Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 21 November 2012 at 10.00 am

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Mick Rooney (Chair), Sue Alston, Janet Bragg, Katie Condliffe, Roger Davison, Tony Downing, Adam Hurst, Cate McDonald, Pat Midgley, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

Sheffield Local Involvement Network
Anne Ashby, Helen Rowe and Alice Riddell (Observers)

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Healthier Communities and Adult Social Care Scrutiny Committee exercises an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods area of Council activity and Adult Education services. It also scrutinises as appropriate the various local Health Services functions, with particular reference to those relating to the care of adults.

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday, or you can ring on telephone no. 2734552. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings. Please see the Council's website or contact Democratic Services for further information.

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

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Scrutiny Policy Officer on 0114 27 35065 or email emily.standbrook-shaw@sheffield.gov.uk.

FACILITIES

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

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
21 NOVEMBER 2012

Order of Business

1. **Welcome and Housekeeping Arrangements**

2. **Apologies for Absence**

3. **Exclusion of Public and Press**
To identify items where resolutions may be moved to exclude the press and public

4. **Declarations of Interest**
Members to declare any interests they have in the business to be considered at the meeting

5. **Public Questions and Petitions**
To receive any questions or petitions from members of the public

6. **Minutes of Previous Meeting**
To approve the minutes of the meeting of the Committee held on 17th October 2012.

7. **Birch Avenue/Woodland View: Update for Information**
Report of the Scrutiny Policy Officer

8. **End of Life Care**
Kate Gleave, Sheffield Clinical Commissioning Group, to report

9. **Intermediate Care: Progress on New Build Facility**
Tim Furness, Sheffield Clinical Commissioning Group, to report

10. **Grenoside Grange West Wing**
Tim Furness, Sheffield Clinical Commissioning Group, to report

11. **Local Account**
Howard Middleton, Development Manager, Planning and Performance, Communities, Sheffield City Council, to report

12. **Work Programme**
Report of the Scrutiny Policy Officer

13. **Date of Next Meeting**
The next meeting of the Committee will be held on Wednesday 16th January 2013 at 10.00 am in the Town Hall.

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

New standards arrangements were introduced by the Localism Act 2011. The new regime made changes to the way that members' interests are registered and declared.

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

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

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

You **must**:

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

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

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

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

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

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -
  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

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

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

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

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

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

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

Under the Council's Code of Conduct, members must act in accordance with the Seven Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership), including the principle of honesty, which says that 'holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest'.

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

You have a personal interest where –

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

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

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously, and has been published on the Council's website as a downloadable document at -http://councillors.sheffield.gov.uk/councillors/register-of-councillors-interests

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

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

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

Further advice can be obtained from Lynne Bird, Director of Legal Services on 0114 2734018 or email **lynne.bird@sheffield.gov.uk**

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 17 October 2012

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, Tony Downing, Adam Hurst, Cate McDonald, Jackie Satur, Diana Stimely, Garry Weatherall, Joyce Wright, Rob Frost (Substitute Member) and Keith Hill (Substitute Member)

Non-Council Members (LINK):-

Anne Ashby and Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Katie Condliffe and Roger Davison, and Councillors Rob Frost and Keith Hill attended as substitute Members.

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified.

3. DECLARATIONS OF INTEREST

3.1 Councillor Mick Rooney declared an interest in item 7 on the agenda (Partnership Review: Sheffield City Council/ Sheffield Health and Social Care NHS Foundation Trust), as a non-executive director of the Sheffield Health and Social Care Board, and left the room for the duration of this item. Councillor Cate McDonald took the Chair for this item.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 12th September 2012 were approved as a correct record, subject to the noting of HealthWatch under item 7.7 as a member of the Health and Wellbeing Board.

4.2 Arising from the minutes, the following updates were noted:

(a) with regard to 7.21 (b), a glossary of key health terms had now been circulated to all Members of the Committee by the Scrutiny Policy Officer;

(b) with regard to 7.21 (c), the theme of Health and Wellbeing being picked up by all five of the Council's Scrutiny Committees as a workstream would be brought to the next meeting of the Scrutiny Management Committee as an agenda item;

(c) with regard to 9.12 (c), the information regarding the Memory Clinic would be distributed to all Members by the Scrutiny Policy Officer as soon as it was available;

(d) with regard to 8.13 (b), this information requested would be fed into the working group on Child and Adolescent Mental Health Services (CAMHS), and

(e) with regard to 8.13 (c), it was noted that the Members who were interested in being part of the CAMHS working group were Councillors Sue Alston and Janet Bragg, and Anne Ashby and Alice Riddell from LINk.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 Sylvia Parry asked a question about hospital food, stating that she had received several complaints that the food at the Northern General Hospital had not been suitable or up to standard. In many cases, patients had been given the wrong food for the conditions they were being treated for.

