people:

- are more connected – they have made friends and have a peer network for support
- are more resilient – they have coping mechanisms to deal with 'life issues/crisis' better
- know where to go to get timely help – for example to manage long term conditions

People Keeping Well

Within PKW there are 2 distinct strands:

1. PKW Community Partnerships
   - voluntary community organisations
   - Health Trainers and community wellbeing activities
   - Make a referral: www.sheffielddirectory.org.uk/pkw*
     *Webpage currently under construction. See p4.

2. Community Support Workers
   - approx 19 Council staff
   - co-located in GP practices
   - Make a referral: www.sheffield.gov.uk/csw

Making Every Contact Count (MECC)

People Keeping Well follows the principles of MECC – using the thousands of day-to-day interactions that organisations and individuals have with other people every day to:

- Hold opportunistic healthy lifestyle conversations
- Support people in making positive changes to their physical and mental health and wellbeing

Contact us to sign up to our PKW Weekly Email Update

The PKW Team

Emma Dickinson
Commissioning Manager

Amy Claridge
Commissioning Officer

Lee Teasdale-Smith
Commissioning Officer (Carers)

Amelia Stockdale
Assistant Commissioning Officer

Zahira Begum
Assistant Commissioning Officer

Contact us:
pkw@sheffield.gov.uk

PKW Community Partnerships

People Keeping Well is sometimes known as Social Prescribing or community referral. It is all about 'making every contact count' and connecting people to a range of local non-medical services to improve health and wellbeing.

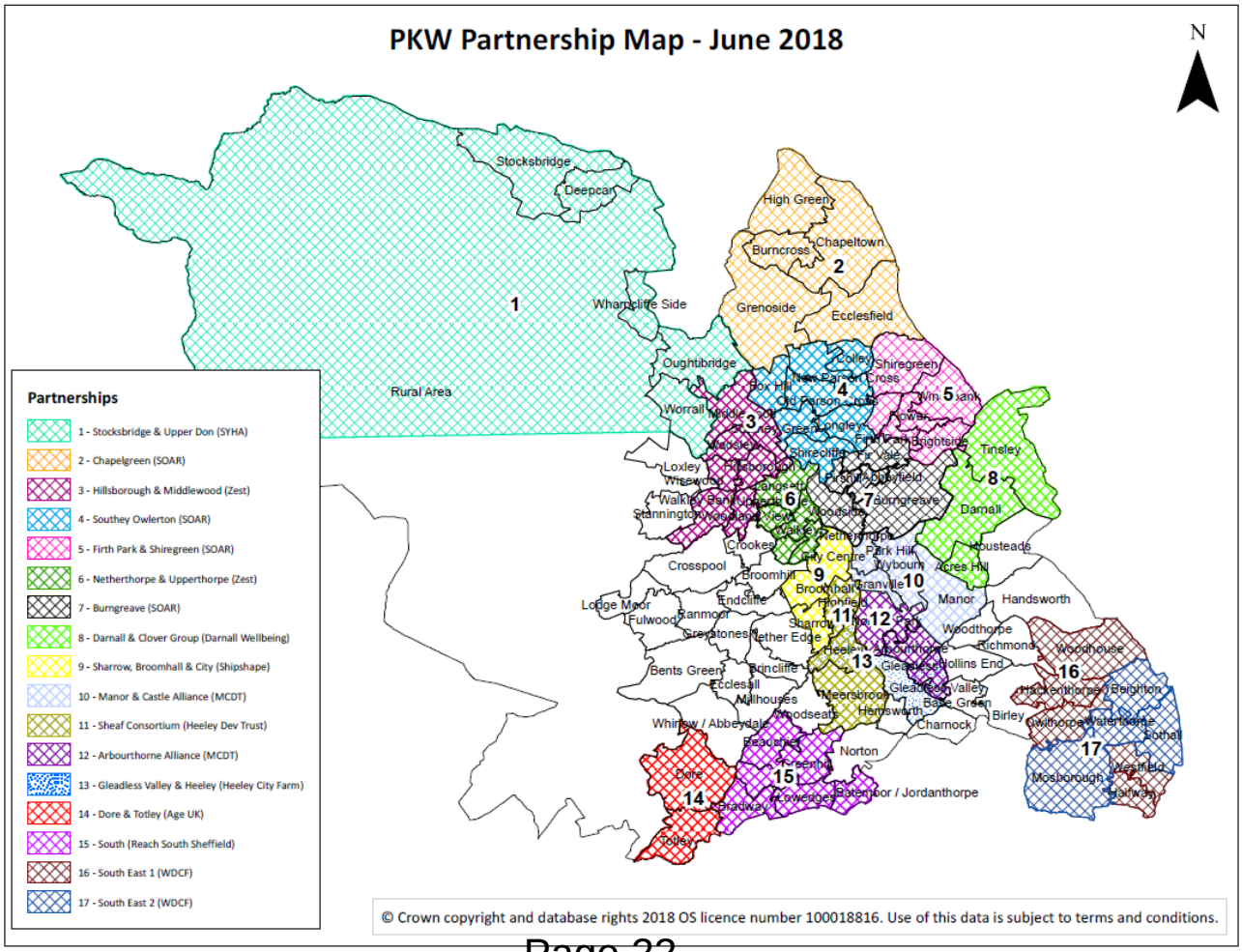
The partnerships meet regularly to consider how they can work together to support the community to live well and tackle local issues.

Each partnership is led by a local voluntary sector organisation which works with a wide range of people who live or work in that community.

Each partnership is different, depending on local needs, but might include other voluntary groups, libraries, local forums, Councillors, neighbourhood Police Officers, transport services, housing associations, TARAS, faith groups, food banks and GP practices.

Social Prescribing includes having a 'what matters to me' conversation to identify what support is needed. People are then put in contact with services that can provide help and advice. Examples include:

- Life admin support eg benefits, housing, advocacy
- Healthy lifestyles and managing long term conditions
- Activities eg arts groups, volunteering, physical exercise and gardening.



At the moment no organisations have come forward to lead PKW community partnerships in the blank areas. However, we're working to cover the whole city.

People Keeping Well community partnerships: how it works

Individual at risk of declining health and wellbeing

Referral made to PKW community partnership Lead Partner

(by self, GP, other professional, family member, friend etc)

Individual has a good conversation with a PKW link worker

Depending on need, individual is signposted to services/activities

Social cafes to get connected with people in their local area

Exercise sessions and health walks to help people get fit and active

Information and advice about housing, debt or employment

1-2-1 sessions with a Health Trainer to help with healthy eating, exercise, social issues

Groups to develop coping strategies for problems such as depression, diabetes and chronic pain

Courses to increase confidence and skills

Volunteering opportunities

Groups to reduce feelings of loneliness and isolation

Area	Name	Neighbourhoods	PKW Lead Partner organisation
1	Stocksbridge	Stocksbridge, Upper Don, Rural, Bradfield, Oughtibridge, Wharncliffe Side, Worrall	South Yorkshire Housing Association
2	Chapel Green	High Green, Chapeltown, Ecclesfield, Burncross, Grenoside	SOAR
3	Hillsborough	Hillsborough, Middlewood, Wadsley, Walkley Bank, Wisewood, Woodland	ZEST
4	Southey	Southey, Owlerton, Fox Hill, New Parson Cross, Old Parson Cross, Southey Green, Longley, Shirecliffe, Colley	SOAR
5	Firth Park	Firth Park, Shiregreen, Wincobank, Brightside, Flower, Stubbin, Brushes,	SOAR
6	Netherthorpe	Netherthorpe, Upperthorpe, Walkley, Langsett, Crookesmoor	ZEST
7	Burngreave	Burngreave, Firvale, Abbeyfield, Firshill, Woodside	SOAR
8	Darnall	Darnall, Tinsley, Acres Hill (& Clover Group GP Practices)	Darnall Wellbeing
9	Sharrow	Sharrow, Broomhall, City Centre	ShipShape
10	Manor	Manor, Castle, Wybourn, Park Hill, Granville	Manor & Castle Development Trust
11	Sheaf	Highfield, Heeley, Woodseats, Gleadless Valley (parts of Meersbrook)	Heeley Trust
12	Arbourthorne	Arbourthorne, Norfolk Park	Manor & Castle Development Trust
13	Gleadless	Gleadless Valley, Gleadless, Heeley	Heeley City Farm
14	Dore	Dore and Totley	Age UK
15	South	Lowedges, Batemoor, Jordanthorpe, Bradway, Greenhill, Beauchief	Reach South Sheffield
16	South East 1	Woodhouse, Hackenthorpe, Owlthorpe, Westfield, Halfway	Woodhouse and District Community Forum
17	South East 2	Beighton, Waterthorpe, Sothall, Mosborough, Richmond, Hollinsend, Birley, Base Green, Charnock	Woodhouse and District Community Forum

For contact details and to make a social prescribing referral to your local PKW Lead Partner organisation:

www.sheffielddirectory.org.uk/pkw *

* NB webpage currently under construction.

How do we know it works?

This is an emerging approach based on years of community based interventions for health and wellbeing. There is a growing national evidence-base for social prescribing:

- https://www.health.org.uk/publication/how-should-we-think-about-value-health-and-care
- https://www.nesta.org.uk/report/more-than-medicine-new-services-for-people-powered-health/

The difference it has made to people

"My GP doesn't need to increase my beta blockers for high blood pressure now, because of the progress I've made"
Eat Well Course, Manor & Castle Development Trust

"I'm 84 and live on my own but I like to keep going and get out and about to this"
Chair-Based Exercise, Woodhouse & District Community Forum

"A community event like this is great for reducing social isolation and people get the opportunity to meet other people and find out what is happening locally. It's great to see so many people from different cultures, eating together and enjoying themselves and voting for their favourite dish"
ZEST, Ready Steady Cook event

"I'm a full-time carer for my husband. I used to stay at home all the time and never went out due my caring responsibilities, but then realised I needed to think about my own health and started coming here to take a break from caring and still enjoy doing things like cooking, baking and socialising!"
Community Lunch, The Terminus Initiative

"I've not even run for a bus in the last 10 years but this week I did some jogging!"
'Bounce & Burn' Trampoline Exercise Class, Manor & Castle Development Trust

"I feel normal here, no-one judges. If someone forgets their words no-one minds"
Dementia Memory Café, Parson Cross Forum

"I have a bit of depression so I was quiet at first but I talk now because it's so relaxed and calm"
Chronic Pain Group, SOAR

"It's nice to meet new people and socialise. It can get really lonely living on my own"
Coffee Morning, Heeley Trust

"When I first came, I found it hard to keep up with the rest of the group, struggled with using a computer and wasn't keen on group learning, so the staff asked one of the volunteers if they could work with me one-to-one. Now I'm pleased with the progress I've made in short space of time. I can confidently go on the internet"
Silver Surfers Internet Session, Reach South Sheffield

"A few of us have formed a walking group and regularly meet up and go for walks round the local area. Before coming to the exercise class, we didn't see walking as a form of exercise"
Ladies Exercise Open Day, Shipshape

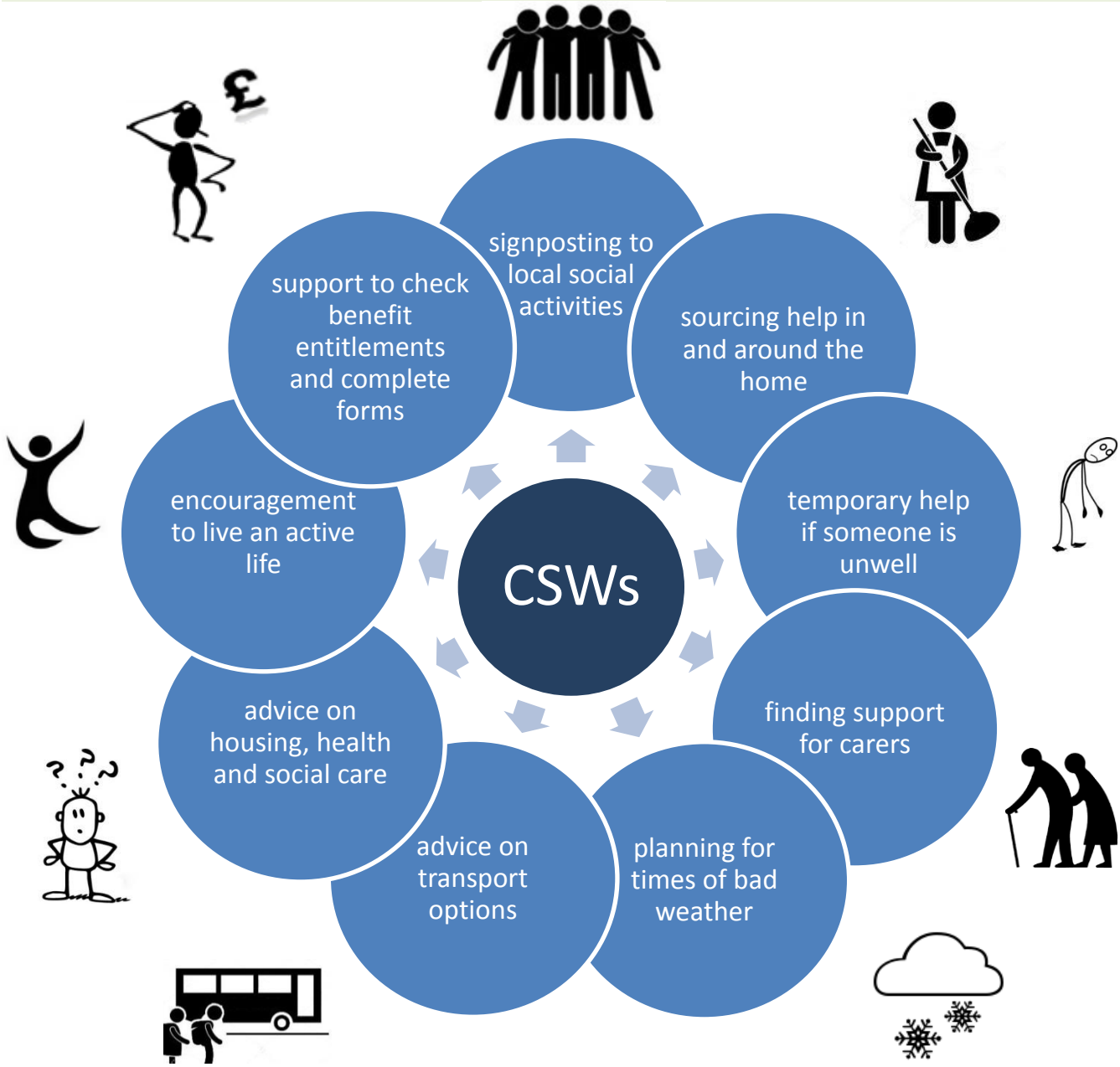
"I was made redundant and have been out of work. Volunteering here helps me gain experience and also gives me something to do in my spare time and meet people, as I don't want to be stuck at home all the time''
Green Gym Community Growing Project, Heeley City Farm

"I've been making my own meals now. I realised it doesn't have to take all day to cook"
Eat Well Course, Manor & Castle Development Trust

"My Sciatica has been eradicated; I couldn't stand for even 5 minutes but now can walk for 1.5 hours a week"
Health Walk, Darnall Wellbeing

Community Support Workers (CSWs)

Based in GP surgeries, providing support for approx 3 weeks per client



Make a referral to a Community Support Worker (via the central referral hub)

- CSWReferrals@sheffield.gcsx.gov.uk
- 0114 2057120
- www.sheffield.gov.uk/csw

CSWs and PKW Community Partnerships work closely together – if you're not sure who to refer to, make a referral to one and they will pass on the case to the other if needed.

Update on Housing plus in the Housing and Neighbourhood Service Scrutiny

Bev Mullooly, Head of Neighbourhood Services

Housing+

Housing+ is a ‘patch-based’ service, in which Neighbourhood Officers have responsibility for all Council homes and delivering Council Housing Services within a geographical area.

The Housing Plus journey

- Annual visits completed - 27,000
- Household Plans drafted 7,000
- Whole household approach – diverse, complex needs uncovered
- Increased demand for other services – especially mental health
- Good local working relationships & links across SCC services/partners but need to do more

What next?

