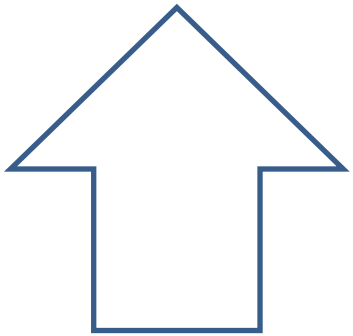
Integrated Commissioning Programme

People Keeping Well

NHS Sheffield Clinical Commissioning Group

Sheffield City Council

Strong, Resilient Communities



People Keeping Well

Risk stratification
people who would benefit from support are identified and prioritised

Life navigation
helping people maintain independence, control, and 'make it through'

Wellness planning
People plan to achieve their wellbeing goals – with support where necessary

Fix / support
sorting out and supporting - connecting people to community assets and services

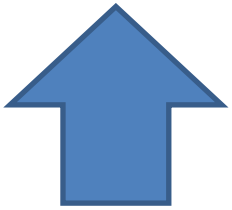
Inform and Advise
people are well informed and advised – this is a human interaction

Strong, Resilient Communities…

- Community infrastructure, leadership, activists
- Safe public spaces and places to come together
- Activities, celebrations and things to do
- Local amenities and services
- Voice and influence – "we're listened to and worked *with*"

Community Wellbeing Recipe

Improved wellbeing outcomes for the people of Sheffield



People Keeping Well…

- Risk stratification, prioritising people
- Life navigation (medium-term personal support)
- Wellness planning, goal-focused, person-centred plans
- Fixing and supporting – sorting out
- Inform & advise: signposting

Strong, Resilient Communities…

- Community infrastructure, leadership, activists
- Safe public spaces and places to come together
- Activities, celebrations, things to do
- Local amenities and services
- Voice and influence

‘buy from on high’

£ GP care planning

Floating support

£ support workers

£ health trainers

£ CPM

Link workers

£ Community Wellbeing Programme

£ small grants

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Community Wellbeing Recipe

Community Wellbeing Partnership with an integrated wellbeing budget for local population (20k – 50k)

People Keeping Well…

- Risk stratification, prioritising people
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Strong, Resilient Communities…

- **Community infrastructure, leadership, activists**
- Safe public spaces and places to come together
- Activities, celebrations, things to do
- Local amenities and **services**
- Voice and influence