5.2 Helen Rowe stated that LINk had already raised this topic as a concern, following an enter and view visit by LINk, and had produced a 15 point action plan of change for Sheffield Teaching Hospitals, which had not been implemented.

5.3 Members were extremely concerned about this topic, and several other cases of poor practice around hospital food were cited by Members of the Committee.

5.4 Members also queried whether doctors had any input into what patients were given to eat, and raised particular concerns around appropriate food and feeding assistance for patients with dementia.

5.5 **RESOLVED:** That the Committee;

(a) notes its concerns over the standard of hospital food in the City;

(b) requests the Scrutiny Policy Officer to convene a working group on hospital food;

(c) notes that Members interested in taking part in this working group are Councillors Sue Alston, Janet Bragg, Tony Downing, Diana Stimely, Garry Weatherall and Joyce Wright, and Helen Rowe (LINk), and

(d) requests the Scrutiny Policy Officer to further investigate why the LINk action plan and subsequent recommendations on hospital food were not implemented by Sheffield Teaching Hospitals.

6. PARTNERSHIP REVIEW - SHEFFIELD CITY COUNCIL/SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST

6.1 The Committee received an update on the Partnership arrangements between Sheffield City Council and the Sheffield Health and Social Care NHS Foundation Trust. In attendance for this item were Stephen Todd, Commissioning Manager,

Communities, Sheffield City Council, and Jason Rowlands, Director of Planning and Performance, Sheffield Health and Social Care NHS Foundation Trust.

6.2 Mr. Rowlands explained that the partnership had been established in 2001, with the idea of developing an integrated model of care between linked City Council and Health Services, to ensure a smooth service for all users.

6.3 The work of the partnership had been considered a success, but there were concerns that perhaps the earlier energy of the partnership had decreased, and therefore, it was the right time to conduct a review of arrangements. To sustain and progress the partnership, both partners wished to reaffirm through this review their joint commitment to the following key objectives;

- Focus on people
- Commitment to integration
- Commitment to the City
- Business-like partnership

6.4 Mr. Todd went on to explain that seven work streams had been identified, which were as follows:

- Integrated Working
- Social Care Leadership in Mental Health
- Resources
- Commissioning
- Delegated Functions (Assessment and Care Management)
- Delegated Functions (Provider Services)
- Governance Arrangements

6.5 Members were keen to ensure that the ‘package of care’ around an individual was seamless, so that the patient did not even have to be aware of whether it was the City Council or the NHS providing the care and support they needed. It was also essential to avoid duplication of services where possible, and ensure consistency around City Council/ NHS protocols, practices and procedures.

6.6 Members were also keen that the focus was placed on preventative measures being put in place, such as treating anxiety at an early stage to prevent the onset of physical symptoms and/ or the need to have time off work and more long-term treatment. Mr. Rowlands emphasised that the City Council’s ‘Right First Time’ programme aimed to tackle these kinds of problems, ensuring that prevention was better than the cure and more cost-effective ultimately. This ‘invest to save’ model needed streamlining though, as, often the services who were investing monies initially were not the ones making savings ultimately, and there needed to be incentives for services to invest in preventative measures which meant that they would not lose out financially.

6.7 With regard to Community Mental Health Teams (CMHTs), Managers were working very closely with Housing Officers to develop awareness around mental health issues, in order to signpost tenants to appropriate services.

6.8 With regard to Self-Directed Support (SDS), Mr. Todd informed members that

Sheffield was ahead of many other large Cities in the way in which this programme was being developed, and the number of people accessing SDS was increasing all the time, with positive results.

6.9 Mr. Todd stated that the SDS system had meant it was often more difficult for smaller providers to survive, as they no longer had a guaranteed fixed monthly income. However, some providers were doing very well with the new system, and some previously ineffective providers had been 'filtered out'.

6.10 Mr. Todd emphasised to Members that a 'single front-door' approach was being developed, in order to make it easier for patients to access care without having to go through many different providers, and in order to simplify the system. With regard to this, some Members still had concerns that, for example, older people's social and mental health workers were still not fully aligned with their housing workers.