- Exploit opportunities joint & locality working
- Develop & establish new local network & links – statutory & voluntary
- Focus on prevention and early intervention to achieve better outcomes
- Testing joint working with Children's in the North Neighbourhood Team focussing on prevention
- Closer links/relationships with local GP practices – direct referrals to the service for support

Housing Plus Case study

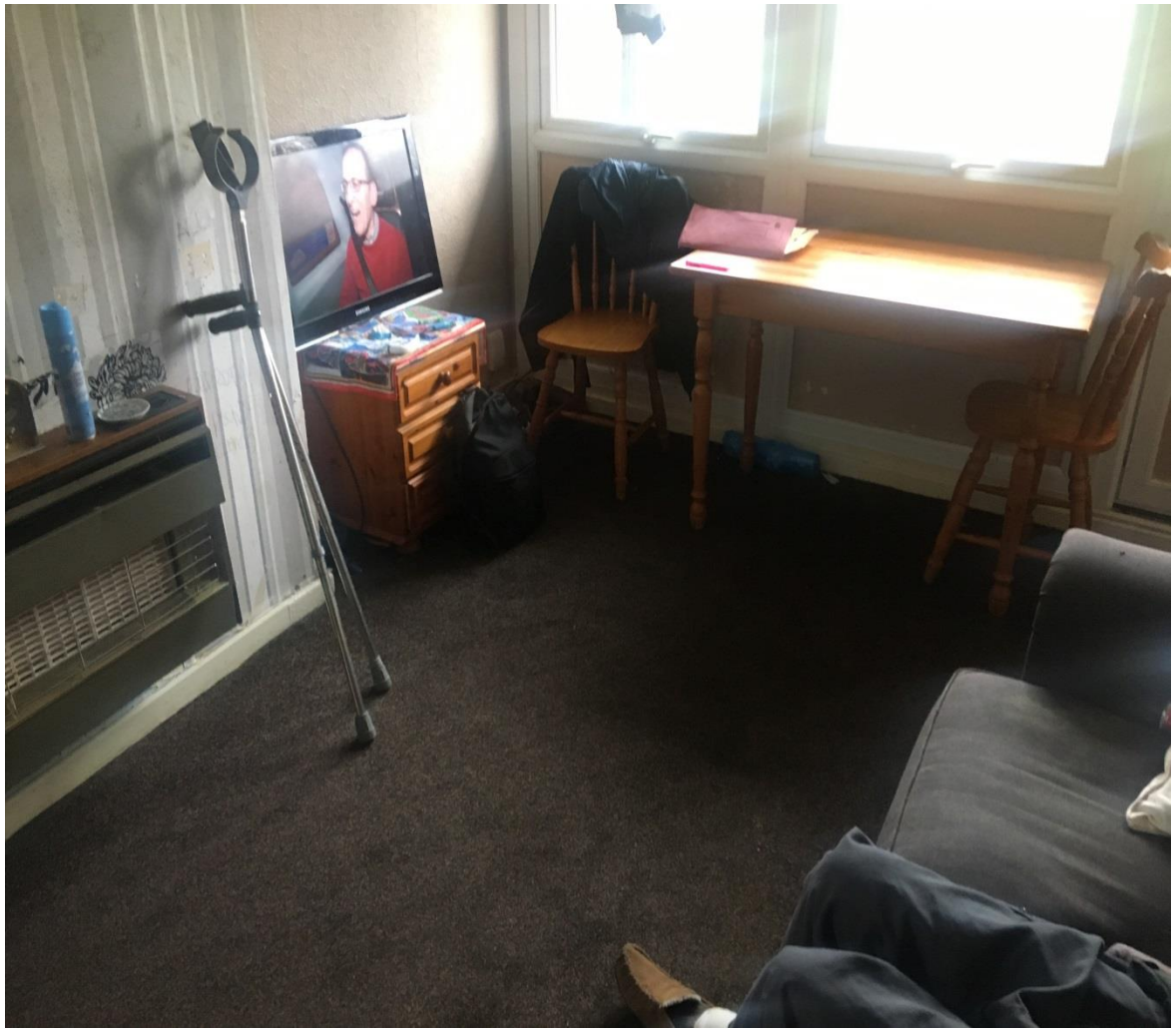
- 40 year old single male living in a block of 6 properties
- Drug and alcohol issues, and has been received support from SCC & other agencies for several years
- Neighbours complain about his behaviour
- Served with a Notice Seeking Possession for breach of tenancy conditions - noise

Living conditions

His Health

- A number of health issues & discharged from hospital after major surgery.
- Health professionals were reluctant to provide home help due to living conditions
- Missed appointments and would not engage with carers or health professionals
- Collaborative working, several joint visits with Neighbourhood Officer with other SCC services and agencies

Current position



Lunch Clubs Briefing Note

Lunch clubs are so much more than lunch. They provide opportunities to socialise, volunteer and take part in a range of activities. Feedback from clubs in their quarterly reporting indicates that lunch clubs continue to have a hugely positive impact for older people and are a good example of community action to address local need – providing opportunities to both contribute and receive.

The Lunch Club Fund aligns with the Council's Corporate Plan 'Better Health and Wellbeing' priority. In it, the plan states that people are more likely to maintain good health if they have support from friends, family, neighbours and their wider community. This is where lunch clubs play an important part in the ongoing health and wellbeing of older people in Sheffield.

Membership of a lunch club not only provides a hot meal to people that might otherwise not cook from scratch for themselves but the connection with other people and making friends can provide wider support which ultimately prevents over reliance on statutory services, and helps people maintain a fulfilled life and independence. Statistics from the Royal College of General Practitioners show that each day, GPs see 1-5 patients because they are lonely (Tackling Loneliness, A community Action Plan)

Varying degrees of impairment and chronic health conditions are common as we age and with people in the older stage of old age hospital admission and care provision are under pressure. Lunch clubs in Sheffield cater for a wide range of members but the over 80s form a large group, often frail, living alone and isolated. We know that people who are socially isolated are between two and five times more likely to die prematurely than those who have strong social ties so every effort to support lunch clubs to provide this function is essential 'in the last 10 years, the number of people aged over 85 in Sheffield increased by 139%' (A City for All Ages – Making Sheffield a Great Place to Grow Older)

Elaine Goddard
Health Improvement Principal
November 2018

Annual Report 2017-18

Lunch Club Fund

Lunch clubs enable older people across the city to make long lasting friendships, share good food, and enjoy interesting activities. They are friendly and supportive groups, predominantly run by volunteers with a desire to give something back to their local community. The Council's Lunch Club Fund provides small grants for clubs across the city supporting them to help reduce loneliness and isolation of older people.

In addition to small grants for lunch clubs, part of the Lunch Club Fund budget is set aside for a development support grant. In 2017-18 Voluntary Action Sheffield provided the Lunch Club Development Service with this grant, which offered support to any club in the city on a range of things from budgeting, volunteer recruitment, safeguarding, food hygiene, health & safety and organisational development.

£170,860
invested

51
lunch clubs received a grant

2,316
lunch club sessions held

53,505
hot meals served

1,555
lunch club members

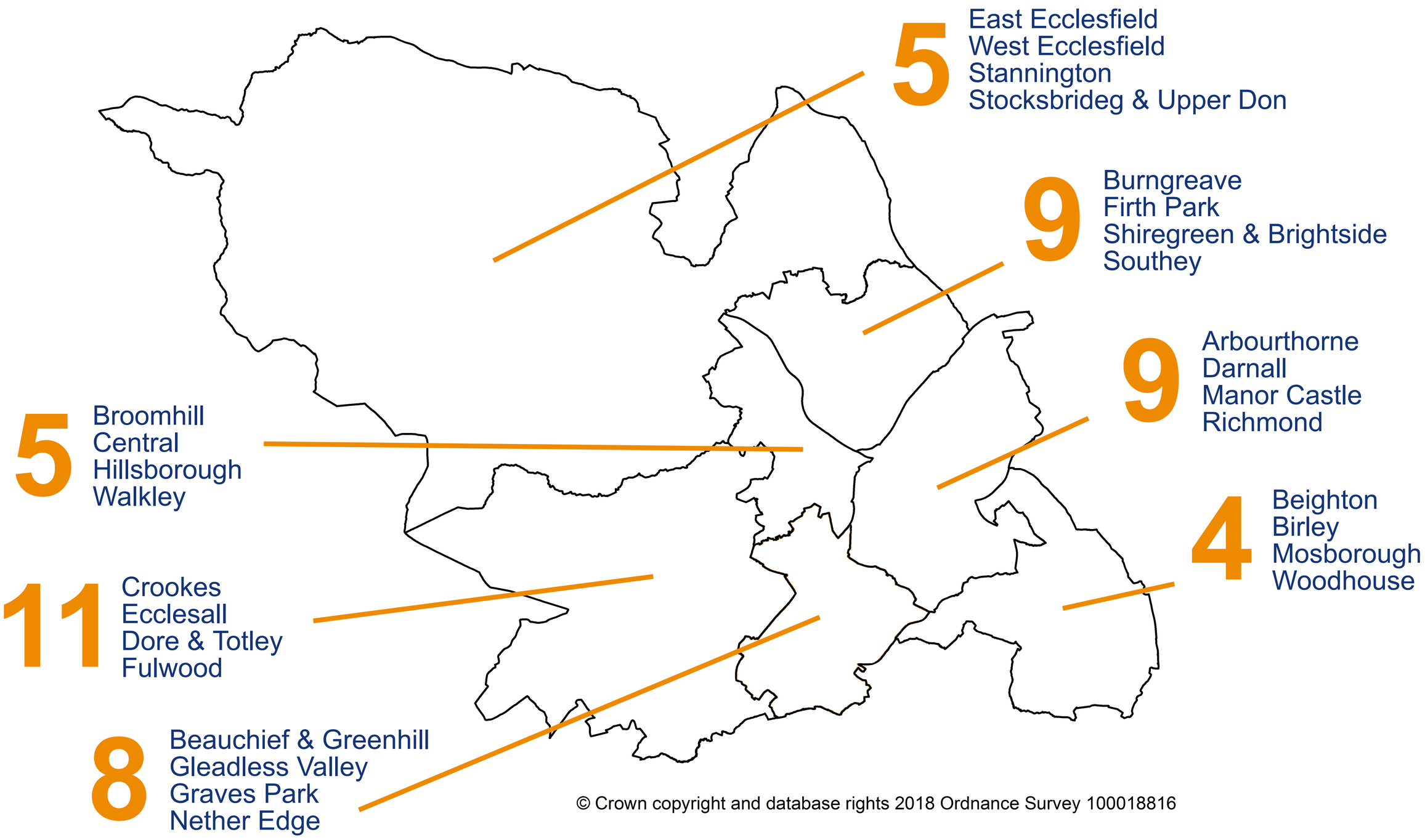
£2.40
grant investment per person per session
(towards the running of the club)

Contact the Voluntary Sector Liaison Team for more information:
Tel: 273 4631 Email: vslt@sheffield.gov.uk Web: sheffield.gov.uk/lunchclub

Sheffield City Council

About Lunch Clubs

51 lunch clubs across the city received a share of **£128,674**



"I've come here for the last 2 years and it's important that it is local and so convenient to get to"

53,505 hot meals were served at an average price of **£3.50**

Every lunch club served a two course meal

"I enjoy not having to cook, its lonely just to eat on your own"

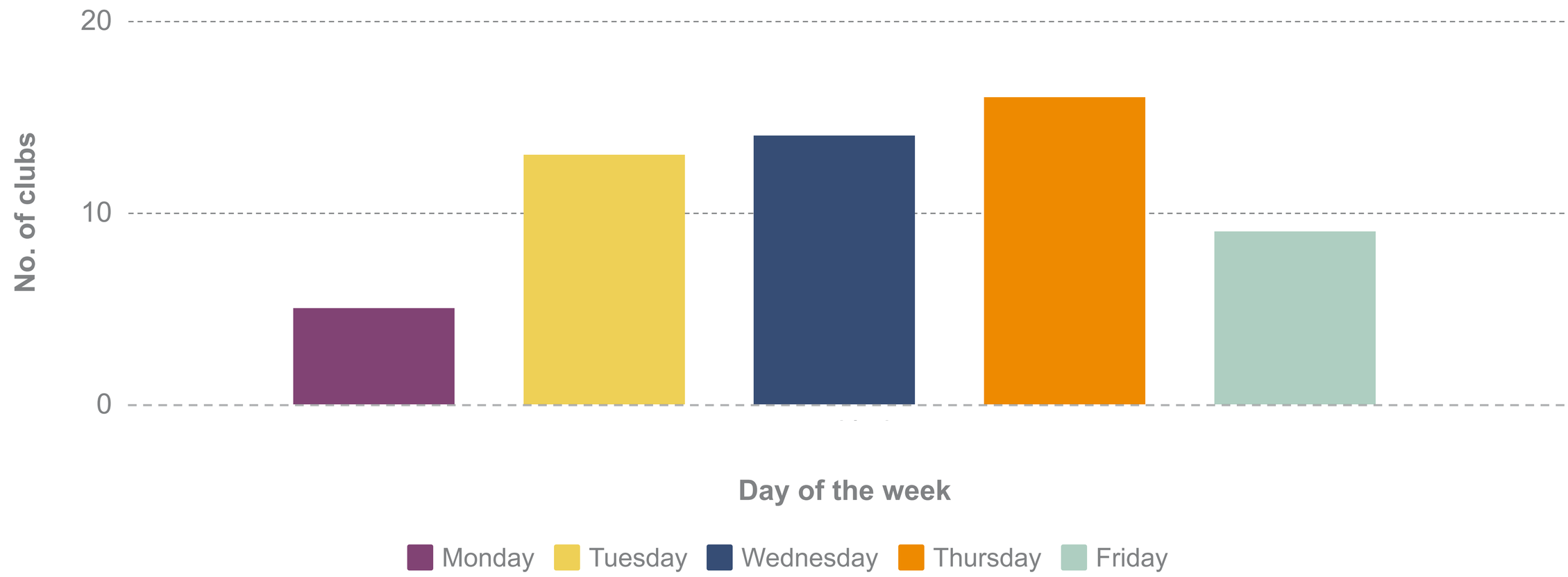
"I enjoy the company and chatting about old times"

2,316 lunch club sessions were held

41 clubs met **weekly** and **6** clubs met **twice weekly**

1 club met **monthly**, **3** clubs met **fortnightly**

Day of the week lunch clubs met



Attendance at clubs

Up to 15 members — **10 clubs**

16-25 members — **23 clubs**

26-35 members — **14 clubs**

Over 36 members — **4 clubs**

"This is the only time I get out of my flat and see others"

" It's like a close knit family here, everyone is kind and helpful"

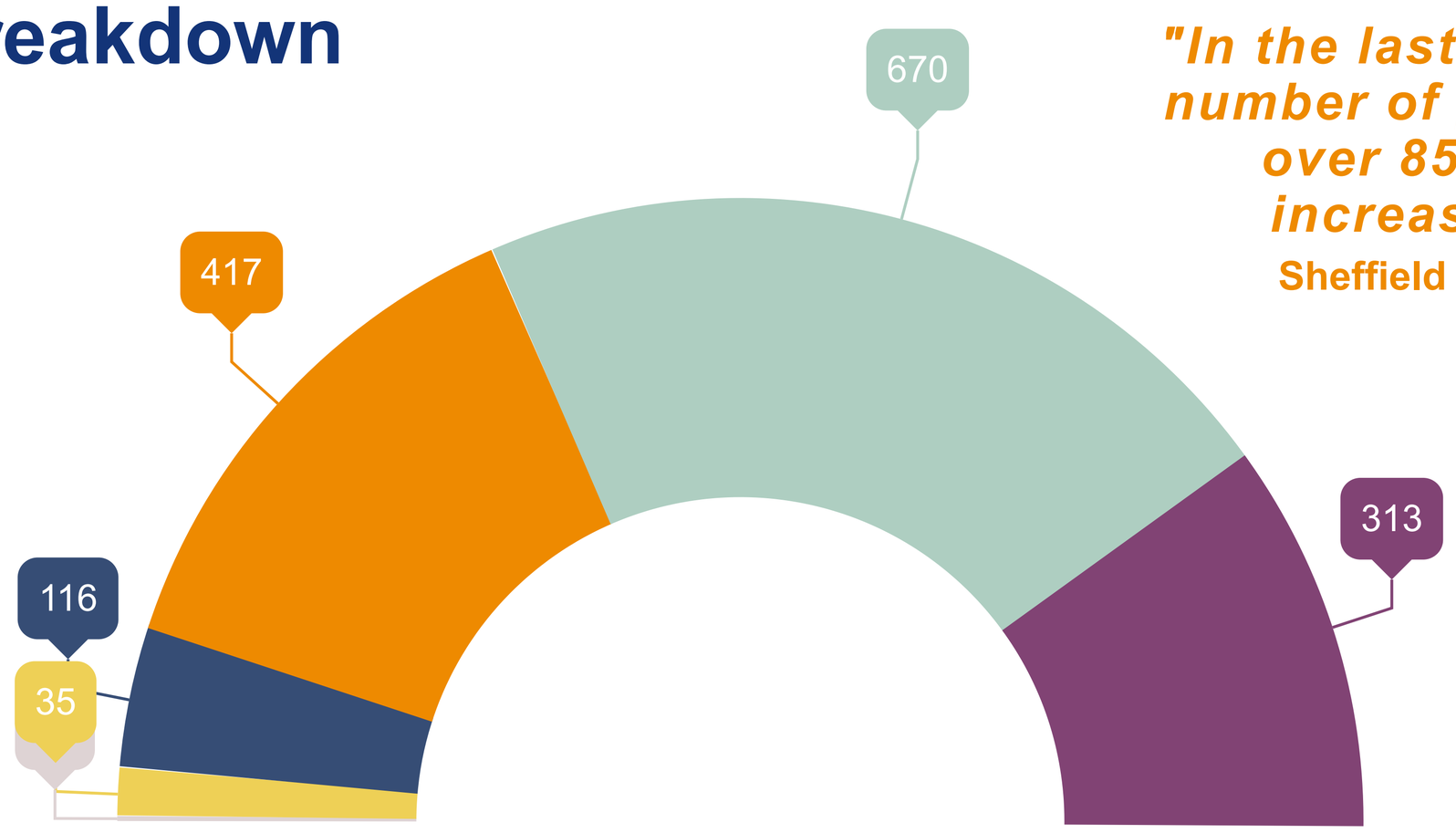
" It's a reason to get out of the house"

About Members

Club's supported by the Lunch Club Fund had **1,555 members**

men (27.01%) women (72.99%)

Age breakdown



Aged 50 or under (0.26%) Aged 50-59 (2.25%) Aged 60-69 (7.46%) Aged 70-79 (26.82%) Aged 80-89 (43.09%) Aged 90 and over (20.13%)

"In the last 10 years the number of people aged over 85 in Sheffield increased by 139%"

Sheffield a City for All Ages

63% of members are aged over **80 years**

36% of members reported having a **disability or long-term health problem**

NB Member statistics do not include information from one club which was not available.