2015 funders 2020

Outputs

Competition, insecurity, tension

Outcomes

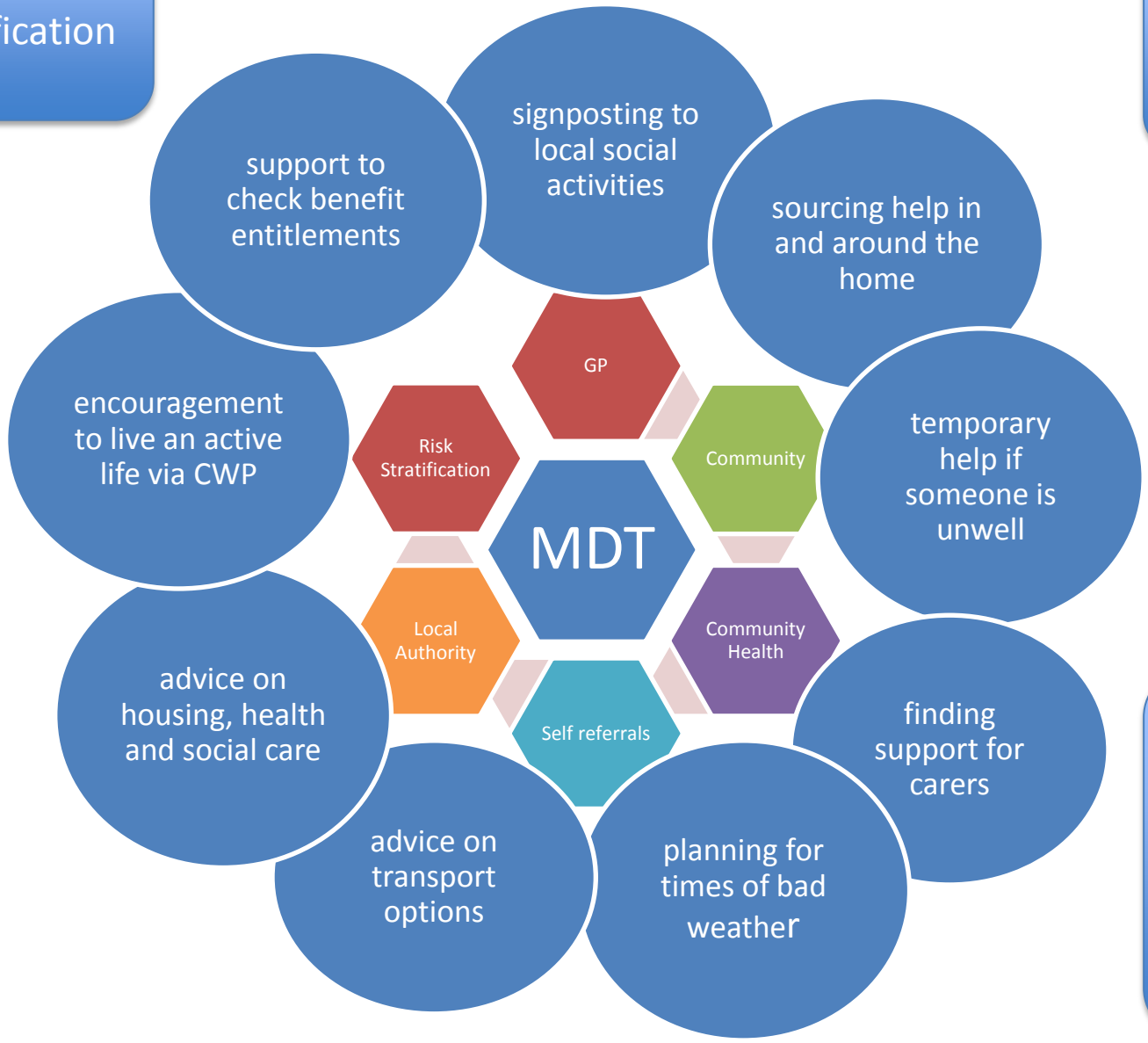
Partnership, stability, and collaboration

people and neighbourhoods

What Does it Look Like in Practice?

Risk Stratification

Central Referral System



COMING SOON

Community Partnerships

Mr Computer is in his 80s and recently lost his wife who he had cared for full-time for a number of years. The GP was concerned that Mr Computer wasn't coping with his grief and wasn't eating properly which was impacting on his diabetes – He was referred to the MDT

Listened & Observed

Listened to Mr C talk about his loss and looked at photos on the computer of his wife.
Observed great IT skills!
Talked about Mr C's diabetes

Information and Support

Encouraged to give Cruse Bereavement Counselling a try and he agreed to a referral to CWP to look at improving is diet

Suggested Mr C might want to share his IT skills with other older people – put him in touch with the local UK Online Centre

New Purpose

Mr C has not only helped at the UK Online Centre but set-up his own IT Class at his local library!
Mr C attended a healthy eating/cooking class and made new friends

Outcome

The GP reported a huge improvement in Mr C's outlook and was no longer concerned about his diabetes

86yr old Mr W was referred by local lunch club organiser because they noticed his appearance and outlook seemed to be deteriorating and he kept missing sessions.

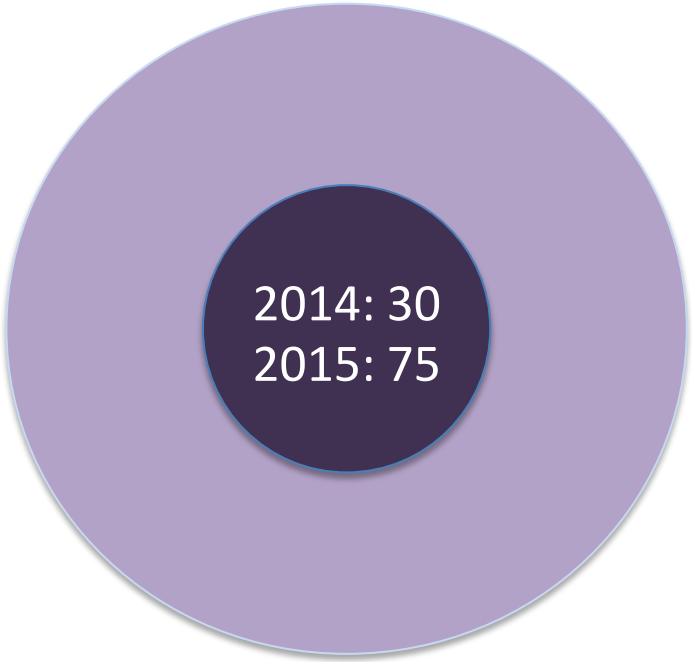
A community support worker called round to have a chat to Mr W and this is what she found…

