Sheffield Better Care Fund Plan 2022/ 2023

Introduction

Prior to the Covid-19 pandemic the population of Sheffield experienced high levels of complex health and social care needs disproportionately across the city. Many individuals were struggling with poor health and wellbeing and the concerns of day-to-day life did not enable an environment that promoted prevention. The impact of the Covid-19 pandemic has exacerbated this situation and placed pressure on services and resources within the system to deliver in increasingly challenging conditions.

Sheffield City has a strong history of partnership working to meet these challenges and the existing links between partners were further developed across the city with strong relationships being required to deliver strong health and social care services to keep the population safe. In 2019 Sheffield developed a partnership of organisations, the Accountable Care Partnership, now Health and Care Partnership to develop a Sheffield Partnership Plan to ensure a dynamic approach to meeting the needs of the population were achieved. Building in the needs and learning from the pandemic a recent iteration has been undertaken which allows commissioning organisations to feed the additional information found through the engagement with services and the public into their commissioning intentions.

At each stage all the Sheffield Partners, including voluntary and community organisations and public service users, have been involved in formulation of the overall delivery Plan for Sheffield – Shaping Sheffield. The documentation and an overview of the process undertaken can be found at the following link Our plan for 'Shaping Sheffield' - Sheffield Health and Care Partnership (sheffieldhcp.org.uk).

The Better Care Fund plan and programmes are aligned to deliver the Shaping Sheffield vision of “Prevention, well-being and great care together”, acknowledging that housing and the local community are an important factor to achieving this ambition.

In writing this narrative to the underlying plan contributions have been made by the following services and teams:

Health and Care Partnership Organisations:

ICB Sheffield Place: Commissioners for Community Services, Acute Services, Mental Health Services, CHC and On-Going Care support, Discharge and Primary Care Services.

Sheffield City Council:

Adult Social Care, Housing Services, Adaptations, Housing and Health Team, Equipment Commissioners, Care and Support Services, Reablement Services, Advocacy Commissioners, Vulnerable People’s Services, People Keeping Well/Resilient Communities Team.

Voluntary, community and social enterprises (VCSE) Partners:
Voluntary Action Sheffield, Healthwatch, Sheffield Churches Council for Community Care (SCCCC) and Sheffield Carers.

Business Intelligence and Data:
ICB Sheffield Place, Sheffield City Council and Sheffield Teaching Hospitals NHS Foundation Trust (STHFT).

The Health and Care Partnership has undertaken the role to support system wide engagement in the development and delivery of our plan, in particular reinforcing the role of our VCSE and non-statutory partners. (Public Pack)Agenda Document for Sheffield Health and Wellbeing Board, 23/06/2022 14:00 – from page 115.

Executive Summary
2022-23 has been a transitional year for the Sheffield system with the ending of Covid restrictions leaving a legacy of an increase in health inequalities and poverty within the city, driving growing needs for health and social care provision. Nationally the focus has shifted to increasing access to primary care services and volumes of elective care delivery to reduce the backlog in health referrals. While rising to these challenges Sheffield has worked hard to build sustainable and cost-effective services. These services are transforming to meet the increase in need, within a reducing financial envelope and challenges with recruitment and retention within the workforce. Whilst system flow and the need for timely discharge remain a priority in the Sheffield system, more emphasis is being placed upon joined up pathways and shared accountability for the population health outcomes. It is acknowledged at all levels that services must work together, be person-centred and be able to be tailored to meet both health and social care needs to deliver the best outcomes for the population.

The transformation work has been set within the changing political landscape and while structures within the two commissioning organisations were taking place, CCG to ICB and LA Cabinet to a Committee structure. As part of this process the system is taking the opportunity to reviewing the direction of Health and Social Care and the overall vision for Sheffield, captured within the Shaping Sheffield Plan, has been refreshed to reflect the evolving position of the city.

Alongside the Better Care Fund and Joint Commissioning environment the Health and Care Partnership was developed to bring together the key system partners into one collaboration working together to ensure the best possible outcomes for the citizens of Sheffield.

The Better Care Fund programmes are aligned to delivering the Sheffield System priorities which for 2022-23 have been agreed as:

- respond to the COVID-19 pandemic and the subsequent unmet demand within the system.
- reduce health and social care inequalities across Sheffield.
- focus on improving access to and availability of health and care services.
- ensure all children across Sheffield have the best possible start in life.
- improve the support and treatment for your mental health and wellbeing.

- ensure that health and social care support is personalised to needs.

Since the submission of the 2021-22 Better Care Fund plan the key focus of the Sheffield system has been reshaping services, pathways and provision to remove blockers to delivery. Services are being reviewed to align with the locality and primary care network footprint to ensure they are proactive to the specific needs of the users and adaptable to the demand in each part of the city. This is being done as a collaboration with system partners, including service users and other stakeholders, both internal and external to statutory organisations. A number of the stakeholders have been instrumental in the formulation of this narrative update and are acknowledged in the above section.

The change in organisational structures has allowed a reassessment of the process of joint commissioning intentions to make them more ambitious and allow them to be fully embedded in every decision made by the partners. This has then fed into the Sheffield Outcomes Framework, which at each stage is being co-produced with system partners and is the basis of all contracting decisions and the measure of successful services. It aims to be a framework which can be managed at a service level but also tailored to allow patient centred care to be delivered.

Adopting a personalised outcomes approach to commissioning allows the identification of the assets within the city and how best to utilise them to support people, services, and providers. The learning from the Covid-19 pandemic around the importance of wrap around care and support networks has been embedded within the recent review of carer support, highlighting the importance of the wellbeing outcomes for those who look after and advocate for our population as well as the statutory service users themselves.