6.11 With regard to some of the clients suffering from long-term mental health issues, Members emphasised the need to provide purpose and goals through volunteering schemes such as the successful one currently run at Heeley City Farm, for example.

6.12 **RESOLVED:** That the Committee;

(a) thanks officers for the report now submitted;

(b) supports the requirement for a review of existing partnership services, and

(c) welcomes continued work upon increasing emphasis upon preventative treatment and more simplified pathways for patient care.

7. CARE AND SUPPORT PERFORMANCE REVIEW

7.1 Members considered a report of the Executive Director of Communities, regarding Performance within Assessment and Care Management, and in attendance for this item was Robert Broadhead, Head of Care and Support.

7.2 Mr. Broadhead reported that adult care and support had been undergoing major changes both nationally and locally, with the introduction of new ways of working, such as Self Directed Support (SDS), increasing demand, and a reduction in funding. In response to this, Sheffield City Council had developed and commenced the implementation of a 2015 Vision for Adult Social Care.

7.3 Mr. Broadhead reported that, during this period of change, there were a number of key performance areas within the Care and Support Service Business Plan that had been increasingly challenging to deliver at the level desired, which were as follows;

- Average number of days to complete Adult Social Care, Self Directed Support assessments;
- Average number of days to receive all Adult Social Care services after the Self Directed Support assessment;

- Percentage of adults receiving a review as a % of those receiving a service.

7.4 Part of the reason why the targets had been harder to achieve had been the introduction of SDS, as care plans were taking longer to put together. However, Mr. Broadhead was convinced that SDS was a positive step forward, once any initial processing issues had been resolved, as, hopefully, the self-made plans would be more sustainable in the long-term, without clients having to constantly seek to adjust them. There had also been the issue of reduced staffing resources in the team, in line with Council-wide budget reductions, which had created additional pressures within the team.

7.5 Members expressed some concerns over the length of time it took to see a client after they had presented to Sheffield City Council, as, at one point, this had been an average of 103 days waiting time, when the national guideline was 28 days. It was noted that social work teams did keep all cases under review during waiting times, and that any emergencies were dealt with as and when they arose, but Members were keen to keep this figure under review.

7.6 Mr. Broadhead stated that it was hoped that the reintegration of public health back into the Council would help to improve processes and waiting times, with services working more effectively together. It was acknowledged that there was currently a backlog of cases, but it was hoped that there would be long-term efficiencies in terms of putting together SDS plans. Members felt it was essential to keep these waiting times under review.

7.7 It was noted that the assembling of the SDS care packages was done by external planners, and some Members felt that there were too many layers in this process, and that consistency of staff was essential, especially for patients suffering from dementia. It was confirmed that the care plan assessors monitored the work of these external planners to ensure that an effective job was being done, and that all plans met the legal requirements specified of the City Council. All plans were double checked before sign off.

7.8 **RESOLVED:** That the Committee:

(a) thanks the officers for the report now submitted;

(b) requests officers to;

(i) return to the Committee at a later date with a report upon how the process of assembling Self Directed Support (SDS) plans could be streamlined in order to improve waiting times,

(ii) provide a series of performance indictors upon which the effectiveness of the SDS service can be measured, and

(iii) review the role of the Equipments and Adaptations service and Occupational Therapy within the SDS service, and

(c) wishes to keep under review the waiting times for the completion of SDS plans after a patient has presented to Sheffield City Council.

8. WORK PROGRAMME

8.1 The Scrutiny Policy Officer provided an update to Members upon the Work Programme for the Committee for 2012/13.

8.2 **RESOLVED:** That the Committee notes;

(a) the contents of the Work Programme 2012/ 13 now submitted;

(b) a report submitted by LINk upon Care Homes in Sheffield and requests a further review on this issue to be added into the Work Programme;

(c) that working groups upon the topics of Hospital Food and Children and Adolescent Mental Health Services are to be set up and meeting dates circulated in due course, and

(d) that the Scruitiny Policy Officer will circulate further information to Members upon the current review of Paediatric Cardiac Services.

9. DATES OF FUTURE MEETINGS

9.1 It was noted that the next meeting of the Committee would be held on Wednesday 21st November 2012, at 10 am in the Town Hall.

Birch Avenue / Woodland View Update for Scrutiny Committee

This briefing has been supplied by NHS Sheffield / CCG at the request of the Scrutiny Committee. It briefly describes the current position regarding the Birch Avenue and Woodland View care homes.

A paper was presented to the NHS Sheffield Board on 11 January 2011 proposing the withdrawal of the top-up funding arrangements from the two homes. This would almost certainly have led to the closure of the homes.