459 members used transport arranged by the lunch club at an average cost of **£1.70** per session

About Volunteers

613
regular volunteers supported the lunch clubs

Each volunteer contributed between **2** and **7 hours** per session

Volunteers contributed a total of **56,270 hours** equivalent to salary costs of **£492,365** using the real living wage.

153
members
took an active part in their club by volunteering

3 clubs
were supported by offenders via the Community Payback Service

“I became a volunteer to get a better work-life balance but now I'm part of an extended family"

"Our community bus driver and escort are both exceedingly good. We would find it difficult to carry on without their help, they are terrific"

NB Volunteer statistics do not include information from one club which was not available.

Lunch Club Development Support

Voluntary Action Sheffield (VAS) received investment from the Lunch Club Fund in 2017-18 for the following Lunch Club Development Service:

£42,186
2017-18
Grant Amount

2 year
Grant Agreement

The Lunch Club Development Service supports lunch clubs across the city to become sustainable, well managed clubs who are able to meet the necessary legal and financial requirements and aspire to meet the agreed minimum standards and operate within a good practice framework.

Supported **52** volunteers to remain in their role

99 support interventions with **35** lunch clubs

85 volunteers from **23** clubs received formal training at workshops in:

- Food Safety
- First Aid
- Safeguarding Adults
- Health & Safety

FUNDED BENEFICIARY OUTCOMES

The grant to VAS was a contribution to the following outcomes:

Lunch clubs are able to recruit the volunteers they need and to develop their skills and knowledge to manage volunteers to best practice.

Lunch clubs have the skills and capacity to develop tools to demonstrate the impact of their services/activities

Lunch clubs can manage to respond to internal or external change by means of adapting their ways of working and/or embarking on partnerships, collaboration and mergers or where appropriate winding up.

Click here to read VAS' 2017-18 IMPACT REPORT

which demonstrates the positve impact their service had on the lunch clubs they supported

Community Support Worker – Case Study

It's the little things that can have the big impact!

A fundamental part of being a Community Support Worker is taking notice of people. Understanding what their circumstances and situations are. Listening, observing, and then acting to make positive change for the individual their families and our communities. The case study below shows that being attentive and noticing the little things means we can have a big impact on people's lives.

Listening and understanding

I first spoke with EW on the phone before visiting her. This contact was important as I later discovered EW had anxiety, in particular social anxiety. Speaking to her on the phone beforehand meant we'd started to build a relationship and this made it easier for EW to tell me about her circumstances and disclose sensitive personal information. This is critical to working out a strategy to support that person and potentially their wider family. Through listening, asking questions and noticing the little things I found out:

- EW was repeatedly going to the GP because she felt isolated. It was a chance for her to talk to someone rather than her needing medical support;
  - EW had social anxiety, which was further contributing to her isolation;
  - Poor transport links from Chapeltown was exacerbating her isolation;
  - EW had been referred to Increased Access to Psychological Therapies (IAPT) and it hadn't worked as it was too short (6 weeks) so didn't have the desired impact;
  - EW's husband had been diagnosed with Alzheimer's and this meant
1. Family relationships were strained due to him being aggressive and swearing.
2. Friendships fell away due to EW's embarrassment at her husband
3. He could no longer drive and EW didn't drive either so it further isolated her.
4. EW was doing more caring which was starting to impact on her wellbeing.

  - EW had been to the Alzheimer's Society Dementia Café before and liked it but sopped going due to anxiety;
  - EW had had the Alzheimer's Society befriending services before but hadn't realised as she was a little confused.
  - EW's daughter was a nurse who wanted to help more but didn't know how. She was travelling in once a week to do shopping but her dad's Alzheimer's meant she felt her family relationships were becoming negative.

Acting

EW is a person not the list of things above I found out when listening to her. However, in order to prevent, reduce or delay the need for social care it is important to understand the individual, what their strengths and needs are then act. It was clear EW would have become more isolated, more dependent on contact with the GP and more unwell due to the stress of being a carer and being anxious and isolated. Ultimately EW circumstances and wellbeing would have continued to decline meaning she would become more costly to health and social care budgets. Community services are vital to helping people keep safe and well in their homes. Due to working in the same locality I know what support is available. I wanted to build EW's confidence, help her tap into local support to build networks, tap into peer support and reduce caring and financial pressures. I acted by:

- Working in partnership with the GP, Alzheimer's Society and other community providers to align support and make sure everyone knew what I was doing and how that was helping;
- Putting EW in touch with Wednesday Friends (befriending) which was local to her;
- Linked her to Age Better's IAPT which was longer, in more depth and they come out to the home which suited EW;

- Arrange a visit from DWP to support with an Attendance Allowance claim. This gave EW more money and freedom to take a break from her caring role;
- Arranged Community Transport to help EW be more flexible in getting into Sheffield. There was only 1 bus per hour;
- Met the daughter and gave her the Guide to Independent Living and explained how Attendance Allowance can be used for companion services to help in multiple ways including easing negative family relationships;
- Talked the daughter through the Council's Recommended Provider list to provide assurance that there were quality services that would meet her mum's needs;
- Provided the family with a fridge magnet with my contact details on so they could get in touch with any further problems. This gave peace of mind that someone was there.

Big Impact

It is great to see the positive changes as a result of what we as community support workers do. As a result of what I did:

- EW and her daughter had arrange further support from Home Instead (who EW liked) using the Attendance Allowance to cover the cost. This helped EW take a break from caring and meant the relationship with the daughter improved as EW was able to talk to other people about her husband and offload before seeing her daughter;
- EW had started going to the Dementia Café again and was more confident;
- EW stopped going to the GP, which means the GP was happy as EW wasn't unnecessarily using their resources;
- EW's daughter was happy as she said she wouldn't have thought of applying for Attendance Allowance and didn't know how to help;
- Most importantly, EW was happy that she'd got help from someone who she thought really listen to her and understood what she was going through.

Through paying attention to the little things it's possible to have a big impact. Not just to the individual to families and communities too.

Access and Prevention update on increasing the shift to Prevention -

First Contact, First Contact Prevention and First Local – development, progress and next steps

Sara Storey, August 2018

First Contact

Aims and vision

1. First Contact is a new access model that aims to manage and reduce demand and provide better outcomes for people as near to their first point of contact with Adult Social Care as possible. It was also deemed a vital element in supporting the move to a Localities model in 2017 by managing and reducing demand on upstream, formal services through a reduction in the rate of people contacting the Council who go on to receive a care package.

2. Prior to the creation of First Contact, people calling Sheffield City Council to discuss issues relating to adult social care would speak to a call advisor in the corporate call centre. Although some signposting and appropriate urgent advice was given, in most cases, a brief description of the person's situation would be recorded and then forwarded on to the relevant social care team. This process could take several days for the first 'screen' of the contact; and involved several hand-offs. For people calling the Council, this could mean a delay in getting the help they needed, heightened stress and confusion, and an increased risk of their circumstances worsening.

3. Now, a multi-skilled team of care managers, social workers and occupational therapists are on hand to answer calls directly and provide clear, pertinent information in a timely manner. Conversations focus on prevention, putting people in control through self-help and ensuring that all possible alternatives could be exhausted before funded care was required. Fundamentally, staff work to the principle of providing support to meet outcomes as close to initial contact as possible in order to reduce hand-offs and delays in prevention processes. *The first contact a person has with the organisation sets the tone for the rest of their on-going relationship - it's important we get it right - so we need our best people 'up front'.*

Resource

4. The initial First Contact pilot involved existing staff from two teams in Access and Prevention: CAPT (the Community Access and Prevention Team) and ADAPT (the Adult Duty Access and Prevention Team), which included safeguarding social workers and care managers.

5. In addition, the model originally included 3.5 FTE call advisors from Resources, who were in post under a service-level agreement. However, these staff have now returned to Resources and the cost of these has been returned to First Contact.

6. An occupational therapist was also involved in the initial pilot and there continues to be involvement from a number of staff from the Equipment and Adaptations team on a rota; as such, both the pilot and the current model make better use of existing resources within and across a number of teams, and no additional investment has been required. As part of the Adult Social Care MER, the Sensory Impairment team has now also joined First Contact.

Timeline

7. In **January 2016,** a small scale project supported by Impower placed one care manager into the customer services Access team to start to listen and learn.

8. Business strategy support enhanced and sped up planning, and preparations for the pilot phase were made in **late 2016** and **early 2017**.

9. The initial 12-week pilot ran from **April to July 2017**.

10. First Contact was implemented as business as usual in **August 2017** and expanded to include the Sensory Impairment team. A total of 35 staff now work in the teams. None of these are new posts, so the full First Contact service did not require any new investment. The new model instead pulled together existing resources in the prevention and safeguarding space and focused those resources to develop an innovative and responsive way of working.

    Pre-First Contact in Adult Social Care-
    City Wide Duty (ADAPT) 1 x Team manager, 13 care manager and social worker posts
    CAPT 1 x Team Manager, 5 posts
    L D Duty, Safeguarding and Early Intervention 1 x TM, 10 posts (including 2x Prevention officers)
    Sensory Impairment Team 5 posts

11. First Contact was home to the first Conversations Count innovation site in **February 2018**, with the approach being rolled out in **April 2018** across the whole team.

12. In May 2018 the transfer of some of the value of the 3.5 FTE call advisors from Corporate Resources along with filling vacancies helped to create 4 additional Prevention Officer Posts. It was decided to recruit prevention officers (g6) rather than care managers (g6) to signal a change in approach – preventing the need for care rather than managing care. In the recent round of recruitment (August) over 50 applications were received for 4 posts, including people from many diverse backgrounds – e.g. ex teachers, police officers, housing – enabling a broadening of the knowledge and skill set of the teams.

Progress on success

13. The initial 12-week pilot showed that: people were receiving more effective information, advice and guidance than before; staff were able to employ new means of supporting people and preventing through new equipment, additional services and an enhanced team skillset; work processes and people's journeys had become significantly more efficient and streamlined; and demonstrable savings and demand reduction had been achieved.

    Results from the pilot concerning the "conversion rate" of people who contacted the Council and went on to receive a formal assessment and/or care package:

    The pilot showed that, over the course of the year, 2946 fewer interactions were expected to result in a social care referral – a reduction of 59%.

    The full-year effect of the pilot also indicated that 323 fewer social care referrals were expected to result in a package of care – a reduction of 37%.

14. Data continues to be collected on every call taken in First Contact in order to assess the savings achieved as a result of implementing First Contact following the success of the pilot. The following figures are correct as of July 2018 and are based on the reduced demand on core purchasing budgets, better-quality conversations with people based on

strengths leading to fewer formal care arrangements, reduced hand-offs and lag times, and improved crisis management and prevention.

15. In terms of reduced workload for localities - based on new people with agreements whose latest contact was via the community route, in 16/17 there were 71 per month of these, in 18/19 it's 41. So 30 preventions per month are modelled through the year at an average cost of 5.5k net. This means that locality staff have 30 less assessments and support plans to complete each month.

In the first year, First Contact saved £650k. Total savings in 18/19 resulting from the new access model are forecast as below:

The 2018/19 full-year effect of the changes made part way through 2017/18 amount to £300k.

First Contact is currently on track to achieve additional savings of at least £500k, taking the total to around £800k for 2018/19.

16. An additional element to First Contact's performance framework is people's satisfaction. A system is now in place for staff to phone people back after a couple of weeks to ask how satisfied they were with the initial conversation over the phone and to prompt them to follow up on any information and guidance provided that they have not yet acted upon.

Satisfaction findings:

Across April and May 2018, 100% of people who received a callback had been able to follow the information and advice they received

In the same period, 94% of people said that their needs were met by the advice given, and only 12% wanted different or additional advice

Case studies

17. *A person called to say that she was no longer able to pay for her package of care – meaning that the Council could be at least partly responsible for funding it.*

Previously, she would have gone through to a call advisor in our corporate call centre, who would have added her details to a form. This form would have then been looked at by a "screener", whose job is to identify whether an issue should be classed as urgent or not. If not, it would have gone on a waiting list. Eventually, the form would have been looked at by a care manager, who would then need to read all the relevant information and phone back the first point of contact listed, before finally sending out a financial assessment form. The whole process would take over a week.

In the First Contact team, this person came straight through to a care manager who listened to what she had to say and dealt with her issue there and then by taking some initial financial information over the phone and using this to provide a rough indication of how much she and

the Council would have to contribute financially. The Care Manager also sent the financial assessment form straight out via email after speaking to her over the phone – cutting the time taken from over a week down to about half an hour.

- ➔ **The person's issue was dealt with much more quickly, meaning that she didn't have to wait very long to find out what was going to happen. Otherwise, the wait could have been very distressing**
- ➔ **She was also able to learn immediately what she could expect to happen at the end of the assessment process**
- ➔ **The person had to speak to one person only, and therefore had a much smoother journey**

  The Care Manager only had to speak to one person, and could deal with the issue there and then on the phone – reducing the amount of work involved to process the enquiry

18. *Someone called to say that he struggled to get in and out of his home, and needed a ramp and a dropped kerb in front of his property.*

    Previously, he would have gone through to a call advisor in our corporate call centre, who would then have made a referral to the Equipment and Adaptations team. This referral would have eventually been picked up by an occupational therapist after being on a waiting list for over three months. Only then would the person have been informed whether the work could be performed or not, and whether he would have to pay anything towards this.

    In the First Contact team, the Care Manager who took the call was able to pass the call through to the Occupational Therapist in First Contact immediately, who was able to have an in-depth conversation about the person's circumstances and gather enough information over the phone to sufficiently manage the person's expectations through advice and information. A referral was avoided and the Occupational Therapist ordered a rail for access to the front of the property – all within the space of an hour or so. The Care Manager was also able to listen to how the Occupational Therapist dealt with the issue to build up her own knowledge for future reference.

- ➔ **The person's expectations were managed and although he didn't receive what he had originally asked for, he was satisfied with the result. If he had waited over three months for the same outcome, he would have been a lot less satisfied**
- ➔ **A referral to Equipment and Adaptations was avoided, thereby reducing the workload upstream**
- ➔ **The Occupational Therapist was able to share expertise with the Care Manager, who was subsequently better able to deal with calls relating to equipment and adaptations in future**

First Contact Prevention

Aims and vision

19. The First Contact Prevention service acts as the face-to-face element of the Access and Prevention (community) model, bringing together three previously separate teams into a combined service with a single referral route.

20. The team provides – and has developed – skills and expertise relating to intensive prevention work across First Contact, and brings with it specialist knowledge about working with people with learning disabilities. Staff support initiatives to embed a consistent preventative approach across Adult Social Care, and are also able to help further manage demand in accordance with the principles of First Contact. Services include support with anything from accommodation, travel, criminal justice, employment and volunteering through to equipment, mental health support, money management and help finding social and community activities.

Resource

21. The First Contact Prevention service has been formed through posts being pulled together from three teams: CEPS (the Community Enablement and Prevention Service), CATS (the Community and Tenancy Support team) and Wrap Around, with the latter two mainly working with people with learning disabilities. As such, there has been no increase in the number of staff working as part of the new combined team, as a pooling of resources has allowed for a more efficient service. A total of 29 staff.

CEPS	1 x TM, 2 x Support Managers, 2 x CSW's, 7 x Support Workers
Wrap Around	1 x TM, 1 x Employment Officer, 1 Sensory Impairment Worker 4 x Travel Trainers
CATS	1 x TM, 2 x Prevention Workers, 7 x Prevention Officers

Timeline

22. The three teams that form the First Contact Prevention service transferred into First Contact in **August 2017**.
23. A review of roles, responsibilities outcomes and models of working was undertaken between **August and October 2017.**
24. Following the review, job descriptions were reviewed, new systems implemented, and the combined Prevention teams developed – this work (detailed below) was largely completed by **July 2018,** although of course skills and expertise continue to develop.

25. The aims identified after 3 months of assessment of the three teams (business case available on request):-

- Develop LD skills and expertise across First Contact services
- Develop comprehensive guidance on the role and function of preventative services within First Contact
- Create one referral route to include a single telephone number access model
- Create a single allocation model whereby the same person undertakes both the assessment and provides the service/support
- Develop one job description for all face-to-face front-line prevention workers and address role and grade anomalies and issues
- Initially, make the best use of specialist and individual expertise across the teams, working progressively towards each team member being able to undertake and deliver the same preventative function
- To support service initiatives to embed a consistent preventative approach across ASC
- To manage customer expectations and demand accordance with the First Contact principles, including responses and timescales
- Further collaborative work with CSWs to provide a seamless service and a more efficient workflow, identifying interfaces where handoffs are minimised

26. In **June 2018**, five CSWs (Community Support Workers) moved across to join the team. This represents a further remodelling of existing resources into the First Contact model. No additional investment has been made.

Progress on success

27. First Contact Prevention has become pivotal to delivery as the face-to-face element of an inclusive adult social care model, and is essential in ensuring that the service is able to adhere to the principles of "no hand-offs" and "the first person to hear about an issue deals with and resolves that issue as far as possible". The enhanced skillset of the three teams combined with improved work processes have enabled people's journeys to become significantly more efficient and streamlined.