The short-term commissioning service reviews have focused upon how best to support the most vulnerable within the city, preventing health deterioration where there were pre-existing conditions, enabling self-care to delay health and social care requirements with wrap around support that can be tailored to an individual, and overall maximising the outcomes achieved by the system resources.

Governance
The Governance Structure across Sheffield is overseen by the Sheffield Health and Wellbeing Board. They delegate oversight to the Executive Management Group who in turn task Executive Management Group Working Party with delivery and co-ordination of the Better Care Fund Programmes.

Executive Management Group (EMG) membership is derived from the two Sheffield Commissioner organisations, ICB Sheffield Place and Sheffield City Council. EMG is responsible for the development of commissioning strategies within the overall direction set by the Health and Wellbeing Board. It is also responsible for the implementation of agreed commissioning strategies, oversight of service. The functions of the Group are undertaken in the context of increasing quality, efficiency, productivity and value for money and removing administrative barriers. A number of the responsibilities of the Group are to satisfy requirements within the Section 75 Agreement. Each member of the EMG shall be an officer or Member of one of the Partners and will have been appointed by the relevant Partner to carry out its role and responsibilities.

Executive Management Group Working Party (EMG WP) shall ensure that it progresses the functions delegated to it from EMG. It provide assurance to Executive Management Group (EMG) on all the responsibilities delegated to it and updates/reports and recommends specific actions, ie; proposed business cases for areas of service integration and transformation; on-going review of performance; review budget variations to ensure proposals do not destabilise the health and social care system; oversee delivery of the details programme of work to achieve the aims of the Pooled Fund and identify areas where performance is off-track; interdependencies between workstreams where delivery of one scheme is affecting another and suggest actions to correct performance; prepare reports for partner organisations including Health and Wellbeing Board (HWBB); review the adequacy of non-financial contributions to each individual scheme; provide detailed scrutiny of the financial and operational performance of the Pooled Fund; complete quarterly and annual returns in accordance with BCF planning requirements. Members are officers from South Yorkshire ICB Sheffield Place (SYICB) and Sheffield City Council (SCC) and are appointed by the relevant partners to carry out its roles and responsibilities.

The terms of reference for each group are included within the following files:

EMG WP Terms of Reference Review Sep

EMG Terms of Reference Nov 2021.p

Approach to Integration

Sheffield's commitment to co-production and collaborative working has been further cemented by the agreement of Joint Commissioning Intentions, ensuring sustainable service delivery, transformation and improvements to continue to be implemented against a backdrop of continued cases of Covid-19, implementation of the elective recovery plan and structural changes with the local council and NHS organisation.

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

The high-level priorities identified for 2022-23 can be found within the following document which was reported at the CCG Governing Body in May 2022.

22 23 joint Commissioning Plan (

Joint Priorities in 2022-23:

- respond to the COVID-19 pandemic and the subsequent unmet demand within the system.
- reduce health and social care inequalities across Sheffield.
- focus on improving access to and availability of health and care services.
- ensure all children across Sheffield have the best possible start in life.

- improve the support and treatment for your mental health and wellbeing.
- ensure that health and social care support is personalised to needs.

To deliver the Sheffield Joint Commissioning Intentions a Joint Commissioning Committee and Development Group were established:

Joint Commissioning Committee (JCC) the purpose of the Committee is to bring a single commissioning voice to ensure new models of care deliver the outcomes required for the city. The Committee will support SCC and SCCG to deliver national requirements, including but not limited to the NHS Long Term Plan, Social Care Green Paper and Spending Review. The Committee will ensure, in the first instance, delivery of outcomes in the three priority areas of focus; Frailty, Send and Mental Health. The JCC is a meeting of the Council Cabinet and ICB Sheffield Place's Governing Body representatives with the purpose of agreeing joint health and social care commissioning plans for the City. In discharging this, the Committee does not have any direct decision-making powers delegated to it: all decisions will still be ratified separately in accordance with statutory requirements; however, by meeting jointly the joint decision making will be simplified. Any future delegations would have to be agreed by SCC and ICB Sheffield Place. The Committee is also authorised to create working groups to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group. The existing Executive Management Group officers will report to and support the Joint Commissioning Committee. The Committee shall strengthen the way that we commission health and social care together. In particular, the Committee shall focus on; i) giving a single commissioning voice; ii) Single commissioner plan; iii) ensure new models of care deliver the outcomes required by the city; iv) building on Better Care Fund and Section 75, driving forward change.

The Terms of Reference for the JCC and the Development Group are included within the following file:

JCC ToR June 2021.pdf

Paper B - Joint Commissioning Devel

During 2022/23 Sheffield City Council has transitioned from a cabinet to a committee structure and NHS Sheffield CCG has become ICB Sheffield Place as part of South Yorkshire ICB. This has presented an opportunity to take stock of the joint commissioning arrangements embedded to date, in particular:

- Ensure we keep the good joint working, learning and progressed made to date but that we are jointly facing challenges such as financial risk and work force pressures.
- Ensure that we understand the distinction between JCC and HCP arrangements in the new context and look where links can be strengthened, and potential duplication removed.
- Consider how we continue to align the commissioning tole the council still has alongside NHS new focus on strategic planning

The following documents set out the terms for the ACP, now titled HCP, Executive Delivery Group and Accountable Care Partnership Board. The meetings were changed during the Covid-19 pandemic to reflect the city's command and control response and are being updated as described above.