The CSW found out that Mr W was having problems with neighbours and local youths. He avoided going out and could no longer manage to get his bin to the pavement. He didn't want to upset his neighbours further by leaving rubbish outside so had kept it in his house.

The CSW discussed moving house. Mr W was very reluctant because of the upheaval it would mean but agreed to think about it. The CSW checked Mr W's patient record and found he had been admitted to hospital on 6 occasions for various respiratory conditions and falls.

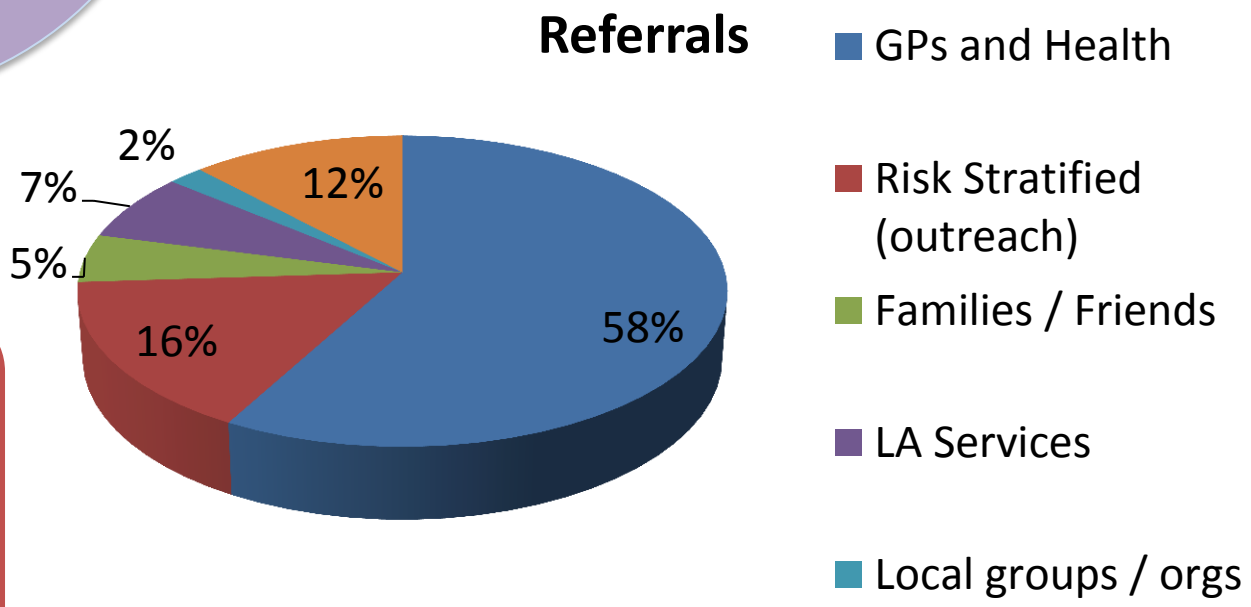
Because of the complexity of the Mr W's problems he was assigned a "Life Navigator" who worked with him for 12 weeks……

GP Practices Covered…



500+ referrals per month and increasing…

… less than 1 in 20 referred on to social care



Connected people to over 500 organisations and services

£1 million pounds of additional benefits claimed by some of the most at risk people in the city (£10m in 3 – 4 years)

All GP-registered people in the city have ‘health risk score’ - used to target outreach and response. Just secured funding to expand risk stratification to social factors

1,800+

Older people who struggle to cope in poor weather, matched to

200+

local volunteers who can drop in and make sure everything is OK

Internationally renowned evaluation partner (ScHARR) on board to test impact, help us learn and fine tune as we expand at pace