28. A business case was undertaken in autumn 2017 as noted above. The case for change reviewed the work roles of the three teams (CATS, CEPS, and Wraparound) and assessed the working models, and sought to assess the financial impact the teams already had. This estimated that the teams collectively reduced or prevented costs of around £2m per year. These savings have not been put forward as 'new' savings, however; as it was assumed that the work of the three teams already contributed towards reducing pressures on budgets and was already accounted for in budget forecasting. The net effect of the improvements made to processes is therefore difficult to account for separately to the whole First Contact savings, however it is clear that there has been a positive impact.

29. It is also clear that improved and increased joint-working across both First Contact and First Contact Prevention – including all the varied roles now based together across the teams – is key to the overarching ambition of the model. The team ensures that the Council can respond to people quickly, in a preventative and enabling way.

30. The inclusion of a small number of CSWs has further enhanced the response, and has reduced some previous hand-offs. As such, the flexibility and the skillset of the combined response is now proving invaluable. CSWs have commented that since moving into First Contact, they enjoy seeing cases through from start to finish and are able to do quality work: Being around other roles that have a close fit with their own is expanding their knowledge and skill.

31. Prevention workers have also been able to broaden their skillset; for instance, they can now install City Wide Care Alarms, prescribe and install small equipment, and monitor and use assistive technology.

Case study

32. *A safeguarding concern was reported by a daughter who was worried that her 85-year-old mother was being mistreated by a second daughter. She had seen her mother looking dishevelled. She also reported that her mother spoke no English as she was Haitian and spoke a creole language.*

    First Contact Prevention was able to undertake an immediate "safe and well check". As one of the team members speaks French (a language widely spoken in Haiti), the team was able to arrange to go out for a visit within a few hours, and there was a staff member already in the area. She went to the home address on our system, but as the person in question wasn't there she decided to go to the second daughter's property as it was close by. The mother was there with family around with her, sitting with rollers in her hair waiting for tea. The house was

also immaculately clean and tidy. The second daughter explained that her mother had had a hip operation and was recovering at her home as her mother's flat had stairs up to it. Our staff member was able to speak with the mother a little and judged that she was happy, coming to the conclusion that the first daughter had become estranged and was possibly trying to cause an issue.

While the staff member was there, she was also able to help with a small benefits issue and pass on advice on social groups in the local area.

- ➔ **The team was able to act quickly and proportionately, feedback to the social worker dealing with the safeguarding concern, and close down the alert**
- ➔ **The staff member offered a "see and sort" approach, resolving additional issues that became apparent during the visit**
- ➔ **Increased workload upstream was also avoided, such as a social worker attempting an initial over-the-phone screening and referring to a Locality team for a face-to-assessment**
- ➔ **The language barrier alone would have necessitated a home visit by a social worker, possibly with an interpreter or use of the Language Line interpreting service, which could take up to a week to coordinate**
- ➔ **The family had to speak to one person only, and therefore had a much smoother interaction with the Council**

First Local

Aims and vision

33. First Local is an innovation site set up during the second phase of the Conversations Count trial process, supported by Business Strategy colleagues. The project involves a multi-skilled team made up of staff from First Contact, Equipment and Adaptations and Locality 6 Team 2 co-locating at the Darnall Primary Care Centre.

34. The project is designed to offer a new way for people who could benefit from very early intervention and prevention to engage with Adult Social Care. The team can provide information and advice as well as demonstrate equipment and telecare devices, and visit people in their homes. The aim is to take prevention to the heart of an area of Sheffield that sees a high proportion of GP referrals to Adult Social Care, changing people's perceptions in the process and engaging with people who might otherwise not become known to the Council until they are in a crisis.

35. The team run a full-time drop-in service during the surgery's opening hours for anyone to approach them to have a chat about promoting their independence, increasing their level of social inclusion and improving their opportunities in life.

36. GPs from Darnall Primary Care Centre itself alongside a number of other GP surgeries in the area are able to direct people to the drop-in as an alternative way of asking Adult Social Care to help.

37. The project aims to resolve issues as early as possible, engaging with local communities in the process and collaborating intensively with local voluntary and community organisations as well as with NHS colleagues.

Resource

38. First Local, as with First Contact and First Contact Prevention, has not received any additional investment for staff resource; it is run jointly by staff across First Contact, Equipment and Adaptations, and Locality 6 Team 2.

39. It was hoped that CSW's (who are linked to GP surgeries) would also support First Local, however it has not yet been possible for any CSW's to engage with the innovation site.

Timeline

40. Planning for the project began in **early March 2018**.

41. The team started officially on **Monday 2 July 2018** and will run for 13 weeks, in line with the Conversations Count approach to trialling innovation sites for this period while evaluating its success on an ongoing basis.

Progress on success

42. Now that First Local is up and running, the team has collected a great deal of learning about complex partnership working as well as practical and logistical considerations that will help feed in to any future local access points in the city. A lot of time has been spent on building strong relationships with Health staff across surgeries and the CCG, and these will also prove valuable for the future.

43. While the project is in a very early phase, over the first couple of weeks roughly 2/3 of the 60 people who attended the drop-in had not previously approached Adult Social Care. Most people enquired about issues relating to access and mobility issues (either their own or a relative's), and most people had come because they had either seen a poster or flyer in a GP surgery, or because a GP had suggested they attend directly.

44. In terms of the difference the project is having on people's lives, the vast majority of people who spoke to a member of the team would otherwise have done nothing to improve their situation – meaning that their circumstances or those of a loved one may have otherwise deteriorated, unnoticed, until they reached a crisis point.

45. Most staff have also reported that they are highly satisfied with this new way of working, as they can see for themselves how they are able to relieve anxiety, respond quickly, spend quality time with people, reassure people that someone is listening to them, and see people go away happier in the knowledge that they don't have to face issues alone.

46. Following the formation of the 'People Portfolio', Access and Prevention are working closely with colleagues to review the two separate travel training teams (currently working separately with adults and children) to agree joint aims and vision, and consider ways of working better towards an all age disability offer. There may be further elements to explore in terms of a holistic approach, as for example although it is mainly people asking about support for adults who have approached First Local, our Equipment and Adaptations service also works with all ages to offer Disabled Facility Grants to adults and children with disabilities.

Case study

47. *One of the innovators at First Local was approached by a person who explained that she had received a letter from her Housing Association demanding that work be done to her bathroom to remedy an issue with the floor. The person in question was distressed and did not know how to deal with the demand.*

    By listening to the person, the innovator learned that the person was suffering from a brain tumour and that she was climbing in and out of the bath with assistance from her daughter, who was then pouring water over her using a jug. The innovator arranged to visit the person in her home there and then. At the same time, she contacted the Housing Association to explain about the person's medical and personal circumstances – for instance, how her illness was affecting her vision and causing distress – as well as requesting a shower head that could attach to the person's bath taps as an immediate, interim solution.

    As a result, a full assessment of the person's home can take place to see how her home might be adapted quickly, and the Housing Association has said that it will stop contacting the person with its demands until the innovator has been able to finish working intensively with the person herself. They have also said that they will look into long-term solutions themselves, such as changing the flooring in the bathroom.

- ➔ **The innovator felt as though she has made a real difference in the person's life by preventing her having to continue living under considerable stress**
- ➔ **Ultimately, the Housing Association would have contacted the Council to get involved and would not have dealt with the person with as much empathy**
- ➔ **Only now can the person concentrate on her progress and her treatment. If she had not visited First Local, she would still have to contend with significant anxiety that would have added an extra pressure to an already vulnerable person**

Summary and next steps

48. First Contact and First Contact Prevention have proved successful at bringing a strong, multifaceted preventative approach to people accessing adult social care. Together in a single office, social workers and care managers sit alongside occupational therapists, community support workers, prevention officers, travel trainers and sensory impairment officers – all to the benefit of people who want a streamlined, efficient and effective service based on an in-depth understanding of what a good life looks like to them.

49. First Local adds another dimension to this model by creating a local access point focused on enhancing prevention out in the community, and enhancing the 'no wrong door' approach. We are seeking to bring information and advice to the places where people go, rather than try to push people into using existing access channels. We are also seeking out people who may not always seek early help through what they see as 'formal' channels.

50. Across all projects, no additional investment has so far been required. And while up to date data on the financial impact of First Local is not yet available, First Contact itself has achieved – and continues to achieve – considerable savings. Now though, it is apparent that the limits of what can be achieved within existing resources in Access and Prevention have been or are close to being reached.

51. In terms of developing the model further by taking a strong local access model out to different communities across the city, Access and Prevention is unable to resource any

more than one local access point using its current resources (unless or until demand shifts significantly), as these have already been rationalised across the teams in order to deliver on the vision for each project as outlined above.

52. In order to manage additional local access points, building on the learning and success already being achieved through First Local, input from Locality teams alongside the involvement of occupational therapists/occupational therapy assistants and further community based preventative support (e.g. CSW's) would be key in progressing the model and continuing the shift from case management to prevention.

53. Although no additional practitioner resource has been required so far, it is important to note that the successes of these changes could not have been achieved without the support of Business Strategy colleagues who have planned, developed, measured and evidenced the change, and worked closely with social care staff to maintain a clear vision throughout. The value of these relationships should not be underestimated and on-going support will be vital if the roll out of First Local is to be achieved.

Recommendations to PLT

1. Note the contents of this report and the successes of the shift to prevention over the last 18 months.
2. Consider how further re-modelling of existing resources could be utilised to further progress the First Contact and First Local model. This is likely to include work with Locality teams, Community Support Workers, and other professionals in neighbourhoods.
3. Consider this report to inform long term workforce planning and development – e.g. Access and Prevention is signalling a shift from recruitment of grade 6 care managers to grade 6 prevention officers and OT assistants.
4. Consider in our long term plans resourcing a further shift to even earlier intervention and prevention – advertising and seeking out opportunities to provide information and advice – (e.g. early planning with family carers of people with learning disabilities).

First Local

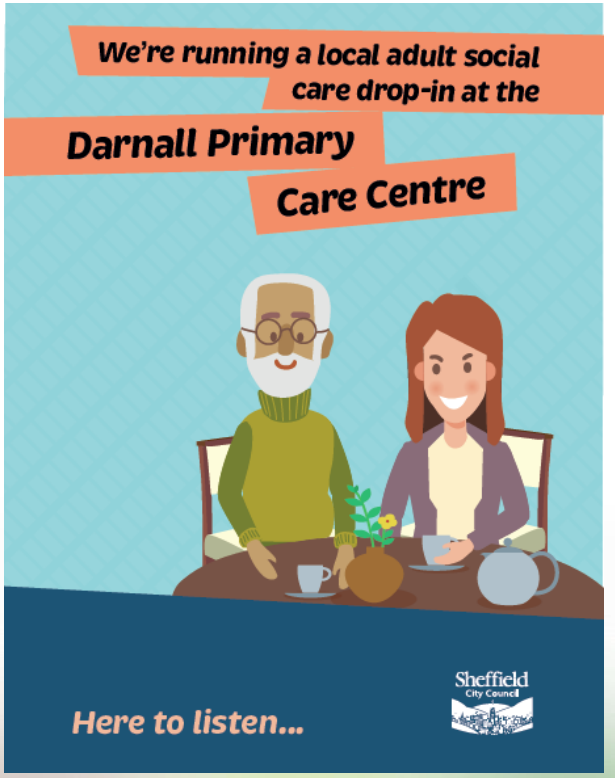
Final report – 21 September 2018

Aims and vision

- First Local was designed as a new way for people who could benefit from **very early intervention** and **prevention** to receive **information and advice** from Adult Social Care
- The **multi-skilled team** was made up of a Prevention Officer, Care Managers, Social Workers, Occupational Therapy Assistants and Occupational Therapists
- The team was based at Darnall Primary Care Centre from **9am to 5pm** Monday to Wednesday and on Fridays (and until midday on Thursdays)
- These staff have been available to have **very informal face-to-face conversations** focused on helping people to find **practical solutions** there and then
- The team has also been able to **demonstrate equipment and telecare devices** and **pop home** with people to offer immediate support
- A key aim was to **change people's perceptions** about adult social care by seeing them in their **own community** at a convenient time and place
- Staff also had access to a **private room** when needed; as such, there were **no constraints** on reasons for visiting First Local
- **GPs** were asked to simply send people round to the team whenever they thought it would be beneficial
- There was **no criteria** and **no booking system**

Timeline

- First Local has now been running for 12 weeks out of a proposed 13-week initial innovation period
- This report has been put together at this point to allow decisions to be made on the site's future prior to the end of the initial 13 weeks



Engagement

- To raise awareness, over the course of the past 12 weeks, First Local staff have engaged with:
  - GPs and Practice Managers
  - Darnall Library
  - Local businesses (e.g. supermarkets)
  - Local voluntary and community groups

Who have we seen?

After 12 weeks at Darnall Primary Care Centre, we have listened to..

78 people

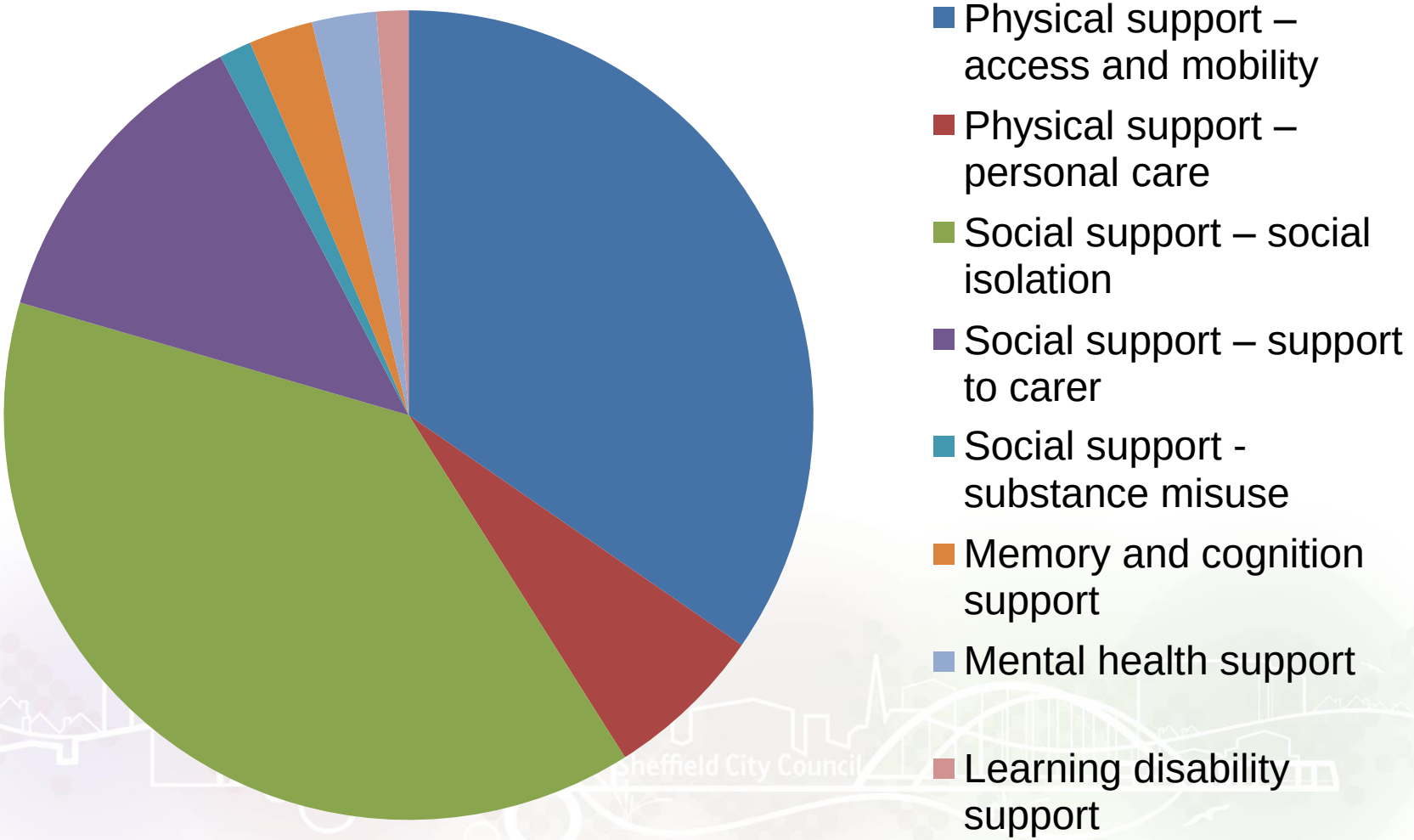
Of these, 31 were already known to us and 47 were “new”

Everyone has been at Conversation 1

Who have we seen?