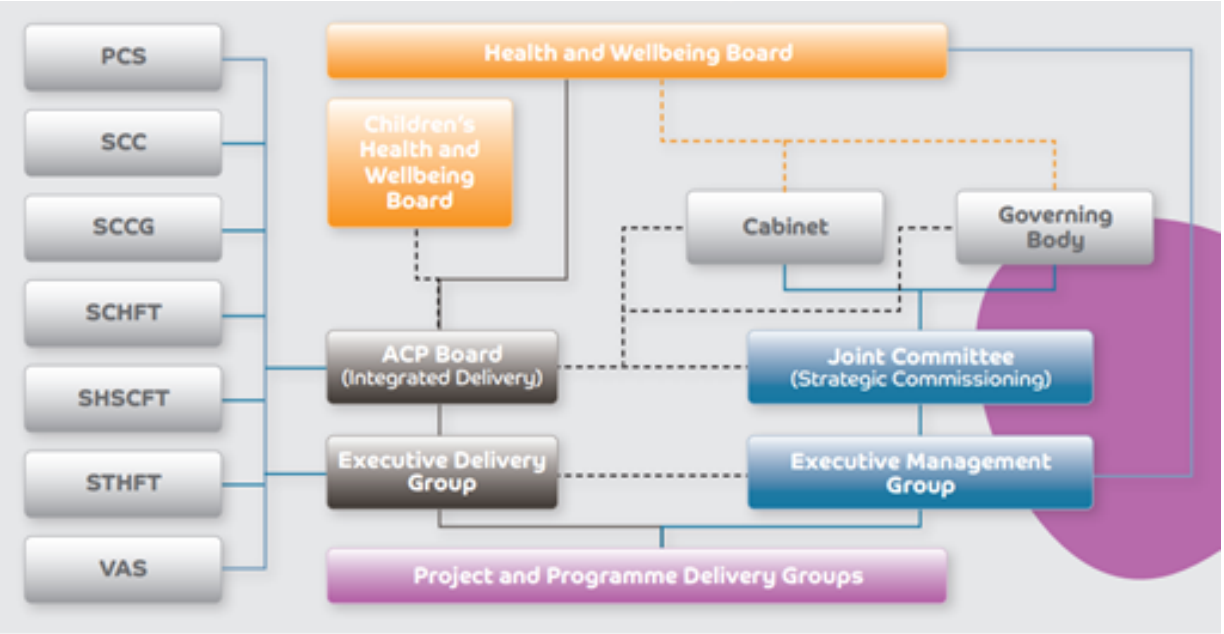
ACP Board T of R FINAL.pdf

Update to Terms of reference ACP.pdf

Terms of Reference ACP EDG .pdf

The aim of this city partnership is to ensure all services are targeted to need, responsive, transformational and co-produced with all stakeholders. This means involving all parties at the outset to identify and understand the needs of the Sheffield citizens and look at the most effective way to meet that need.

Therefore, in parallel to the joint commissioning work streams, the Health and Care Partnership structure looks at delivery of longer-term transformational plans which require all system partners working together to deliver. The governance structure of the Partnership is captured within the following diagram alongside the BCF structure.



Our planning and delivery plans also take into account that non-statutory partners, VCSE and citizens remain at the forefront of delivery of safe and high targeted quality services, with recognition that partner organisations and Providers are facing the same challenges in terms of financial resilience, capacity within services, workforce shortages and fatigue alongside increasingly complex care requirements. Voluntary Action Sheffield represent these organisations as part of the Health and Care Partnership.

The key changes in 2022-23 have focused upon moving away from the reactive command and control commissioning which was necessary during the height of the Covid-19 pandemic to sustainable commissioning which aims to make services more streamlined for users, removing duplication of contacts, improving reporting and reducing blocks to the system.

Sheffield's Better Care Fund goes beyond the minimum required contributions to include services where there is benefit from a joint commissioning focus and application of the Better Care Fund principles will drive sustainable services and efficient use of the limited system resources. Work is underway and reassess the themes and pathways within the programme to ensure with the aim of expansion of the current fund and risk sharing arrangements.

The Joint Commissioning Office team has also been expanded in year to recognise the broadening of the joint ambitions and scope of the workload. The team now includes additional dedicated programme management support, a role focused upon the development and monitoring of the outcomes framework and a medicine's management role to offer pharmaceutical advice and support to community staff and carers, where skills in this area were identified as a reason for low retention rates within these staff groups.

The development of the outcomes framework has been a great success in year. More information around the development of the outcomes framework is described in the file embedded within page 5 of this narrative. The Outcomes Framework Steering Group has been established to ensure co-production and delivery of the outcomes. The terms of reference and membership can be found in the following file:

Final TOR Sheffield Health and Wellbeing

To enable delivery of the outcomes and the system desire to achieve transformational change across all services there has been a decision to work towards alignment of services to the Primary Care Network (PCN) footprints. This will allow staff to be part of the network and to understand the needs of the population, working within their network to achieve tailored health and social care. This has meant reorganisation within our statutory partner services and commissioning structures as well as re-procurement of services from independent sector providers such as home care and care home packages to align with the PCN boundaries.

The first stage of the process has been to align the teams within SCC delivering social work provision, enablement services, Short Term Intervention Team (STIT) which delivers reablement, care home support teams to PCN or neighbouring PCN areas, depending upon the volume of workload in each network. This is being enhanced by on-going work to build stronger relationships with GP practices and the social prescribing and ARRS roles within their staff. This will also allow previously generic citywide teams to be more tailored and specialised to the needs and outcomes expected within each network.