A four month consultation which provided extensive feedback from residents, relatives, staff, other stakeholders and the public, expert advice to the Board, the opportunity for care assessments of the majority of residents, full analysis of the care home market, an assessment of the quality of care provided and a number of other inputs all led to an alternative proposal being presented to the Board in July.

The NHS Sheffield Board decided on July 5 2011 that the two homes should be re-commissioned as providers of enhanced care for people with dementia.

New admission criteria were agreed and came into effect on August 1 2011. Both homes have been operating to the criteria since that time.

Contracts were agreed with South Yorkshire Housing Association (Birch Avenue) from April 1 2012 and with Sheffield Health and Social Care NHS Foundation Trust (Woodland View) from July 1 2012.

From this time usual contract monitoring arrangements have been in place. Providers have been working hard on development plans to ensure that the homes are able to deliver high quality care to people with dementia who have enhanced care needs.

NHS Sheffield CCG would expect that any operational concerns that residents / their family and friends may have should be discussed with senior staff within the homes in order to find resolution. We understand that suitable fora and mechanisms exist for such discussion and would hope these can continue to be used appropriately. We will of course intervene if there are concerns about the quality of care provided.

Sarah Burt, Senior Commissioning Manager, NHS Sheffield / CCG

Tim Furness, Chief of Business Planning and Partnerships

October 2012

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Report to Health and Community Care Scrutiny Committee 21st November 2012

Report of: **Chief Operating Officer, NHS Sheffield**

Subject: Update on progress towards achieving an increase in preferred place of death for Sheffield residents

Author of Report: Kate Gleave, Senior Commissioning Manager, End of Life Care, kate.gleave@nhs.net

Summary:
A vast proportion of the population wishes to die at home or in their care homes, however, we know that both nationally and locally, the majority of people continue to die in hospital. This report sets out the progress made in Sheffield over the last year to improve the quality of End of Life Care and to increase the number of people who are able to die in their preferred place. This report has been requested by the Committee to update it on progress and to enable it to note the ongoing and planned actions to further increase the number of people who achieve their preference.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	√
Other	

The Scrutiny Committee is being asked to:
Note this report.

Category of Report: OPEN/~~CLOSED~~ (please specify)

Report of the Chief Operating Officer, NHS Sheffield
Update on Progress towards achieving an increase in preferred place of death for Sheffield residents

1. Introduction

1.1 End of Life Care (EOLC) has been defined by the Department of Health as encompassing all with advanced, progressive, incurable illness, in all settings, in the last year of life, and includes patients, carers and family members (including bereavement care)[1]. Research has concluded that 63% of people in Yorkshire want to die at home[2], although in 2008-10 57% of deaths in Sheffield occurred in hospital. This is significantly higher than the England average of 54.5%[3] of deaths occurring in hospital.

1.2 NHS Sheffield and EOLC providers (including Sheffield Teaching Hospitals NHS Foundation Trust and St Luke's Hospice) across the city have been working to increase the number of patients who die at home by addressing issues raised in the National[4] and Sheffield[5] EOLC Strategies. This paper provides an update on actions taken over the last year and those currently being planned. It also outlines the actual and expected impact of these actions on Sheffield's drive to increase achievement of preferred place of death.

2. Background

2.1 In November 2011 a paper entitled 'Achieving an increase in preferred place of death for Sheffield residents' was submitted to the Committee. This outlined the initial phase of a project to increase the support available to enable patients to die at home/care home. At that point, a Clinical Working Group had identified a number of barriers to achieving a good quality death at home/in a care home and was in the process of prioritising these and proposing high level actions to address them.

2.2 This phase of work was completed and approved by the Adult Transforming Community Services Partnership Board in January 2012 and the focus transferred to implementing solutions to remove/reduce the barriers. Non recurrent funding was obtained from both St Luke's Hospice and Macmillan Cancer Support to support implementation of some of the necessary actions.

2.3 The prioritised list of barriers, the actions taken and planned plus the expected/actual impact of these are summarised in Appendix 1. Most of the barriers require an interrelated mix of cultural, behavioural and process changes as well as improvements in knowledge and skills. Addressing any one of these areas won't in itself, reduce or remove the barrier. The actions taken and planned are presented quite simplistically in Appendix 1, but in reality the actions are being managed as part of an overarching system wide improvement plan.