- Demand has remained fairly steady over the innovation period
- The proportion of people known to us to “new” people has stayed roughly unchanged throughout – approx. 40% of people are “known” and 60% are “new”
- **On average, 1-2 conversations a day are being recorded**

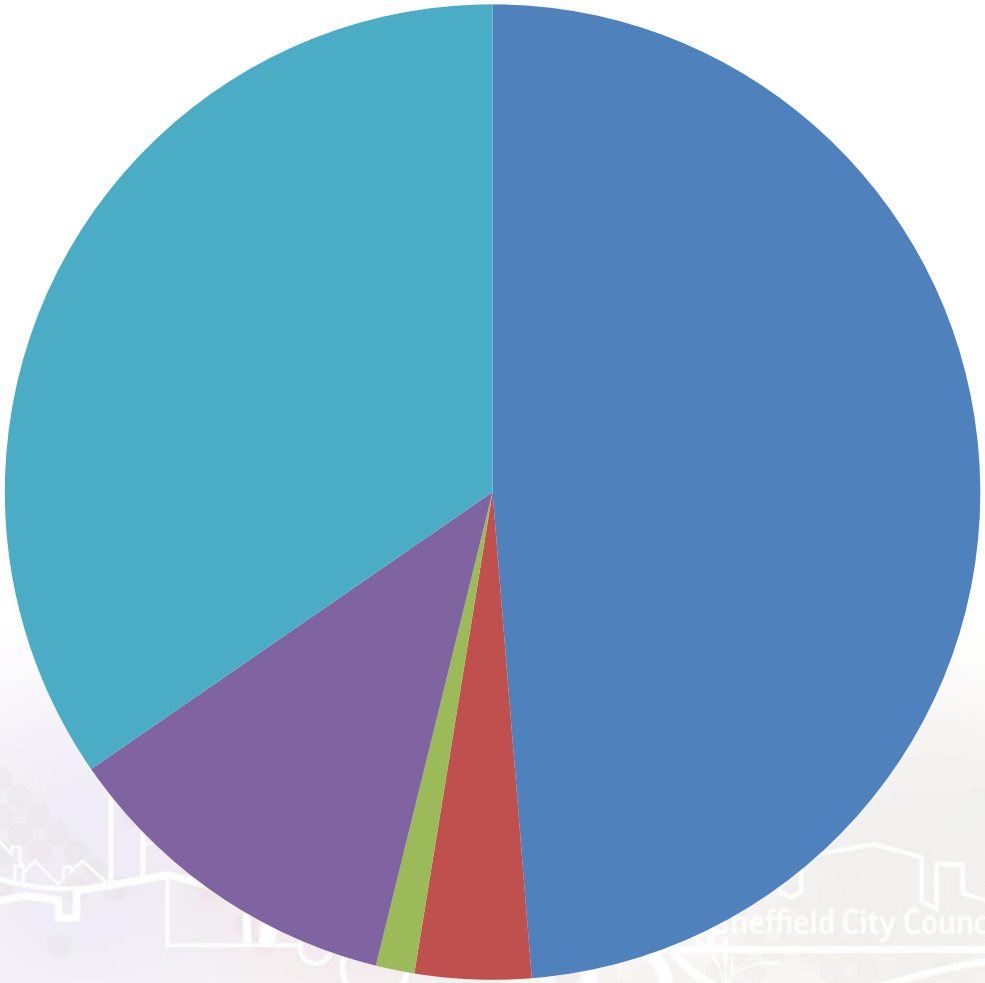
What are the primary reasons for people needing support?



What is the primary reason for people needing support?

- By far, the two main reasons for needing support are related to **access and mobility** and **social isolation**
- Alongside social care staff, the role of OTs and OTAs has therefore been key to making a difference in people's lives

How did people hear about us?

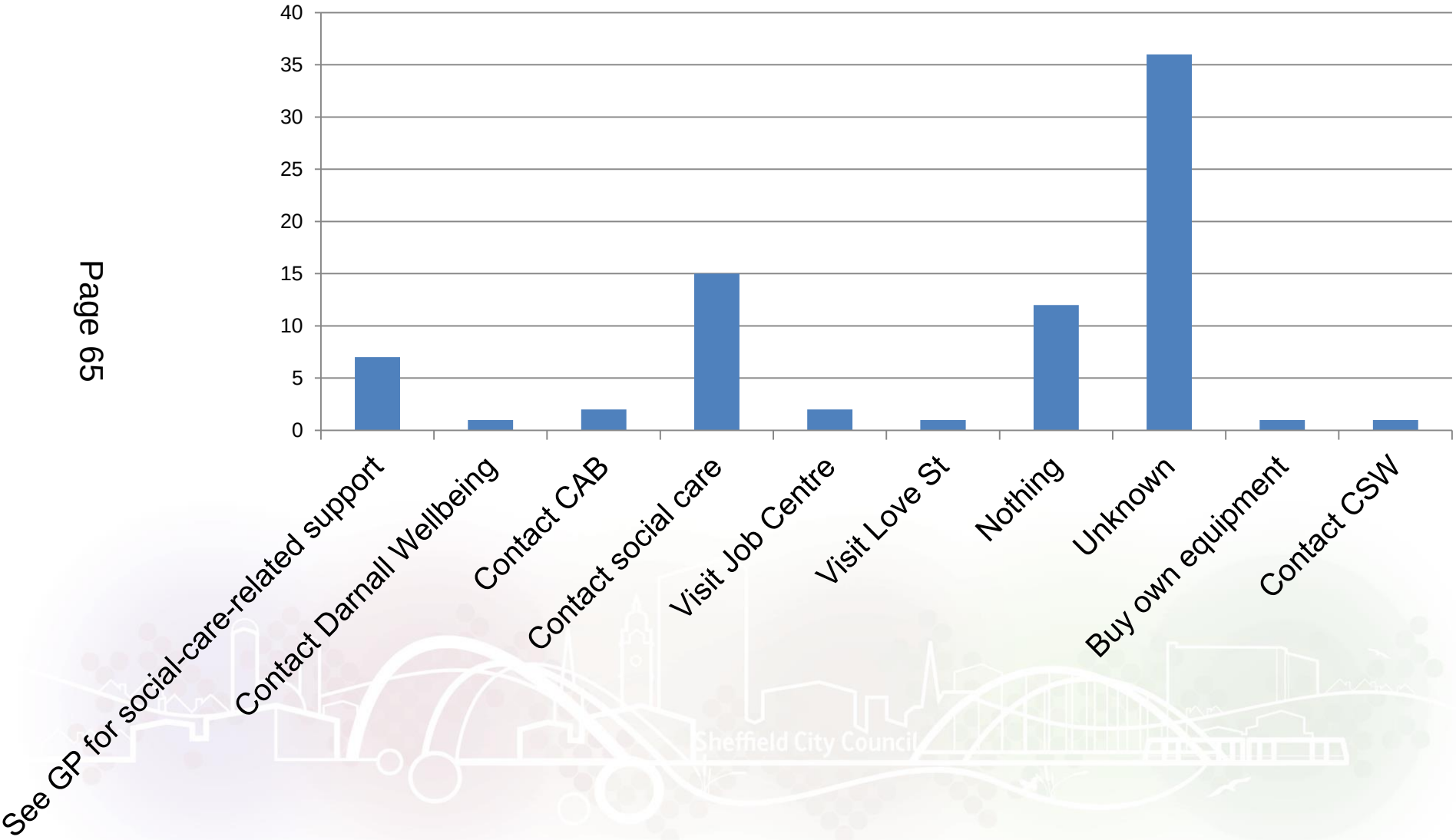


- Sent by GP/visiting GP and saw stand
- Sent by CSW
- Sent by Housing
- Came through voluntary sector, e.g. Darnall Wellbeing
- Not specified

How did people hear about us?

- The primary means by which people are hearing about First Local is either through a **conversation with their GP** or by spotting the stand in the waiting room and **approaching independently**

What would people have done if First Local wasn't there?



What would people have done if First Local wasn't there?

- Of the people we known about, the main alternatives to people using First Local remain **contacting social care via another means** (likely by calling First Contact) or **doing nothing** – and potentially risking a **deterioration** in their situation

Stories of Difference – an example

- *One of the innovators at First Local was approached by a person who explained that she had received a letter from her Housing Association demanding that work be done to her bathroom to remedy an issue with the floor. The person in question was distressed and did not know how to deal with the demand.*

- *By listening the person, the innovator learned that the person was suffering from a brain tumour and that she was climbing in and out of the bath with assistance from her daughter, who was then pouring water over her using a jug. The innovator arranged to visit the person in her home there and then. At the same time, she contacted the Housing Association to explain about the person's medical and personal circumstances – for instance, how her illness was affecting her vision and causing distress – as well as requesting a shower head that could attach to the person's bath taps as an immediate, interim solution.*

- *As a result, a full assessment of the person's home can take place to see how her home might be adapted quickly, and the Housing Association has said that it will stop contacting the person with its demands until the innovator has been able to finish working intensively with the person herself. They have also said that they will look into long-term solutions themselves, such as changing the flooring in the bathroom.*

Stories of Difference – an example

- **The innovator felt as though she has made a real difference in the person's life by preventing her having to continue living under considerable stress**
- **Ultimately, the Housing Association would have contacted the Council to get involved and would not have dealt with the person with as much empathy**
- **Only now can the person concentrate on her progress and her treatment. If she had not visited First Local, she would still have to contend with significant anxiety that would have added an extra pressure to an already vulnerable person**

Feedback from staff

- Things that have worked well:
  - "We're always able to offer immediate help"
  - Quality conversations and strong Stories of Difference
  - **The mix of skillsets has been "excellent": Staff have genuinely been able to learn a lot from each other**

Feedback from staff

- Things that have not worked as well:
  - On the whole, staffing levels have exceeded demand
  - The location is “not quite right” – less footfall than expected, and people seeing GPs don’t seem to “make the link” between why they’re there and social care
  - Difficulty building relationships and engaging with GPs (often locum) and reception staff (high turnover)
  - Some practical issues (regarding e.g. privacy, health and safety)

Feedback from staff

- Things that we could change:
  - No. of staff
  - No. of days available at the surgery
  - Times when available (mornings busier, so 9am-1pm?)
  - Location:
    - Darnall has a high level of need, but also has a high proportion of community resources (other areas may be much more under-resourced)
    - Could somewhere like a library or a supermarket work better?

Other feedback

- Feedback from the practice as well as from Darnall Wellbeing and CAB (both of whom have a presence in the waiting room alongside First Local) has been formally requested
- Anecdotally, staff report that Health Trainers at Darnall Wellbeing have found First Local useful (by allowing them to understand better the adult social care system and to help people more quickly by working together)
- CSWs in the area have also commented on the team's excellent knowledge and their positive experiences
- A meeting will be set up close to the end of the 13-week period to receive further feedback from representatives at the surgery in person. **This meeting should further inform the analysis and recommendations of this report**

Analysis

- The quantitative and qualitative data shows that First Local has definitely had a positive impact on people's lives
- In particular, the presence of OTs and OTAs has proved invaluable
- The main issue with the current model is that the current resource level exceeds the level of demand
- The lower-than-expected demand could be down to a number of factors:
  - The area (which is already home to a number of community resources)
  - The location (there is a sense that a GP surgery isn't quite right)
  - Engagement has been difficult and slow – with Darnall Primary Care Centre and even more so with the surrounding surgeries
- The Team Managers would like to thank everyone involved for all their hard work and willingness to move out of the comfort zone to try new things
- At a strategic level, staff who are not from Access and Prevention have not fully engaged with the preventative nature of this work, and this has led to some tensions on the ground
- As such, the focus on "lower-level" prevention work, combined with slow numbers, may have created a perception that First Local has not made enough of a difference to warrant the resource involved
- Despite this, most staff think that they have had positive impact and have made a real difference
- It should also be noted that the project has involved very complex partnership working – and issues regarding engagement with Health colleagues were always likely to take longer than 13 weeks to resolve

Recommendations

- Continue running First Local as it stands from Monday 1 October onwards until further decisions have been made (in conjunction with the surgery) about any changes to times, staffing levels etc. at Darnall
- Put together a revised timetable to reflect demand and meet with the surgery to discuss an appropriately reduced presence based on the following:
  - Mornings are generally much busier than afternoons
  - Fridays are normally extremely quiet
  - The busiest times are Monday mornings (start of week), Wednesday mornings (when CAB are also there) and Thursdays
- Consider a revised staff rota and the future involvement of Locality 6 (limited engagement so far) and E&A (First Local has proved that a community OT presence can make a real difference and options for expanding this should be explored)
- Ensure that staff are always working in pairs to mitigate anxieties over safety, privacy etc.
- Consider alternative options for the area to run alongside the stall at the surgery, including basing the stall at Darnall Library one day a week to see if the change in location affects demand
- Identify 1-2 new locations in Sheffield in other parts of the city to explore rolling out the model in areas with different levels of need and support (involve the CCG in any decisions)
- Consider how this work can be used to specifically address the need for a shift from case management to prevention out in the city's communities
- Re-engage with stakeholders at the surgery to build on the relationships that have been built, address any ongoing issues, and consider further refinements, e.g. attendance at MDT meetings with Community Nurses and GPs to highlight where there are issues arising for people with no current social care packages and "get in early" to prevent hospital admissions or long-term care (such as someone in the area who regularly falls)

Focused Reablement

Quarterly Report

September 2018

Document Author: Eleanor Pryde: Project Manager, Business Strategy

Version History

Version Number	Changes since last version	Status	Date
0.1	First Draft	Draft	29.09.18
0.2	Second draft – detail added in data sections. Additional stories of difference added.	Draft	01.10.18
0.3	Third draft – Additional text added in section about the Likert Scale Survey. Two additional issues added in 'issues and challenges' section. Last review date added to stories of difference and all anonymised.	Draft	02.10.18
0.4	Fourth draft – section about Likert scale removed until we have a greater sample size and are confident in data quality. Changes made to tighten up text in various points in report.	Draft	02.10.2018
Final	Added further detail in savings section and updated charts. Spelled out acronyms in stories of difference – final check to anonymise.	Final	09.10.18

Contents

1. Aim of project

The aim of the project is to apply and develop a robust and holistic approach to supporting adults of working age on a progression from their current circumstances, potentially right through to gaining employment or voluntary work, and full independence. Individuals might start anywhere in the journey depending on their circumstances, and may only achieve a small step change. Some individuals however may progress to full independence and therefore live a significant proportion of their lives without the need for formal social care support.

The project covers three key areas of focus:

My Home – *My home is an enabling environment, not a disabling one; I am supported to be as independent as possible in my home; I can come and go as I choose to; I feel like I am part of my local community, not isolated in a house that makes my life more difficult.*

My community, friends and family- *I am able to go to places in my local community that are necessary, like shops, GP surgery, and the post office/bank. I am also able to see friends and family when I want to. I am able to find and make friends and form relationships when I want to. I can go to places and join in activities, for fun and for work.*

My day to day activities – *I am planning how I will stay as independent as I can, for as long as I can. I have the least restrictive level of formal support possible. I am supported to regain skills and fitness and stay well. I am supported to engage with and make informed choices about risks, and explore opportunities.*

We have brought together a team of occupational therapists (OTs) and prevention workers (PWs), managed by a Team Manager, and supported by a Project Sponsor, Project Manager and Project Board, to help us achieve our aim.

2. Review of delivery to date

Delivery began on 18th June 2018 with a cohort of 586 people meeting the following criteria:

- Aged 18-64
- Not in employment
- Not in a care home
- Not in supported living
- Not in in-house days services
- Receiving packages worth £0-£200 per week
- Not on mental health caseload
- Including people regardless of whether they have previously had a CEPs referral or not
- Receiving **independent** provision (including day services, home support, direct payments)

The cohort size has since been increased to 725 people through the inclusion of adults up to the age of 70. The current cohort is 48% male, 52% female, with the largest age group being 60-69 years old (Figure 1).

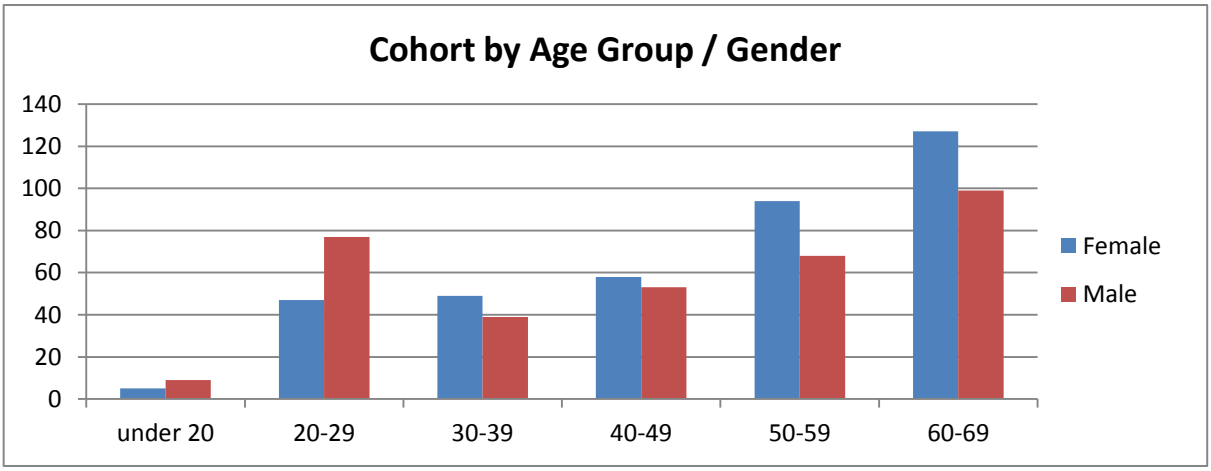


Figure 1: Cohort by Age Group/Gender

The cohort has a wide range of primary support needs, with the largest two being physical support and learning disability support. Figure 2 shows primary support need in relation to age.