The principles from the Sheffield Adult Social Care Strategy being applied at each step of this redesign process are:

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

To avoid duplication within this narrative the Sheffield approach to personalised care is included within the update of meeting national condition four and the links with housing services is included within the update of the delivery of the DFG.

Personalised Care

Our vision within Sheffield is for care to be person-centered at all points of contact. The key to wellbeing and improving quality of life lies in people's ability to be able to live a life they have reason to value. This may be achieved by drawing on their own strengths and networks or by being connected to the assets and resources in their local communities and the wider city.

As a city our basis of together is true collaboration, people, communities and organisations, to build places and services that support and sustain these assets and resources.

This means changing how we do things in Sheffield so that people and communities to have greater control of what matters to them and can see how they can influence their care.

The Principles that Underpin 'Person Centredness

Asset based: knowing that people and communities are resourceful. Building on what skills are already there. Focusing effort on searching out and developing strengths. An example of this is capture within the embedded document which shows the City's approach to building, supporting and maintaining resilient communities.

Resilient
Communities Overvie

Population Health Information contributions to the design of services to meet the current needs of the demographic as well as to extrapolate expected future need requirements and to ascertain if any impact is being evidenced of preventative work already in place.

Enabling and Engaging: making it easier for people do for themselves, or 'work with'. Avoiding 'doing to' unless absolutely essential (we recognise that there are situations where 'doing to' is most appropriate). The ethos of "What matters to you" is embedded across our health and social care partners with the lead for the city being a GP who also holds a role within our main provider FT. This has allowed the message to be a key part of the PCN and locality development with ARRS social prescribing and our People Keeping Well services applying the principle.

Personalised: any support is tailored to the person's context to help build capabilities. This means we must be able to understand people's strengths and where they need additional support and a personalised response. The Sheffield Team Around the Person Service is multi-organisational, multidisciplinary and makes use of public health data to identify measures which can be put in place to prevent likely outcomes. This is also linked to the Ageing Well workstreams, enhanced care in care home, the falls prevention service, community AHP services and EOLC support where appropriate.

System Focused: we look at the whole picture as a city, for example strategy development, policy choices, service redesign, recruitment procedures; and use coproduction, connections, and community knowledge and expertise to improve quality of life and wellbeing for everyone. The aim is for one consistent message is shared across all our meetings, partners and staff groups to ensure the culture in Sheffield is reflective of the overall strategic vision and system

priorities. Alongside the core BCF and HCP structures sub-groups with representation from across the partners are held to support this aim. For example, the Workforce, Culture and Leadership and Community of Interest Group, NEY Personalised Care Board has representation behalf of SY ICB and Sheffield Compassionate City Board.

The benefits of being person centred in Sheffield

- **To People**: Stronger consideration of each person's unique set of strengths and needs. Feels better and helps them to maximise their potential. Great sense of being in control, guiding own destiny.

- **To Professionals**: Better job satisfaction (feeling of doing the right thing), 'joy at work'. For example, co-design of long covid service with experts by experience.

- **To Systems**: Achieves best value from limited resources. Builds trust. Over time can reduce waste. 'Teach a person to fish' approach is more sustainable in medium to long term.

- **To City**: Better quality of life, reduced inequalities, stronger economy (healthier workforce), more sustainable services, positive reputation.

The focus for personalised care over next 12-18 months includes:

Delivery of the national person-centred strategic priorities:

- Embedding a Personalised Care Ethos
- Reducing health inequalities
- Enriching Personalised Care approaches across health and care (SDM, Choice, PCSP, PHBs)
- Workforce Development

Delivery of the 6 key components of Personalised Care:

- Shared decision making
- Personalised care and support planning
- Enabling choice
- Social Prescribing and community-based support
- Supported self-management
- Personal Health budgets

Delivery of the Long-Term Plan Personalised Care Metrics:

- No. of Social Prescribing Link Workers
- No. of Social Prescribing referrals
- No. of Personal Health budgets
- No. of Personalised Care and Support Plans
- No. of workforce that have undertaken personalised care training (including eLearning and accredited training which can be accessed through the Personalised Care Institute)

Other work underway to enable national requirements:

- Strategic co-production: Recruit peer leaders and work collaboratively with them
- Workforce: Support Personalised Care ARRS roles, for example, SPLWs, Care Coordinators and Health and Wellbeing Coaches
- Personalised care is included in digital strategies
- Strengthening Finance contracting and commissioning for Personalised Care

Personalised Care Examples

There are some excellent examples of teams and services working in a person-centred multi-disciplinary way across Sheffield. An example of this is the Citywide Prevention Programme led by Sheffield City Council who are working with Providers, Service Users and Statutory services to co-produce plans ensuring that every contact counts for the individual. Another examples funded through BCF schemes is the Twice Weekly Escalation Meeting, with representation from all system partners tailoring discharge packages to an individual's circumstances when leaving secondary care and the wrap around support for end of life and bereavement support where statutory partners work with VCSE and St Luke's Hospice to ensure personal choice and dignity in death as part of our compassionate city promise. Focus now is to build on that success by building a culture of personalised care and asset-based approaches across the city driven by senior leadership across the city and the development of a city-wide strategic personalised care programme.

Personalised Care Future Focus

From a health perspective we are above trajectory for all long terms plan metrics in Sheffield however SY MoU includes some challenging stretch targets for all elements and a particular focus is required to achieve for PHB and workforce training.