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[1] Department of Health, Working Paper on End of Life Care, 2007

[2] [2] Gomes B et al, Local preferences and place of death in regions within England, Cicely Saunders International, 2011

[3] 2008-10 data, National End of Life Care Intelligence Network atlas available at http://www.endoflifecare-intelligence.org.uk/profiles/Place_of__Death/atlas.html

[4] Department of Health, National End of Life Care Strategy, 2008

[5] NHS Sheffield, Sheffield's End of Life Care Strategy, 2008

2.4 Two of the lynchpins of this plan are a new EOL Home Care model and the recently developed Sheffield Electronic Palliative Care Communicating System (EPCCS). The next section focuses on the progress made with these two specific areas of the project.

3 **New EOLC Home Care Model and EPCCS**

3.1 The barrier identified as the highest priority for action in order to increase the number of people who die in their preferred place of care was the lack of capacity and inequitable access to home care support. There is currently a range of health and social care providers who deliver similar care, but in different ways with different access criteria at different points, in the patient's last year of life. As a result, a new model for generic EOL domiciliary care has now been developed by health and social care commissioners and provider representatives.

3.2 The aim of this generic model is to meet both the patients' health and social care needs relating to their end of life care and to support their family carers' wellbeing to enable them to continue caring for the patient during their last year of life. The basic principles of the model are outlined in Appendix 2, these have been derived from the feedback obtained through the 2011 EOLC patient and public consultation.

3.3 A business case for the model, which is currently being developed, is predicated on the premise that the model combined with all of the other system wide improvements will reduce avoidable hospital admissions in the last year of life. This will fund the necessary increase in capacity and free social care to support patients who wish to die at home.

3.4 An outline business case will be submitted to NHS Sheffield for approval in December 2012. The case will also be submitted to Sheffield City Council and it is anticipated that this will progress through the system for Cabinet approval in March 2013. A consultation with existing and potential providers is planned for January 2013. Assuming there are no material changes to the business case as a result and approval is granted by both Commissioners, the de- and re-commissioning process for the new model will be able to start in April 2013. It is envisaged that the new model will 'go live' in October 2013.

3.4 As indicated earlier, the introduction of the new home care model by itself will not automatically increase the number of deaths at home. Clinicians also need to identify patients who are in their last year of life, ascertain that the patient wishes to die at home and ensure that their care is tailored to this end. One of the key enablers for all of these actions is the Sheffield EPCCS.

3.5 The Sheffield EPCCS, which was developed as a response to a DH requirement for locality wide End of Life Care registers, aims to facilitate the following objectives:

- identification of patients in their last year of life
- act as a prompt to assess and advanced care plan for this group of patients
- increase communication (both between professionals and patients/carers and between secondary and primary care professionals)
- prompt a change in behaviour and culture amongst secondary care clinicians (recognising when a plan for active treatment may no longer be the most appropriate focus of care).

3.6 A pilot of the EPCCS commenced in November 2011 and enables Secondary Care teams who have identified patients who are in their last year of life to communicate information regarding the patient's understanding of their diagnosis, prognosis and aims of treatment, key workers, Foci of care (summary term for aims of treatment) and management plan recommendations to the patient's GP.

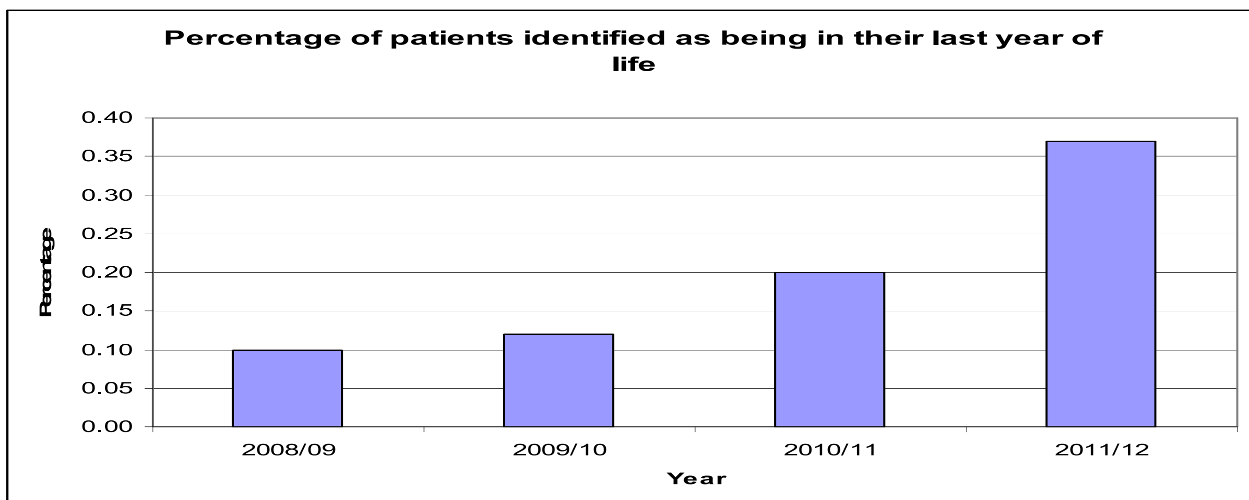
3.7 To date, information on over 1000 patients has been shared through EPCCS and both primary and secondary care clinicians are providing very positive feedback about the usefulness of the information and prompts provided. A formal evaluation of the system is about to commence, and assuming this supports the feedback, it is anticipated that EPCCS will be mainstreamed from April 2013.