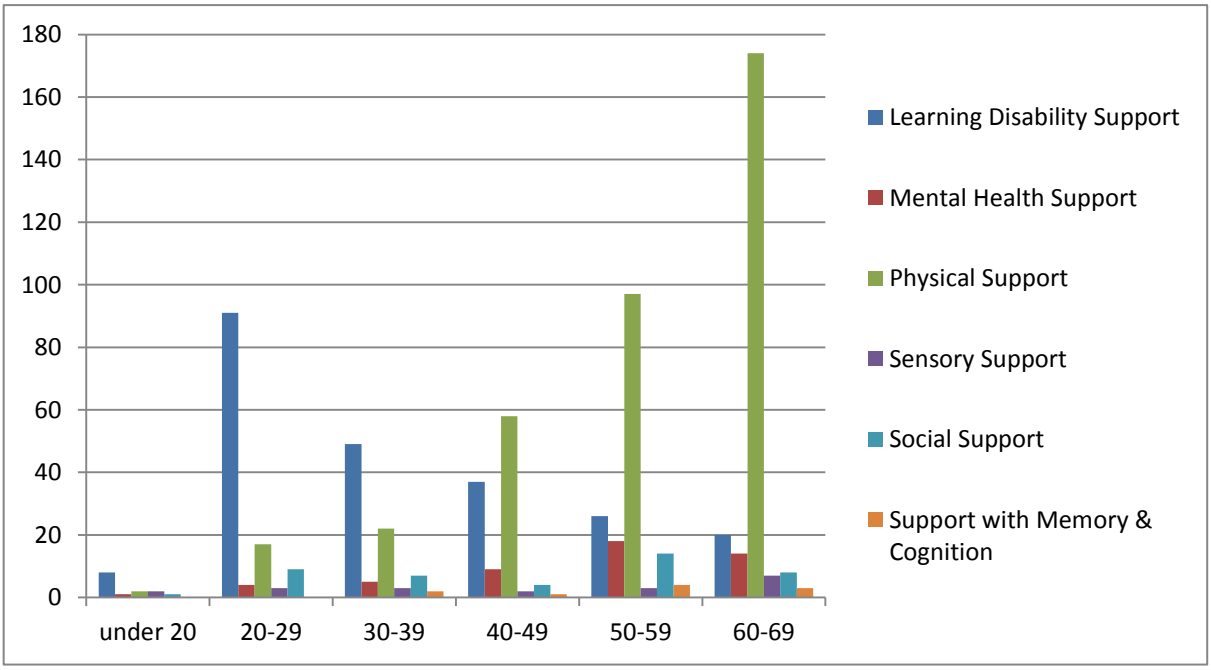


Figure 2: Primary support need in relation to age

2.1. The delivery team

We are very pleased with the quality of the people on the delivery team – both OTs and prevention workers. There is a wide mix of skills and experience and everyone is strongly committed to doing the best for customers. All staff have been working very hard and can really see the value in what the project is trying to achieve. One OT said she felt "privileged" to have had time with a particular service user and that she was able to help them to improve quality of life. Another OT said that this approach has made them question their previous advocacy of telephone reviews because of the value they see of taking time to properly speak and listen to someone and the difference that 'smaller' things can make to quality of life. The prevention workers are engaged and enthusiastic despite being on a huge learning curve. They have really embraced their roles. The whole team has

been bonding well and there is a good amount of mutual respect. Prevention workers are supporting the OTs but also taking on their own case load. Some prevention workers are taking a lead in supporting data collection and recording. It has been really helpful having an OT lead as a main point of contact for the OT team.

"*I can honestly say that the team is amazing …. Sandy is a fantastic manager and she encourages outcome led practice that is truly client centred. The other OTs are fully supportive and I really enjoy the peer supervision sessions in that we can all draw on one another's experiences to guide practice.*

The prevention workers are so committed and passionate and really help build a good rapport with clients and gain trust from our clients. They have all got so much to offer and are really keen to learn and get things right for our service users. They work so hard at ensuring the right resources are sourced and that clients are given opportunity to plan and put in place actions to bring about positive change". FR Occupational Therapist

2.2. Facts and figures

2.2.1. Numbers reviewed, packages closed/reduced, cases not progressed

To date, the team has carried out initial visits with 143 people and finished working with 30 cases. Of the 143 people visited, the cases that haven't yet been closed are still ongoing – either OTs need to wait for equipment to arrive and do a follow up visit or the case has been passed to a prevention worker to do further work such as travel training or supporting people to get out to groups etc.

107 cases have not been progressed due to being carers, CHC funded or taken up by Localities.

2.2.2. Demographic trends

The sample size is small at 30, however the following charts show that currently, most of the people we have reviewed are in the 50-59 year old age group (Figure 3), that we have reviewed more women than men (Figure 4) and that the main primary support need of these 30 people is physical support (Figure 5). We will continue to monitor demographic trends over the coming months.

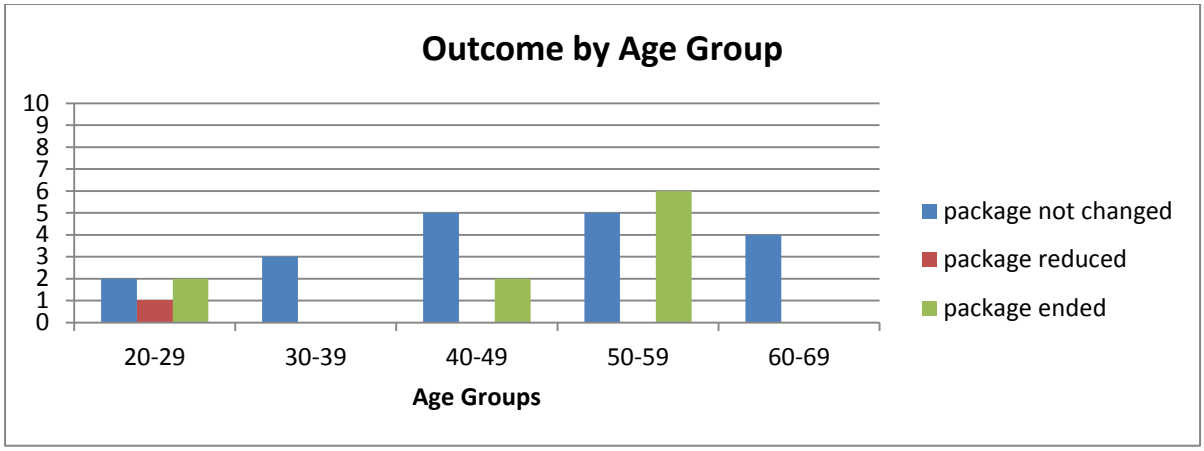


Figure 3: Outcome by age group

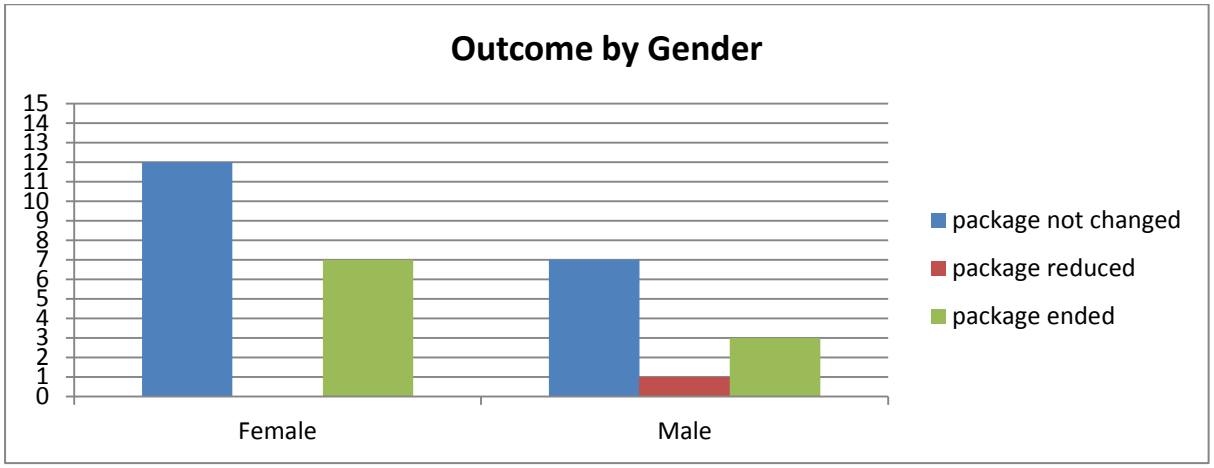


Figure 4: Outcome by gender

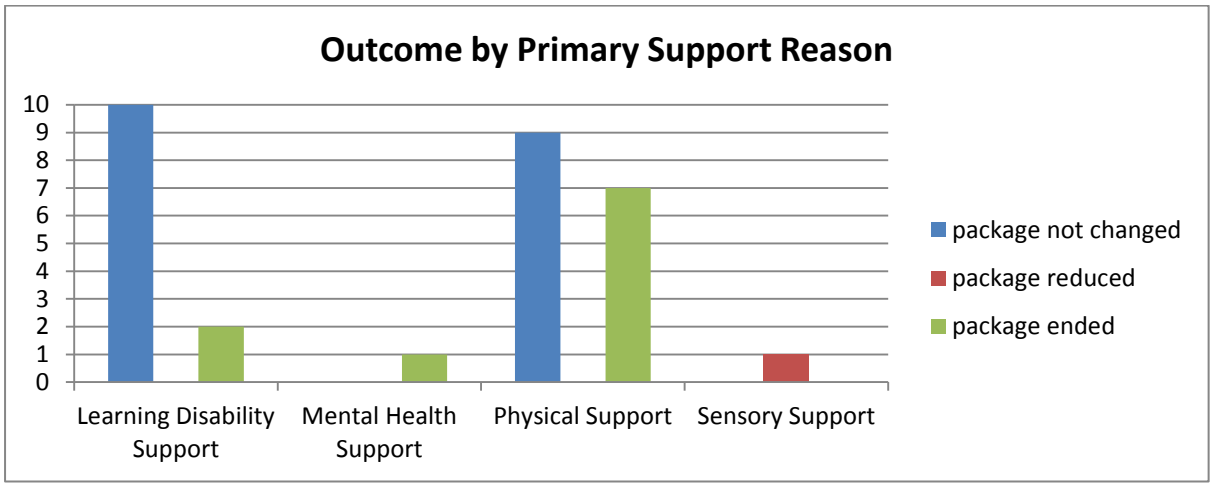


Figure 5: Outcome by primary support reason

2.2.3. Savings

We are recording savings for the cohort. To date, the team's work has resulted in a full year gross saving of £42,014 and a financial year gross saving of £32,460. It is too early to extrapolate potential savings from reablement work across the year, however we plan on doing this once we have closed approximately 10% of the cohort.

- Ten packages have ended. Some of these made savings from non-reablement sources for example in one case the customer had moved away, another was actually a carer, another one cancelled their own package after a visit from us and another we identified that a payment was actually no longer being made but was still being recorded in the budget.
- 1 care package has been reduced (with the possibility of reducing further)
- 19 packages have seen no change in terms of cost (some of these have prevented rising care package costs and some have found a better fit for the customer – see Stories of Difference in Appendix 1).

2.3. Successes and challenges

2.3.1. Successes and feedback

The OT/prevention approach has had a lot of success and we have been told by customers how this approach has differed from their previous reviews – not just helping with the practical things that improve their independence, such as bath seats, walk in showers, ramps and many other innovative approaches, but also with achieving a more positive mind-set and outlook for the future. Some of the cohort has had to wait years since their last review – 284 people haven't had a review since 2016 and of those, over 100 people haven't been reviewed since 2015. The Focused Reablement team has had the time and investment to explore some of the wider options open to customers, which historically other teams haven't always had, due to the pressures of caseloads and imperfect referral systems. This has meant that the Focused Reablement team has been able to identify the potential for positive changes that have sometimes been previously overlooked. It is becoming evident that there is huge value in having time to explore the practical, social and emotional changes that can be made and of having quick response times between the OTs and prevention workers within the team.

Feedback from customers

We have had lots of wonderful feedback from the people we have visited, many of whom have felt isolated for some considerable time.

The customer ***"thanked me for supporting him in using community transport for the first time, to complete food shopping for the first time in over 2 years. He told me he really appreciates me taking the time to support him in this, and that no one has spent any time with him or asked him what support he would find useful since his accident over 2 years ago"***

The customer called to say that she was over the moon that the contractor had arrived and was going to level the side alley and put her three wide, shallow steps at the back so that she will be able to access the garden. She said ***"I can't thank you all enough"***.

*"I have had lots of best moments but the ultimate was hearing (following an initial visit) that a client (in end stages of COPD and palliative and suffering low mood … quite understandably) went out with his wife on his scooter following our visit. This was something he had not done for a long time. His wife shared over the telephone after the visit that they "**both felt really empowered**" and the trip out had gone well. During that visit we also talked of the client's desire to go into the garden. This was not possible because the garden was completely inaccessible due to masses of steps. During the visit, we talked of making changes to a small room overlooking the garden so that the couple could both sit in the room together in order to still enjoy the beauty of the garden (the client had designed and landscaped this himself). The mood when we left the visit was completely uplifted and it felt that we had achieved such a lot during that one conversation. That was the best for me and was one of the first reviews I completed*".

"*This afternoon has been an education…In the past when I have contacted the City Council I have felt that the person on the other end of the phone has been answering my questions from a script this certainly has not been the case this afternoon…We expected you being in the house for about fifteen minutes and then you would have gone".* Customer at the end of a visit by an OT and PW

We have collected lots of wonderful stories of difference. Some of these can be found in Appendix 1.

Feedback from staff

Staff on the Focused Reablement team have also taken a lot of pride in and satisfaction from their roles. Here are just some of the many comments they have made about their involvement in the project:

1. What has been your best moment on the project so far?

"One highlight was taking a client on a bus in his electric wheelchair for the first time ever since his accident. I have taken a great deal of professional pride in being able to achieve outcomes like this!" FR Prevention Worker

"The best thing about the role so far is people's reactions to being listened to. People have been surprised that we are there to support them in whatever ways people would find most effective for them. I've found people have really appreciated the time being taken to listen to their views and something being done soon after." FR Prevention Worker

"I love the experience of listening to people as they take down the barriers and open up about the things that they really enjoy. Also Cycling4All in Hillsborough park – meeting the amazing people that run it (volunteers on the whole) and the people that get so much enjoyment from taking part". FR Prevention Worker

2. What has been most challenging?

"It can be really challenging trying to change people's perceptions of adult services. People I have met, and more often their carers, have had really bad experiences with social care and this can mean they want as little to do with us as possible…it can be very challenging in reviews when people don't really want to talk to you because of their past experiences". FR Prevention Worker

"*In honesty, the most challenging aspect for me is time management given the commitment of delivering 6 assessments per week. This is difficult combined with keeping on top of any follow up work, learning the processes etc. The Care First system has been difficult to navigate and hopefully this will be improved once Liquid Logic is in place*." FR Occupational Therapist

"*The most challenging thing for me has been the enormous learning curve I have been on. I had worked in the housing service for 11 years and I was very housing orientated but this project, very much immediately, gave me a whole load of new things to learn, I've loved it though, it's good to keep fresh and learn new things*". FR Prevention Worker

"Trying to encourage people who are entrenched in a negative mind set to open up and really think about the life they want to live. Using the solution focused approach definitely seems to be the best approach to achieve a successful long-term outcome. However, this can take a really long time for some people. Time is inevitably limited due to the number of new cases each week and this time

constraint can feel incredibly frustrating. Wanting to take a holistic approach with everyone but not always being able to do so". FR Prevention Worker

3. What have you learned?

"So much!

- *How many incredible people there are working in and around Sheffield to support people in our community.*
- *I've learned a lot about medical conditions that I was unaware of before.*
- *Brain in Hand – the training was really interesting and I'm excited to get started with the role out. I think it has a lot of potential.*
- *It's been incredibly humbling to witness the strength of many people (and their carers) who face emotional and physical challenges every day.*
- *I've learned about bus passes and access cards and charities and church groups and volunteering opportunities and accessible health centres and support services.*
- *I've been to areas of Sheffield that I didn't know existed".* FR Prevention worker

"*What have I learned? All sorts! Information on benefits, PIP, Care First, lots about occupational therapy, how to ask the right questions, listening better*". FR Prevention Worker

4. How effective have you found the approach that the project is taking?

"*I love the approach of the project, its giving people a chance to have a conversation that they might not have had for years*". FR Prevention Worker

"*My experience has been that the conversations model cuts through so many of the usual superficial and often difficult layers to get through when meeting someone for the first time. It very quickly tunes in to people's 'real and authentic' selves. The model allows people the freedom to explore their own potential and aspirations and purpose in life. Many people have shared they have been stuck in a rut and not looked to the future. As practitioners we are able to use a biopsychosocial model to look at a whole range of approaches to enable people to move on to a better place of being and living*". FR Occupational Therapist

"I'm finding the conversations count model challenging but really rewarding. It can be difficult to come away from a review on a positive note when what clients are telling me isn't positive or is upsetting. Yet it's exactly these situations where it is most rewarding both for the client and myself." FR Prevention Worker

Feedback from external agencies

Finally, we had some great feedback from a Victim Care Advocate from Victim Support South Yorkshire, who worked with one of our prevention workers. They said "…*The victim spoke very highly of* [the PWs] *professionalism, their kindness and approachability. They were able to arrange the fittings of window retainers and improve security of a shared gate at the back of the victim's property. They also found the smoke/fire alarms in the property to be ineffective and had these*

replaced. They referred the victim to Occupational Therapists within their team who are working on improving fixtures and fittings of the property that will aid the victim with their mobility needs. Throughout the entire process of working with [the PW] *I was very impressed with their professionalism and willingness to discuss the specific concerns I had for the victim. I was kept updated throughout, as was the victim. I am very grateful for the work that* [the PW] *and their team have put into this case and genuinely feel that it has improved the quality of life and safety of this victim".*

2.3.2. Issues and challenges

There have been a number of issues and challenges faced by the team. These are outlined below:

1. We quickly found that **Occupational Therapists were spending a lot of time sifting through cases on Care First after allocation** – due to poor data quality and misinformation on Care First. This caused delays with setting up visits and was not a good use of their time, given they are each targeted to do 6 reviews per week. To resolve this, prevention workers have taken on the role of supporting OTs to sift through the caseload, with the agreement that the OT still books the visit.
2. **A lot of people in the cohort have been found to be carers, CHC funded or have been picked up by Localities since the cohort list was produced**. In order to counter this, we have expanded the cohort to include adults up to the age of 70 and this increased the cohort to 725. We are monitoring this situation and will expand the cohort by increasing package cost to £250 per week if necessary.
3. **OTs and prevention workers have struggled at times to get customers on the end of the phone.** There have also been some last minute cancellations, which is frustrating as they impact on the OT target of 6 visits each per week. We are monitoring this to ensure it doesn't become widespread.
4. **Visits take about 2 hours if done properly**. Some assessments have taken longer, however they are having positive results so we consider them worth the time. Until recently, OTs and PWs were carrying out joint visits, however we are now getting to the point when some of the reviews are not done jointly – because there isn't enough time in the week for PWs to complete all the training, follow-up on existing cases, write up the conversations and attend 3-4 new reviews. We will monitor this over the coming months to ensure that all customers are getting the most appropriate support possible to improve their independence and we are looking very carefully at how effectively we do handovers.
5. **Some customers have a historical fear that adult social care services are only going to reduce their care package,** even if it means improved independence for them. This is a new team that is still learning how to have occasional difficult conversations. We continue to train staff and empower them.
6. **The quantity of ongoing cases is rising and as such, prevention workers' workload is also rising.** There are currently 114 ongoing cases and there is a risk that the quality of service could drop as the workload increases and that prevention workers could begin to feel overwhelmed. There is also a risk that we lose track of what is happening with each ongoing case. The team is trialling approaches to keep a close eye on activity and the status of each case and the Team Manager is having regular supervisions to ensure workload is distributed evenly and no one feels it is too

much. The new Liquid Logic system may help us with tracking cases and we will continually monitor this situation.