From a Planned Care perspective inclusion / continuation of personalised approaches in planning and delivery of areas such as virtual ward, hospital discharge pathways, Ageing Well and links with intermediate care, community equipment and adaptations.

Focus on personalised care as an enabler for reducing health inequality and improving population health.

Continue to develop expertise in co-design, co-production in the promotion of building skills, confidence, and expertise within our population with one or more long term conditions to enable greater self-care / self-management as part of our strategic approach to frailty prevention / greater focus on proactive care and prevention

Risks to achieving Personalised Care:

- Lack of maturity in ICB in terms of relationships between commissioners in different places hinders ability to use funding differently.
- Reduced ability to release workforce for training and development due to service pressures and continued higher sickness rates.
- System under pressure puts personalised approaches at risk as takes time to have What Matters to You? conversation, develop care plans with people / families in a truly multidisciplinary and co-produced way.
- Temporary nature of some funding streams means the financial support isn't always available until completion of the work programmes.
- Pace of change required may reduce ability to co-produce / co-design and hinder the ability to involve all partners to an optimum level.

- Limited digital integration is still incomplete across the system. The digital roadmap for Sheffield has been designed but is still in early stages of implementation.

The Active Support and Recovery Better Care Fund Theme also focuses upon services to enable flow and avoiding inpatient admissions. Work programmes include Urgent Community Response, Enhanced Health in Care Homes and Anticipatory Care as part of the wider Ageing Well system offer. More detail of the current position can be found within the following document:

Ageing Well collaborative Group U

In addition, there has been short term targeted investment to support additional capacity within falls pathways, community dietetics, mental health, including advocacy support to vulnerable individuals through the advocacy hub at Citizen's Advice, and within long term condition pathways to support recovery and remedial actions required following successive lock downs through the pandemic and evidence of significant de-conditioning within some populations.

Discharge Planning

Place system partners work together to ensure plans are developed and implemented to support discharge and care capacity to enable flow. Discharge plans have been developed and aligned to the national hospital discharge and community support guidance operating model and to established elements of the discharge pathways.
Since the pandemic the focus has been to respond to the unprecedented demand on services that provide health and social care for people, to enable a safe and timely return home or move on to another temporary care setting where home is not possible in the short term. This includes:

- **Increased capacity in reablement and intermediate care support**, building on work already underway with partners including trusted assessment.
- **Increased capacity in Independent Sector Support** (home care) including additional capacity for night care and improved processes in the review of patients
- **Increased capacity in Fast Track and provision for End of Life –** including capacity for hospice care and bereavement support
- **Increased capacity in Voluntary Sector Discharge Support** – a wide range of practical support for individuals and support for family cares to ensure people have support on the day they leave hospital and for the days following discharge
  A key partner has been SCCCC who are integrated within the discharge hub and community services delivered by statutory partners. More of the work can be found on their website www.scccc.co.uk and within the following embedded files:

SCCCC presentation at GP PLI Event.pptx

BCF Policy and Planning Q_A webinar

- **Temporary Increases in Bedded Capacity** in care homes to improve flow where home is not a short-term option. The system is undertaking a collaborative review of this service with the aim to re-procurement a new model of support-to-support discharge from September
- **Improvement and Ongoing Development of Arrangements**: Work on processes to reduce delays and improved partnership working around discharge. This is an iterative

process to unblock areas of the system and embed the learning from the Covid-19 pandemic.

Discharge Governance

The governance for the discharge process sits with the system wide group, System Leadership and Partnership working - Sheffield System Discharge Implementation Group (SSIDG)

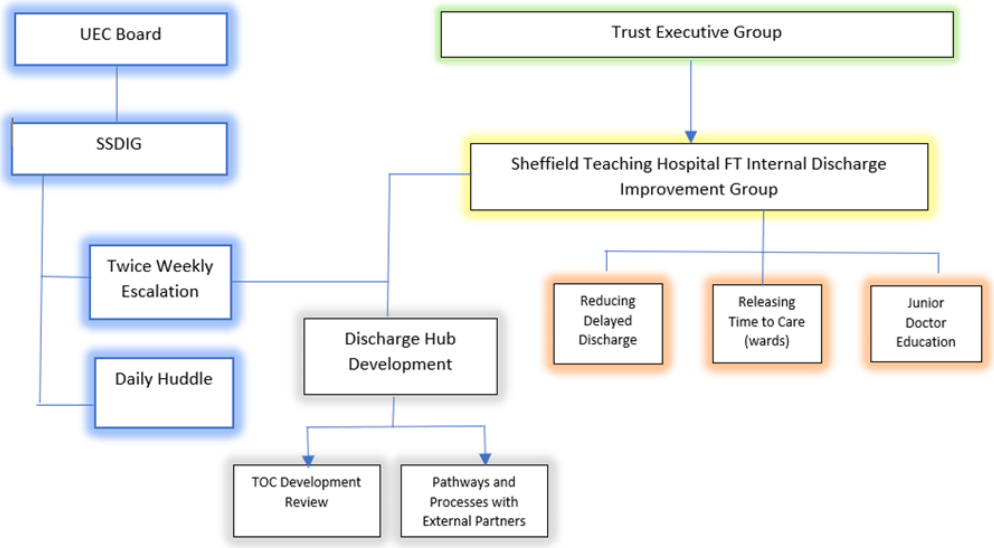
Utilising existing partnership relationship SSDIG was initially set up during the pandemic to streamline the discharge process and ensure delivery and implementation against the new national discharge operating model. As part of the command and control structure the group provide the system with assurance that services were delivered and implemented in line with the agreed city principles and priorities. Following the secession of command and control to deal with the pandemic the group has continued to operate to have oversight of join initiatives and planning and system management of projects that ensure a system wide response to discharge pressures. It has also been responsible for the review of plans and the impact of the additional funding.