7. **The transition to Liquid Logic.** Up to now, the Team Manager has done the care plan, however with the transition to Liquid Logic, the team will have to do them and send them to the Team Manager to authorise. This is new to a lot of the team. The system is also new to everyone so could cause potential delays and discrepancies in recording. We will monitor and provide ongoing support and training as necessary.

2.4. Brain in Hand

Brain in Hand (BiH) http://braininhand.co.uk/is a personalised support website and app for people with a range of conditions including autism spectrum condition, mental health conditions, acquired brain injuries, learning disabilities and other medical conditions. Sheffield City Council has bought 12 licences – two of these are for use by Localities, the other 10 for use between the Focused Reablement project and wider Access and Prevention services. The aim is for BiH to create another way of some customers improving their independence and would become part of existing support provided by the Council, allowing users to create their own solutions to deal with a range of issues throughout the day (such as anxiety) and ultimately become more independent.

We have trained one prevention worker from Focused Reablement, two from other Access and Prevention teams and one from Localities. These people will be our BiH ambassadors and will support further training within services as well as setting up users.

We will monitor and evaluate the success of this app in supporting people's independence and will provide an update in the next quarterly report.

3. Summary: How far we have met our aims

It has been a great start to the project. We are already over a quarter of the way through reviews/initial visits and if we can continue at this pace will have reviewed the planned amount of people (circa 500) by the end of the project. We have made some really positive impacts using the combined OT and PW approach and have already changed many people's lives for the better. We have a dedicated, hardworking and competent team of staff who believe in what we are doing and are helping us to deliver our aims. We have begun to make gross financial savings and we hope to be able to provide some more accurate predictions of savings within the next couple of months.

Where there have been challenges, we are addressing these and in particular are monitoring the ability of the occupational therapists to complete six reviews per week given the time taken to sift cases. We are also monitoring the cohort and will expand it further if necessary to counter customers lost to Localities, CHC funding or who we discover aren't eligible for other reasons.

4. Next steps

Over the next quarter we will continue to keep up the pace of reviews, supporting customers to improve their independence, and will keep addressing issues as they arise. We will begin to make predictions for savings across the project and beyond. Liquid Logic will be introduced in October 2018 and all staff will be trained to use this system. Finally, we will introduce Brain in Hand for some of our customers and will monitor the effectiveness of this in supporting people to improve their independence.

Appendix 1: Stories of difference

Sam's Story

Date of last review: 16/03/2016

In his 50s, Sam (not his real name) fell from a ladder whilst decorating and broke his neck. Consequently Sam had to move home, he currently lives in a council 'ranch' style flat

Medical details

- Paraplegic – wheelchair dependant, he has an electric indoor/outdoor wheelchair
- Previously prone to urinary tract infections (UTIs)
- Depression and possibly some alcohol use

Since the injury Sam has developed good upper body strength

Care package – Formal care – this was the last record of the care provided
LATE MORNING CALL @ around 10:30am - for 30 minutes 1 carer 4 x weekly (Mon/Tue/Thurs/Sat) to assist with personal care - some assistance with showering and dressing especially lower half of body such as socks, getting clothes ready, changing night catheter bag to day one and emptying, and taking bags from internal bins out, to put in large communal bins outside in bin store (which Bin men collect and return to bin store).

EXERCISE CALL - 2pm x 2 carers 20 minutes (Mon/Wed/Fri) support to mobilise with pulpit frame around flat as instructed by physiotherapist.

The exercise call stopped some time ago. The care agency is no longer operational so we cannot be sure of when care was last provided. Sam says that he last had care in January 2018. In July 2018 the care package was transferred to another company but they have never provided a service for this customer. When the Focused Reablement team (FRT) became involved there was an open care package on Care First.

The District Nurses (DNs) visit daily and support Sam with his catheter and bowels.

Informal care – Sam has a friend who visits daily to support him with domestic activities of daily living (DADL) and some aspects of personal activities of daily living (PADL).

Sam's Issues
The transfer from his shower chair to the bed was a particular problem as he currently does not feel confident to make the manoeuvre without someone being present; whilst the assistance provided is minimal it is more of a reassurance as opposed to physical assistance. Sam would like to be able to carry out all transfers independently.

FRT issues

- Sam doesn't get out much, he has an electric wheelchair that can traverse the small threshold

at the front of the property (with a run up and a struggle)
- Safe transfers
- Standing has long term benefits for a wheelchair user – strengthens all muscles, improves bone density especially in the lower body, improves bowel and bladder function, improves circulation and respiratory systems; improves posture especially in the hips and back; can help skin integrity.

Actions
- First Contact occupational therapist (OT) has already arranged for a small step at the access of the property to be ramped. Sam believes this will facilitate his access and consequently his social interaction.
- Reviewed transfers. FRT has special ordered a wall mounted shower seat that should facilitate transfers to and from his wheelchair and advised him to self-purchase a towelling dressing gown that will help him dry after a shower
- Sam rarely goes out to socialise and the FRT have worked with him to develop ability to use public transport (travel training); Sam lives next to bus terminus.
- Sam has agreed for occupational therapist to refer back to physiotherapy to review his standing ability and if this should be resumed

Outcomes
- Safe transfers and increased independence. Sam has rejected care but was still dependant on informal care or was risking unsafe practice, his safety will be increased
- Better access to property
- Better access to shower
- Increased social inclusion, being able to confidently use transport will enable Sam to resume an independent social life
- Physio involvement to review standing – potentially better health care

Claire's story

Date of last review: 06/12/2016

Claire (not her real name) has worked on/off in previous years as a cleaner, which would be a struggle now due to medical conditions. She has attended college and wants to explore opportunities to get back into work or to have further social outlets to become more active as she can feel isolated.

Claire likes to get the bus into town to go shopping and visit the market. She does this using her bus pass. She is confident to get the bus alone.

Care Package
30 minutes per day (provided via the council) they support Claire to wash and do some limited housework. Claire also has a cleaner – paid for privately.

Current Situation

- Claire lives alone in a ground floor one bedroom flat with 3x step access.
- No carpet throughout flat with vinyl flooring in the bathroom and kitchen.
- She has several house cats. The flat is cluttered causing multiple trip hazards.
- Bed lever in situ on the double divan bed. Reports this to help getting in/out.
- Shower over bath, able access shower using the sink (pedestal) for support. Showers every other day due to feeling unsteady when standing in the shower.
- 1x grab rail next to toilet plus uses the door frame to pull up on. Reports to be able to dress self but needs the help to wash.

Functional Ability

Independently mobile indoors/outdoors. Independent with bed, chair and toilet transfers. Good 'range of movement' in shoulders able to touch hands behind. Able to cook all meals in standing. Reports to get back ache when she has done too much but this resolves after resting.

Actions

- Shower board provided – OT checked that Claire was able to use it comfortably
- Escorted by FRT worker to 'Knit and Natter' group – Claire really enjoyed this and whilst there she volunteered to help with other activities that are held in the community centre. Claire engaged well with others in the group
- Advised re cleaner and increasing their hours

Outcome

- Care package cancelled as Claire can bath independently
- Claire less socially isolated due to contacts made when attending group with prevention worker, she has signed up for and attended 2 additional groups at the community centre and through the contacts she made is attending another group elsewhere
- Claire has volunteered to be a helper at the local community centre
- Private cleaners hours increased to try and maintain a suitably habitable environment
- Claire was contributing over a hundred pounds a week towards her care package even when taking the extra payments to the cleaner into account she is financially better off

Tim's Story

Date of last review: 24/08/2017

Tim (not his real name) is in his thirties. Tim lives alone in a one bed council flat which is wheelchair accessible, the flat is mostly level internally but some of the thresholds are raised. Tim is separated from his wife and shares responsibility for his young children most weekends. Tim has a close relationship with his mother and her partner who offer him considerable practical and emotional support; he also has a supportive brother who usually visits for extended stays. Tim has built up considerable debt (about £11,000) mainly from not paying for his care package.

Health

Tim was diagnosed with generalized inflammatory arthritis (Rheumatoid Arthritis) affecting his

immune system following a period of illness in his teens. Tim presents with severe musculoskeletal deformity significantly affecting both hands and feet. Tim's hips, knees and spine are also severely affected. Tim has had a left knee replacement and bilateral hip replacements. Poor dental care and he has lost a number of teeth. Tim is supposed to attend regular hospital visits but doesn't always do so.

Mobility – Tim walks slowly with elbow crutches in his home although the raised threshold at the kitchen door was reportedly problematic. On observation, Tim walks on his toes and as such his balance, stability and endurance is extremely limited. This is compounded by his hand dysfunction and as such he is at risk of falls although he has not fallen to date. Tim has a powered mobility scooter that he uses in order to access the local community. Tim has used the scooter on public transport and has a pass.
Access – has key safe and communal door provides security.
Seating – Tim has a rise recline chair (RRC) he purchased himself; Tim sits in this chair for extended periods of time. Tim leans heavily to his left side with significant posterior pelvic tilt evident. This causes disruption of the natural curvature of the spine which squashes the internal organs such as lungs and stomach. Due to his type of arthritis, when joints including the spine become inflamed they swell and this can lead to the nearby tendons to becoming stretched and less supportive hence the increased risk of a more permanent curvature of the spine and increased respiratory or digestive problems as well increase pressure areas and affect balance and standing. Commonly the neck is affected and in severe cases the spinal cord can be damaged leading to increased disability. When prompted, Tim was able to correct his position however this was not maintained.
Meals – due to reduced hand function he is unable to make meals or drinks, his nutritional intake is poor
Housework/laundry – family do this
Dressing – Tim struggles – he is assisted by carers
Washing – mother assists, the level access shower (LAS) was in situ when Tim moved into the property
WC – Independent - has equipment to assist with transfers but struggles to wipe his bottom
Bed – Tim has a double bed with a pressure relief mattress, he struggles with transfers but he doesn't have the grip to use equipment

Care Package
7x7, 30 mins morning call; 7x7 30mins afternoon call (evening call for a meal)
Tim has never been assessed by the Equipment and Adaptations team (E&A)

Ongoing actions

- **Bathroom** = wash/dry WC, alternative shower seating, replacement rails. The footprint of the wash/dry WC is different from a standard WC so the LAS flooring will have to be replaced, we are taking the opportunity to move/remove facilities and rails to better meet need and to 'special' order seating in the shower, we will be working with the Sheffield Council Housing Service to achieve a more functional bathroom especially as Tim will be a wheelchair user
- **Seating** –to seek alternative more supportive seating – charitable funding
- **Scooter** – the scooter can be difficult for Tim to mount and cannot be used inside the home, we are referring to the NHS Wheelchair Service for consideration for an electric indoor/outdoor

wheelchair, and reviewing the property for wheelchair accessibility

- **Fire Safety** – Tim is a smoker and sometimes smokes in bed we have referral for fire retardant provisions and advice (he says he doesn't smoke when the children are present)
- **Physiotherapy** – Tim has had difficulty accessing hospital based physio, we have referred to community based provision
- **Debts** – phone number of local Citizen's Advice Bureau (CAB) given and he has made contact and has been allocated a case worker,
- **Bed** – we have agreed to provide a hospital bed with pressure relief mattress which will and sleep and facilitate transfers
- **Dentist** – Tim did not know that there were dentists who home visit, we have given him the details of who and how to contact, also discussed electric tooth brush or at least adapting a regular tooth brush for ease of use
- **Nutrition** – ongoing discussions re diet; health trainers will be discussed with Tim to continue this work. We have also discussed adapted cutlery to make eating easier
- Remove raised thresholds & and review wheelchair accessibility

Many of the solutions to Tim's issues will require money; money he doesn't have or is reluctant to spend due to his debts. The team will explore charitable funding as much as possible

Variation from 'traditional' Intervention

Tim has been known to Adult Social Care (ASC) since 2015, during this time he has had a number of assessments, usually addressing his care package. He has never had an E&A referral, which may have picked up some of the ongoing issues above. From what FRT can see the NHS have also not fully recognised the home issues.

Simon's story

Date of last review: 24/05/2017

Simon (not his real name) is in his forties. Simon lives alone in a housing association 3rd floor flat with lift access. Simon has a mild learning disability. He volunteers 2 days a week at a charity shop where he helps to sort and tidy the stock. Simon also enjoys visiting the communal areas in his flats to socialise with other residents.

Mobility/Functional Ability

- Simon is obese although he was not able to give his weight, it's estimated to be between 25- 30 stone; he is approximately 6ft tall
- Irregular heartbeat
- Simon reports a 'twisted' knee; CF records say he has been diagnosed with osteoarthritis in his neck, shoulder, arm and ankle
- Simon says his short term memory (STM) is poor
- He can walk independently indoors and outdoors for short distances
- Independent with transfers - in/out of chair; bed; toilet (with a rail)
- Prompts to shower but independent in the shower, he has a LAS but the shower chair is rusty
- Shortness of breath (SOB) when mobilising

- Can make drinks and microwave meals
- Able to use public transport - will get bus to city centre
- Prompts to tidy and clean up after himself
- Generally lacks motivation (he is taking an anti-depressant)
- Struggles to read complex sentences and conversations; he has good verbal communication

Current care package

- 30 mins daily am visits on weekdays
- Prompt and observe with medication
- Prompt with personal care
- Prompt and support with cleaning
- Prompt and support with laundry
- Support to make appointments
- Penderels (support organisation for direct payments etc.) help to manage his finances

Issues identified by the Simon

- He wants to learn how to cook
- Bed broken (single divan)

Issues identified by carers and/or FRT

- Not taking his medication at weekends when carers are not around to prompt him – carers requesting an increase in care package for meds over weekends
- Bed needed
- Simon spending his weekly food budget on 'junk' foods and drinks
- Joint damage, pain, fatigue and diabetes due to obesity
- Obesity possibly contributing to depression (research indicates that there is no clear causal link but obesity and depression do have a high joint prevalence)
- Rusty shower chair is a risk to skin integrity

Actions

- **Shower chair** – new chair provided
- **Simon enrolled with 'Why Weight'** - This is a free service for residents within Sheffield who are looking to take control of their weight and create achievable goals towards leading a healthy lifestyle. The FRT are supporting him on his first visit and then will then evaluate the need for any additional support to attend from FRT. This will hopefully help Simon to make more suitable choices when shopping
- **Cooking** – we are seeking appropriate local resources to back up and reinforce his attendance at Why Weight
- **Simon has a new bed** – FRT have negotiated with Penderels to purchase a new bed and bedding, we have also arranged for the disposal of the old bed. Simon has been involved in the choice of the bed and bedding
- **Medication** - FRT have negotiated with Penderels to purchase a vibrating alarm watch from Argos, this watch can be set to vibrate at numerous times during the day to remind the wearer to take his medication. When this is set up we are asking the carers to watch to see if it is used rather than prompting; we plan to review this after a month

- **Cleaning/shopping/laundry** – This is to be paid for privately and arrangements have been put in place with the assistance of the FRT

If the watch works then we will not have to increase the care package, it may even allow for a slight decrease. Whilst Simon is overweight and unmotivated it is not feasible to take away his support as there is a high risk of self-neglect. Previously CF records it says that Simon has self-harmed and attempted suicide in the past, he has mismanaged money. In 2012 it says that the more overweight Simon becomes, the worse his arthritis gets, leading him to become even less active etc. increasing his low mood. It is therefore unlikely that his care package will decrease at this time.