The group is represented by statutory commissioning and provider organisations who work closely with Voluntary Sector Partners and includes representation from NHSE. The group report progress and escalations to the System UEC flow board. The relationship can be seen on page 4 of the UEC terms of reference:

DRAFT Terms of Reference Sheffield U

Following changes to the reporting, governance and programme structures during 2022/23 the model will be revisited in detail and updated and expanded as required.

The following diagram gives an overview of the discharge governance in place across the Sheffield system:



Current priorities also include the implementation of the work directed by NHSE:

- The 100-day Acute Discharge Challenge and the work supported by ECIST

- The System Bid (Sheffield's Bid against £250m – work is underway to implement the plans set out in the bids which will include, additional home care capacity and increase temporary care home beds which will reduce a specified number to demonstrate direct reduction in acute beds and any capacity in home care or additional care home beds will be above current baseline. System leads are now developing plans, trajectories, metrics and confirmation of the governance and procurement activity requirements ready for an autumn implementation. This is a key priority for SSDIG partners who will ensure monitoring, oversight and report progress, risks, and assurance back to the UEC Flow Board
- Hospital Discharge Hub Development – ongoing development of the discharge hub and progress of our system and partner work moving forward.
- Current operational Challenges (identified through the Twice Weekly Escalation Meeting 'TWEM'). Work continues around the daily operational challenges and system wide work focussing on the need to increase and maintain capacity across all pathways.
- Complex Needs, work around complex patient pathways is underway linked closely to Mental Health community provision.

Each of the programmes adheres to the principles of the HICM. The following document contains a summary of the position consolidated from updates from the various programmes.

High Impact Change Model Action planning

Supporting Unpaid Carers

Within Sheffield the Carers services are commissioned by Sheffield City Council as part of their lead role for contracting prevention, support and people keeping well services, many of which are with the voluntary and charity sector.

During the past year the support to carers services have been reviewed, redesigned and recommissioned. This has allowed a more holistic approach to identifying carers, meeting the needs of carers and to a contract which is driven by outcomes rather than contacts. This was following engagement with service users and staff who identified a particular need to support wellbeing and mental health of unpaid carers.

The main offer to Carers' is commissioned with the Sheffield Carers Centre as a familiar face in the city. Individuals in need of support do not always feel able to be open with a statutory organisation until the point of crisis. They undertake the Carer Assessment, a requirement of the Care Act 2014, which is designed to understand the role of the carer and signpost to resources tailored to the individual's circumstances. More detail can be found at the following link Carer's Assessment | Sheffield Carers Centre. While the Covid-19 pandemic has made contact with individuals more complex it has proven to be more vital than ever, as many other support networks, such as friends, family, clubs or social events were cancelled. For those able to access online services this offer has been enhanced to maximise contact with those who require support. The Sheffield Carers Centre offer a range of services alongside those commissioned by the council to fully support the needs of Adult Carers. These include:

- **Carers Advice Line:** for 1:1 personalised expert information, advice and support on anything related to your caring role. One of the Carer Advisors is an Urdu/Punjabi speaker, and the service use an interpretation service for other languages.
- **Carer Card:** that gives discounted activities, services and products and space to write two emergency contact numbers.
- **Group activities and workshops:** that meet carers' support needs and provide opportunities for carers to meet each other.
- **Community Connect:** 1:1 telephone support for carers who are isolated.
- **Carers Café:** for social contact with other carers.
- **Carers support groups:** up to date information about all the groups in Sheffield.
- **Carers Enews! for regular up to date information:** Carers who do not have email receive an annual update letter.
- **Information and resources:** can be found on the website of Sheffield Carers Centre.
- **Emergency Planning:** Information and guidance around making preparations to ensure that the person/s you care for are looked after in an emergency.
- **Time for a Break grants:** Small grants to help you in taking a break. As part of a Carers Assessment, the service assesses if this is something you're eligible for.
- **Digital Resource for Carers:** providing information, eLearning, resources, and the Jointly app.
- **Legal Advice Clinic:** Free 30-minute individual legal advice sessions with a legal expert, offering advice around things such as wills, estate planning and power of attorney.

The Health and Care Partnership highlighted the need to enhance the service for young carers, many of whom support relatives who access our Better Care Funded Services. The follow short video highlights the importance of ensuring their needs are understood and their outcomes defined and met as part of our framework planning. https://youtu.be/I4fzMOWGErQ. Sheffield Young Carers are commissioned to specifically support those caring for parent's with a substance addiction where adverse childhood experiences could shape the future life of the young carer. More information can be found on their website Sheffield Young Carers | Dedicated to helping young carers across Sheffield.

As part of the BCF Theme 4 – Mental Health - a carers wellbeing course is also commissioned from Sheffield Health and Social Care FT. This course aims to provide support to family and friends who are adult carers and want to learn ways of managing their own mental and physical wellbeing. The short course helps Carers learn and develop new skills which help build resilience to cope with the demands of a caring role as well as meet a network of people with similar life experiences to draw upon at the end of the sessions.

Alongside the specific services there are other ways in which carers are supported by the city. For example, funded within our BCF PKW Theme programmes, attendance at community groups such as coffee mornings or craft clubs can offer breaks in the day or week to allow carers to undertake normal activities away from their caring responsibilities. Dementia cafes can allow carers to leave their loved ones in a safe space while they go shopping or focus time on themselves. The BCF On-Going Care Theme specifically commissioned packages of respite care can allow a long duration vital break from responsibilities that carers need to avoid deterioration in their own health and wellbeing. Those packages are funded by the local authority IBCF funding except for respite packages for clients with learning disabilities which are commissioned by ICB Sheffield Place.

Support for carers is an area highlighted within the developing outcomes framework and a team are currently undertaking a review of these services to understand where they can be enhanced or where gaps have emerged due to the impact Covid-19 has had on many smaller community-based voluntary organisations.

Disabled Facilities Grant (DFG) and Wider Services

The Sheffield Joint Health and Wellbeing Strategy lays the critical foundation for a strong connection with housing, with a priority that:

'Everyone has access to a home that supports their needs'.

The Sheffield Housing Strategy and Homelessness Prevention Strategy are both due to be renewed. They recognise the importance of health and wellbeing in their plans, as well as the relationships needed between the City Council and their local health partners to deliver them.

Leaders within the Health and Wellbeing Board, and their partners in the Sheffield Health and Care Partnership, recognised that further action was needed to integrate housing within the health and wellbeing agendas across the City. They wanted to explore with their local stakeholders how a more central role for housing could be built and delivered in their future plans. A Sheffield Housing, Health and Wellbeing Summit was established to bring these senior stakeholders together to begin exploring areas for shared opportunity and action in September 2022.

In 2019/20 Sheffield amended their local policy around the use of DFG, adaptations and housing to bring the services closer together and streamline the conversation required to effect change. This led to the creation of the Sheffield Adaptations, Housing and Health Service bringing together a team from social care and housing into one team, and the Housing, Health and Care Reference Group who work with colleagues from health services to assess peoples' living environment to ensure they promote safety, independence and enablement. The team will review appropriate use of the DFG for adaptation and equipment where a person isn't a resident in a council property using their four objectives:

- Reduced hospital admissions.
- Earlier hospital discharges.
- Less demand for formal care services.
- Increased independence and wellbeing – discharging the terms of the DFG legislation to help people remain safe and well in their own homes.

The core team within the SAHH are drawn from social care, contracting and AHP backgrounds including specialist OTs, one of whom is embedded within the discharge team at the foundation trust. One of the key changes brought about by policy was for the team to train their own apprentice OTs to ensure continuity of service as the skills are in high demand across the country and have historically proven difficult to recruit and retain. Over the last 12 months the OTs have also worked with health and social care colleagues undertaking reviews of high value intensive packages of home care. These packages were initiated at pace during the pandemic to enable safe discharges and support flow. Working with CHC nurses and social workers the aim is to understand if the clients' needs could be more effectively met by equipment, adaptations, or assistive technologies such as telecare sensors, which would in

turn reduce the requirement for statutory care hours and ease the intense pressure felt by the home care providers.

Spending in this area has increased significantly over the last two years with an overspend on the DFG allocation, in part by the widening of scope of equipment and adaptation available and offered by the service, where evidence could be given that the intervention would be more effective than on going care provision. The cost pressure also recognises the underlying market costs have increased, in some cases double the pre-pandemic levels, necessitating investment by SCC to continue to meet the demand in a timely manner. The reduction in demand has not yet abated as expected following the pandemic backlog being completed. Work is underway to understand changes in practice against the changes in underlying need in the population.

The equipment contracting team, alongside our equipment provider Medequip and VCSE partner SCCCC, have created training for equipment champions who are embedded within enablement, discharge and reablement teams across the city to promote adaptations and equipment before use of care packages or to minimise additional care requirements.
Where homes cannot be adapted or are not suitable to house the equipment required by the individual the wider housing team based at the council will work to identify alternative accommodation to enable rehousing. The team make use of extra care accommodation while rehoming takes place to ensure safety and ensure discharges are not delayed for those in a hospital setting.

The current standard waiting time for assessment by an OT are around 6 months although our target is to carry out an initial assessment within 3 months of receiving the referral and we have plans in place to meet this target.

For those individuals who are more vulnerable, homeless, rough sleeping, drug and alcohol dependent or with complex needs, mental health or learning disabilities third sector partners are involved in the reviews and remain in contact for up to 12 months to ensure correct placements and appropriate use of adaptations and equipment. Organisations such Thrive, Salvation Army, Humankind, Shelter, CherryTrees and Adullam work with colleagues from South Yorkshire Housing, SCC and the NHS to deliver this additional wrap around support.

Equality and Health Inequalities
We are using information about our population and a differential approach to investment to address inequalities and gaps in services. For example, the People Keeping Well (PKW) BCF theme is commissioned by the Council on behalf of both the CCG and Council and is one of Sheffield's approaches to Social Prescribing. One of the core funding streams is distributed based on deprivation of the city, for example, each of the 100 neighbourhoods is allocated money weighted by the IMD score. PKW, and our community dementia programme, are delivered wholly by the VCSE via community partnerships, of which there are 17 around the city**.** Local intelligence tells us that those with protected characteristics, people who belong to health inclusion groups and those living in the most deprived communities are disproportionate users of unplanned services. Our plans and metrics will impact positively on this as we focus on the underlying causes of this inequity. In particular our emphasis on neighbourhood approaches will enable a greater understanding of the needs of communities to allow services and interventions be tailored and personalised around those who most need them.