Belinda's story

Date of last review: 09/03/2018

Belinda (not her real name) is in her fifties and lives in a 2 bed local authority bungalow which is adapted for her needs with a step lift to the front access and level access shower. Belinda lives with her daughter who works full time, but is generally at home evenings and weekends. Belinda is well connected in her community, having lived in the area for many years. Belinda's mum lives nearby; she has Parkinson's Disease, but is still relatively well functioning and still drives to come and visit Belinda. Belinda goes out in her community / sees friends most days, except Thursday which she describes as a 'nothing day'.

Belinda's care package = 2 calls daily am - 40mins and evening 20 mins, for personal care

Medical History - Belinda has a rare neurological condition - Stiff Persons Syndrome, this is long term and affects the muscles and causes muscle spasms. Belinda is under regular review at the neuro day unit at Northern General Hospital (NGH), where she attends every 12 weeks for IV drugs which she reports are effective at managing her muscle spasms, although she continues to experience pain throughout her body. She has a supra-pubic catheter. She had both knee caps removed as a young adult. Belinda has ataxia (another neurological condition that can cause a lack of coordination and balance) arising from a brain haemorrhage when she was young. She reports that her eyesight is getting 'worse' and she struggles to read text on a white background, due to the glare. She takes and manages her medication independently. There were no concerns re. Belinda's capacity.

Functional Assessment - On arrival to the property, Belinda shouted through an open window to come in, she did not come to the door. She was seated in a RRC with her feet elevated. She has a NHS Quickie Salsa powered wheelchair, which she reports to be able to use independently outdoors, and access her local community most days using her chair.

Belinda was able to operate the controls of her RRC independently, and place her feet in a good position, in order to stand. She pushed up through the armrests of the chair, rising slowly into standing. Once stood, she reached outside of her base of support for her walking stick. I observed that she was able to walk independently with the stick indoors. Muscle rigidity was evident in her posture and gait, however she was well balanced and had good technique with the stick; she walked steadily and did not report pain.

She sat in the chair with a relaxed posture, sitting onto her left hip and she was able to adjust her position independently.

Domestic care – Daughter/ friends, and Belinda is able to carry out many tasks herself – she can make a simple meal and hot drinks

Personal Care – Belinda advised that she is able to get herself up, use the LAS and dress herself, although it is nice to have some help from the carers 'when they turn up'. She asks the carer to fasten her bra, as she finds this awkward. She is fatigued after completing personal care tasks however is well aware of her limitations and paces herself appropriately. She is able to independently manage her catheter care. She is able to get herself ready for 9:30am in order to attend her social groups. In the evenings the carers help Belinda to put on her pyjama top.

Issues – Belinda has a poor relationship with the care agency, they do not turn up when she requires and she often turns them away as she is already dressed etc. when they arrive. This causes her to become stressed.

Actions – Following discussions with Belinda and the care agency it was clear that the care package did not work for Belinda. It did not take into account her medical treatment that had improved her mobility since the care package was first agreed or her need to be ready by certain times in order to maintain her social activities

Outcome –Belinda has been advised of alternatives to a carer e.g. a front fastening bra, City Wide Care Alarms (CWCA); OT to instruct prevention worker re. a short programme of reablement to increase Belinda's confidence and independence in her personal care abilities; the care package is being reduced but at a pace that Belinda finds acceptable.

Richard's Story

Date of last review: 10/05/2018

Richard (not his real name), in his fifties, lives in a one bedroom flat in a tall storey block. Present at the time of our visit were both of Richard`s parents both of who are quite elderly.

The property is adequate for his current needs with the exception of his bath which requires a bathing seat.

Richard served in the Armed Forces from his late teens, and subsequently served in the Falklands conflict. The experiences of dealing with wounded and dying service personal and watching the sinking of other vessels has had a profound effect on his mental health.

Health
Richard suffers from Korsakoff Syndrome (chronic memory disorder; muscle weakness; visual disturbance) which is related to alcohol misuse linked to his experiences whilst serving in the Armed

Forces. He also has benign liver cancer and failure of major organs in body, again related to his previous lifestyle.

Fluid retention in his stomach is a major problem leading to admission to hospital approximately every two to three weeks in order to have a drain inserted to remove the fluid.

Richard`s long term prognosis is poor.

Mobility
Richard has variable mobility dependent on the level of fluid in his stomach, he is able to access local transport, and shops when in relatively good health as outlined above. At the worst when his stomach is distended he spends long periods of time laid on his bed watching TV.

Richard travels by local bus however due to his short term memory problems will purchase a day saver ticket from the bus driver and when he arrives at his destination throw the ticket away as he feels that it is of no value.

Access
Access to the property is via the intercom system to the block, Richard being able to allow care staff and other visitor's access to the property via this system.

Seating
Richard sat in a large arm chair during the whole of the visit and appeared to be comfortable during this time.

Meals
Richard has a tendency to place a meal in the oven and then forgets to take it out when it is cooked or leaves it in too long and it is spoiled. He has a tendency to prefer smoothies as opposed to solid food dependent on his level of well-being. Family promote a healthy diet however Richard makes his own choices.

Housework/laundry
Richard has the ability to put laundry in the washing machine himself, his sister and sister in law assist with the cleaning of the flat on a weekly basis.

Dressing
Richard is able to dress appropriately as required when going out shopping etc.

Washing
Richard enjoys having a bath, however this has sometimes led to him getting stuck in the bottom of the bath due to his inability to exit using his own mobility.

His mother has in the past provided assistance to physically lift him from the bath a situation which has resulted in her injuring herself.

WC
Richard is able to access the toilet himself this is not a particular problem at present.

Bed
Richard sleeps alone in a double bed which is adequate for his current needs, he also lays and watches TV in a reclined position. Richard also advised that he also eats his meals in bed at times when he is feeling ill as previously outlined.

Care Package
Richard receives three visits a day 15mins medication only calls from a care agency. Richard happy that he has a regular carer who is familiar with Richard and recognises when his health is deteriorating.

Ongoing actions
1) Assist to apply for disabled persons bus pass via Customer Services SCC
2) Encourage Richard to contact GP to look at his dietary requirements
3) Contact Age UK to complete a benefits check and application if appropriate.
4) Trial bathing equipment at home to consider the best way forward.
5) Provision of reminder posters designed for Richard to be placed in the kitchen close to the cooker.
6) Richard to purchase a kitchen timer to alert him that his meal is now ready to be removed from the oven / microwave.

Rachael's story

Date of last review: 27/11/2017

Rachael (not her real name) is in her fifties. Rachael lives with her husband, and two adult children in a housing association house. Rachael had a range of jobs from cleaning to factory work but is now retired.

Rachael doesn't go out much she loves Sci-Fi and horror films and reported that she used to love crafting, especially making cards. She also loves art, museums, history, reading, jigsaws etc. and would like to be able to attend some local craft groups or visit museums in order to develop new personal relationships.

Medical History
- Arthritis reportedly affecting all joints leading to pain and discomfort. Reduced range of movement (ROM) affecting her shoulders, she is unable to raise her arms above shoulder level. Degeneration of the spine
- Fibromyalgia - generalised fatigue, low endurance, muscle pain and discomfort.
- Altered sensation - experiences burning, shooting and pulling pains in muscles, especially affecting toes, feet and calves. Morphine patches prescribed
- Muscle cramps

- Irritable Bowel Syndrome (IBS) – incontinence reported and wears pads at all times
- Chronic Obstructive Pulmonary Disease (COPD)
- Bi-polar – struggles to tolerate unfamiliar people, and slow to make relationships
- Reported she can become agitated and verbally aggressive, usually due to severe pain and discomfort occurring in the morning as it takes her a few hours to awake, wash and dress and for pain relief to become fully effective.
- Poor STM
- Weight approx. 18stone; height 5'5"

Her husband is also retired and has health issues - Reduced vision, angina, diabetes. However his is independently mobile and able to conduct independent transfers and is independent with PADL and DADL

Functional ability

- Mobility – variable, furniture walks internally, has a wheelchair for external use
- Stairs – Double curved and unsuitable for a stair lift; on a bead day Rachael sleeps downstairs (there is room for a bed downstairs but she prefers the sofa)
- Transfers – able to transfer in/out of chair/sofa and on/off WC with difficulty
- Bathing – has LAS, requires assistance to wash hair and wash generally
- Dressing – requires assistance although she has adapted her style of clothing
- Medication becomes muddled and husband administers, has a NOMAD (pill dispenser system)
- Nutrition – family organise this

Care Package

Monday	AM: 30 mins	PM: 1 hr – am = getting up, washing dressing and manage continence
Tuesday	AM: 30 mins	PM: 1 hr pm = shower, wash and cream, continence management, undressed for bed
Wednesday	AM: 30 mins	PM: 1 hr – as above
Thursday	AM: 30 mins	PM: 1 hr – as above

Husband and children help to assist with personal care. Rachael also has two close friends who provide assistance when required.

Rachael is dissatisfied with the care package as they frequently send unfamiliar carers and Rachael is unable to tolerate unfamiliar people especially with personal care and will refuse them entry. Alternatively they will come too early and she is not ready to get up.

Outcome

- The option of directly employing a care agency was discussed as this would give them more control of the package of care – this was rejected but it did encourage Rachael and her family to consider the care needs and how they could be met.
- Self-purchasing equipment that would allow for more independence in the shower
- FRT ordered a raised toilet seat (RTS) which is now in place

- The variability of how she feels each day means that her support needs are variable
- To reconsider the help provided by family and friends

After discussing with family and friends Rachael decided to cancel the care package as her needs could be met by family and friends. The main concern was that if care was needed in the future would the cancelling of care at this time affect her ability to access care in the future. Rachael was reassured that if they reapplied for care in the future the request would be given due consideration.

1) Rachael was helped to register for housing both with the council and housing associations
2) The prevention worker is supporting Rachael to find and attend a craft group outside the home
3) The prevention worker has put Rachael in touch with the Home Library service who deliver books, jigsaws, audiobooks and films

Appendix 2: Project approach to customers with a learning disability and their families

One trend that the project has identified is the number of customers with a learning disability (with varying abilities) that have been channelled into day centres, many have been attending for years and they and their parents have become used to the routine. However, this doesn't improve their chances of being included in the wider society and/or improve their chances to make friends locally.

Nationally, current policy is informed by the social model of disability, which identifies structural barriers to participation as socio-political disablers (Oliver 1990 Oliver, M. 1990. *The politics of disablement*, London: Macmillan.)

Furthermore the above lays the foundation for the idea that an ability to participate in the economic, political and social life of one's community is a **prerequisite** to citizenship (Ryan 1997 Ryan, R. 1997. Participatory processes for citizenship for people with intellectual disabilities. *Interaction*, 10(4): 19–24). It could be argued that reducing the number of people experiencing exclusion from mainstream society is one of the major unifying principles of social policy in the UK.

This is exemplified by the Valuing People White Paper (Department of Health 2001 Department of Health. 2001. *Valuing people: A new strategy for learning disability for the 21st century*, London: HMSO.) This purports that people with learning disabilities should live 'full and purposeful lives', the aim of the strategy is the move from a 'disabling to a fully inclusive society'.

These principals have guided the Focused Reablement Team. Where possible we have tried to introduce customers to the support they need in their local areas with or near to family and friends. This is not always immediately possible as some families have entrenched concepts of support, and high levels of anxiety about 'new thinking'.

We have talked to the customer separately from parents to understand the individual's interests; escorted people to local resources; and accepted that people can change their minds; resources can change at irregular intervals and customers may need help to access other resources or employment.

Changing habits and routines is challenging and in some cases we are only able to make small changes and/or plant the seeds for others to follow in the future.

Throughout any intervention we recognize the value and contribution that family provide and aim to always listen to what they have to say.

As well as looking at the here and now the team has tried to engage customers and families to think about the future. Customers are often very well supported by family but future options have not always been thought through, thus the skills the customer may need in the future have not been considered. Again we may not always been able to bring about major changes or reduced care packages but we have altered care packages to better reflect the current and future needs of customers. We have planted the seeds.

Home First (enhanced community reablement) – summary

- In Sheffield, Delayed Transfers of Care, length of stay in hospital, and hospital admissions are high – Sheffield has consistently been in the bottom tier of local authority areas in relation to DTOC targets. Homecare delivery has increased substantially, causing increased financial pressures and continuing difficulties in maintaining enough supply to meet the demand.

- Access and Prevention is seeking to extend the First Contact and Focused Reablement approaches to support people at risk of admission to hospital, or on discharge from hospital who are at risk of reliance on long term, formal social care support.

- We will form a new team to work with a specific cohort of people to explore the above approach. The team will be made up of OT's, and prevention officers, and will work alongside voluntary sector providers to support people in the cohort. Prevention officers and voluntary sector officers will jointly visit people to identify their needs through a Conversation Counts approach, and seek to meet those needs by accessing community resources, equipment, telecare, sorting out practical problems, debt, benefits advice, and finding different ways to do day to day tasks. Once the initial, practical problems are resolved, the voluntary sector partner will support the person to navigate towards longer term planning, to ensure they can live their life in the way they prefer, and with meaning and purpose.

Aim

- The aim of the project will be to apply and develop a robust and holistic approach to supporting people at risk of hospital admission, or on discharge from hospital. STIT currently supports people very effectively, but primarily with personal care, meals, toileting, movement, and medication Staff in that service lack the experience, knowledge and understanding of wider community resources that people can access. The First Contact Prevention approach has been proven to reduce need for formal social care services, therefore this project seeks to enhance the current reablement service provided by STIT to include the interventions that First Contact has developed over the last two years. The Focused Reablement project has shown the value of having OT and Prevention Officer involvement, even with people who have previously been regarded as having complex, long term needs.

This team will seek to identify and support people at three main points :-

- People who are at risk of being admitted into hospital - at the point of Ambulance Reponses, and in FDRT - people that are picked up by ambulance service and because they seem vulnerable or living in poor conditions are taken into hospital for no medical reason or those that do have some clinical needs but that can be met at home
- People who are in hospital and where NHS ward staff feel they cannot go home immediately for environmental reasons – (issues with property , money , clutter etc. or people that need some very practical stuff doing to get them home) or carer support
- People discharged from hospital with STIT/CICS, who without an intervention, will require on-going care from independent sector providers

These are people who are in crisis, so through conversation 2, we will stick like glue to them and focus on the following aims.

My Home – *My home is an enabling environment, not a disabling one; I am supported to be as independent as possible in my home; I can come and go as I choose to; I feel like I am part of my local community, not isolated in a house that makes my life more difficult.* This approach will consider –

- Equipment and small adaptations
- Small personal aids and equipment
- Major adaptations
- Disabled Facilities Grants
- Alternative housing options
- Home improvements
- Access and egress from the property
- Telecare
- Support to remain physically fit enough to move around

My community, friends and family- *I am able to go to places in my local community that are necessary, like shops, GP surgery, and the post office/bank. I am also able to see friends and family when I want to. I am able to find and make friends and form relationships when I want to. I can go to places and join in activities, for fun and for work.* This approach will consider –

- Vocational support
- Travel training and support
- Links to social activities and training
- Awareness and support with community safety, and staying well
- Access to and attendance at appropriate health check ups
- Links to friendship groups, relationship advice and support
- Financial support, including accessing the right benefits and managing money
- Support for family members, friends and informal carers
- Keeping fit enough to go out

My day to day activities – *I am planning how I will stay as independent as I can, for as long as I can. I have the least restrictive level of formal support possible. I am supported to regain skills and fitness and stay well. I am supported to engage with and make informed choices about risks, and explore opportunities.* This approach will consider –

- Equipment
- Telecare
- Small aids, such as medication aids
- Least restrictive level of care package required
- Different approaches, e.g. to moving around and help with movement
- Different ways to manage day to day tasks, e.g. meal preparation, shopping online, electronic reminders
- Capacity assessments and best interests decisions where appropriate
- Risk assessment and positive risk enablement
- Support to access local help with day to day activities
- Fitness, movement, and exercise

Too Long a Lie In – summary

SCC commissioners, Public Health, the Lead OT from STH and Head of Service for Access and Prevention met to discuss some of the recent findings of the SCC care handling team.

The care handling team recently were able to support a person who had been cared for in bed, to enable them through patient, sensitive support, creative techniques and innovative development of equipment to get out of bed and out of the house for the first time in 3 years.

We discussed the harm caused to people who are 'cared for in bed' and the need to seek to reduce this. The care handling team have been supporting people to get back out of bed, but this takes a long time, and people have often lost muscle tone, and need a lot of patient help to enable them to get out and stay out of bed for any length of time. Key then is to prevent people from becoming 'cared for in bed' wherever possible. We need to raise awareness of the harm, and support all providers in the city to ensure they can prevent this happening wherever possible.

Actions

- We need to start to understand the scale of this issue and establish some level of baseline. **SCC contracts team have written to all care home and homecare providers to ask them to identify how many people they have (named) who are 'cared for in bed'.**
- Contracts have also asked providers if they currently use any tools to risk assess the situation of a person being cared for in bed.
- We are organising a conference to be held in February, to raise awareness with providers.

Draft format of the half-day session –

1. **Introduction by Greg Fell**
2. **Workshop session on tables – why do people end up cared for in bed? What circumstances lead to this? What are the barriers to preventing this?**
3. **Break and network, view stands – (CWCA, Care handling team, patient stories)**
4. **Presentation by Nat Jones, lead OT STH. Too long a lie in – What is the harm?**
5. **Presentation by SCC Care Handling OT's**
6. **Patient perspective –Patient rep to give presentation**

Following the conference

- **Long term – to ensure embedded in contract monitoring**
- **Develop leaflets and guidance**
- **Monitor baseline numbers and check if any change.**
- **Links through CCG and GP protected learning days**
- **Roll out through Mental Health, Carers, other identified forums.**

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