All decisions around service redesign, investment and resource prioritisation are taken to ensure full compliance with the Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with CORE20PLUS5.

The following documents are examples of the reviews undertaken by our PKW commissioners of our 17 community partners as part of the assessment of the sector.


PKW Next Steps - DWB response FINAL


PKW next steps questions M&C FINAL


PKW next steps questions SOAR Com

Using local evidence alongside national data the system has been able to identify the following priority areas where health inequalities are more profoundly felt. The key areas are BAME communities; areas of high deprivation and poverty; people experiencing homelessness; people who are experiencing mental health issues; and people who have a learning disability and / or physical disability and impairment.

The common theme which emerges when reviewing these communities is a high level of poverty, which has been exasperated by the Covid-19 pandemic. These groups of the populations are also prone to digital exclusion with high levels of digital illiteracy. The ICB Sheffield Place are leading on a Digital Roadmap which explicitly addresses digital inclusion, digital literacy and digital poverty. One of our outcome measures is that more Sheffield people will be able to use digital and online pathways to meet their health and social care needs.

Alongside this, we are ensuring providers offer face to face care to patients who cannot use remote services; and ensure more complete data collection, to identify who is accessing face to face/telephone/video consultations is broken down by patient age, ethnicity, IMD, disability status etc.

Using the network of organisations within the Health and Care Partnership and the governance structure of the JCC and BCF there are plans for the primary care estate in Sheffield to recognise and support digital inclusion in some of our most excluded communities. The primary care hubs projects being developed as part of the ICS Wave 4B Capital Programme in three primary care networks, City Centre, and SAPA5 and Foundry in the north of the City, will include facilities to enable digital access to health and other services for the local population. A similar approach is being taken in our plans to re-develop void space in LIFT and NHS Property Services premises within the City.

The ICB Sheffield Place and Council have jointly funded a pharmacist post embedded with the Better Care Fund Joint Commissioning Office to support the most vulnerable housebound people in our city, particularly people who are in receipt of social care packages to support them at home. Due to multiple long terms conditions, these patients have complex medication regimes which they may struggle to manage. Non health qualified social care staff and family carers may need additional support to help them with medication, and interventions such as specialised feeding techniques, due to lack of knowledge and confidence. The purpose of this post is to provide pharmacy expertise to support carers, so as to improve patient safety

(reducing medication errors) and improving access and experience e.g. for people with dementia, physical disabilities. This project was deigned to address feedback from vulnerable people and their carers.

As part of our offer as a city to vulnerable people the services are being reviewed to ensure they are streamlined and that every contact counts for the person. Within this cohort of citizens prevention is difficult as they find working with services to be intimidating or repetitive and will wait until the point of crisis before making contact.

The following document gives an example of the types of services under review:

Decision Report
Older People Preventi

As part of a wider focused approach to early help and prevention the review is looking at the needs of the homeless population, those who require advocacy support to navigate services, or who find they aren't able to cope alone and their health needs are deteriorating at an early age. During the last twelve months work has progressed to establish multi-organisational and multidisciplinary teams to support homeless and rough sleepers including outreach nurses and dedicated mental health specialist to work with people on personalised outcomes.

The HALT drug and alcohol services is being redesigned to expand the outreach and identification elements of the service so we can support more people earlier and maximise the potential benefits for service users.

As part of the Better Care Fund On-Going Care Theme are programmes which commission services for our older citizens who live in care homes, who are some of the city's most vulnerable people with complex health and care needs, often with multiple frailty, and including people nearing the end of life. We have used our Better Care Fund in 2022/23 to provide enhanced support to improve the health status of people in care homes, for example dietetics and speech and language therapy to address swallowing issues and improve nutritional status, as well as work on falls prevention (upskilling care home workers).

The learning from working closer with Providers during the Covid-19 pandemic and the fair cost of care exercise are being embedded within the in-year retendering of home care and care home services to ensure a balanced, sustainable offer across the city designed to meet the differing needs in each network. The aim is for the homecare provider footprints to mirror those of primary care networks to cement the relationships and allow seamless services to be offered which can be response to demand in a timely manner and help deliver the requirements of our active support and recovery programmes.

To support our Mental Health Better Care Fund Theme we have developed Local Care Coordination Centres across the City based on the Team Around the Person (TAP) process. The TAP process supports the integration of health (physical and mental) and social care, reduces demand on the acute/statutory services and supports individuals to build their capabilities and resilience. The process focuses on preventing wellbeing problems from becoming more serious, promotes independence and reduces the need for acute hospital and

residential care services. TAP was designed to support the integration of health (physical and mental) and social care and to help co-ordinate personalised support for individuals, who are involved with multiple services, and their needs are at risk of escalating. It is closely linked to our mental health transformation work streams.

To date TAPs have been successful in pilot areas, over 350 referrals have been received and over 40 services/organisations have been involved. Some of the initial key findings are that TAP:

- creates a more accurate assessment of risk and need,
- improves identification of risk, thereby allowing for earlier intervention,
- uncovers multiple previously unmet needs.
- enables a more thorough and driven management of cases and have avoided cases getting ‘lost’ in the system.
- improves standards of care and support and greater scrutiny between professional organisations.
- achieves greater efficiencies in process and resources due to avoiding duplication of services.

In 2022/23 investment has been made for evidence-based changes in the care offered by general practices and networks working within our most deprived populations. This includes extended appointments for patients with the most complex needs to enable a holistic approach to care, and co-location of other groups in PCNs who are able to provide advice and support, such as Citizens Advice within practices.

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