4. Assessing the impact on the quality of EOLC

4.1 The Sheffield EOLC Planning and Commissioning Group has agreed four overarching outcome measures to enable the city to chart the impact of its progress with this system wide project. These are

- Percentage of patients identified as being in their last year of life
- Number/proportion of deaths in usual place of residence
- Families/carers feel that everything was done to meet the person's needs and preferences during the last days of life, as far as possible
- Number/proportion of individuals who die in their preferred place

4.2 The graph below indicates the significant increase in patients who are being identified as being in their last year of life from 2010/11 to 2011/12. This is a direct result of actions such as the introduction of the EOLC Facilitation Team and EPCCS.



4.3 The table below describes the percentage of deaths in each place. Usual place of residence is considered to comprise of both deaths at home and in a care home.

	Home	Care Home	**Usual Place**	Hospital	Hospice	Other
2008-10	18.5	17.5	**36**	57	5	2
2011/12	19.2	18.2	**37.4**	57.8	4.1	0.7

Whilst the data for 2011/12 is only a 1 year snapshot, it does indicate a small improvement in achievement of death in usual place. It is anticipated that when the data for 2009-11 is released later this year, it will support this snapshot.

4.4 Information of whether families/carers feel that everything was done to meet the person's needs and preferences during the last days of life has been collected for the first time this year as part of the national VOICES survey. Unfortunately the data was only published at Cluster level, however the survey is currently being repeated and it is anticipated that the results of both surveys will be published at Clinical Commissioning Group level next year. This will enable Sheffield to establish a clear baseline from which to measure itself against.

4.5 The number/proportion of individuals who die in their preferred place is not something that has been historically collected, either in Sheffield or nationally. However, the development and introduction of the GP EOLC clinical templates will now facilitate this and it is expected that baseline data will be available early next financial year for this measure.

5. What does this mean for the people of Sheffield?

5.1 The progress made over the last year and that planned for the rest of this year will make it easier for patients who wish to die at home or in their care home to achieve their wish. Implementation of the actions has started to generate and will continue to build:

- Greater achievement of preferred place of death
- An increase in the number of patients who receive a clear prognosis regarding their condition and make informed choices regarding their priorities for care and death
- An increase in patient's quality of life leading up to death, particularly in relation to service signposting, improved symptom control and dignity
- An increase in family carers' quality of life leading up to death, through increased carer support and service signposting
- An improvement in family carers' experience of their relative's death and subsequent potential reduction in complex bereavement issues

6. Conclusion

6.1 A wide ranging number of actions have been implemented over the last year to improve the quality of care for patients and their carers in the last year of life. Several of the barriers have yet to be addressed, but the project is planning to focus on these over the next six to twelve months. Early quantitative indications and anecdotal feedback indicate that these are beginning to have the desired impact and it is envisaged that these will be supported by evidence of a significant shift in place of death and improved quality of care over the next eighteen months.

7. Recommendation

7.1 The Committee is asked to note this report.

Appendix 1 **Actions Taken to Address Prioritised Problems**

Theme	Issue	Action Taken	Actions Planned	(*Expected*) Impact
Home Care	Capacity and availability issues: • Insufficient capacity within the Intensive Home Nursing Service • Inequitable access to different levels of home care support • Insufficient care home staff with EOLC knowledge • Delays in Continuing Health Care assessments/placements • Input of social care packages within short timescales challenging	• Clinical Working Group reviewed current service models and redesigned one generic model for all domiciliary EOLC • See actions taken to address variation in management of care home patients for issue relating to knowledge of care home staff	• Business Case for new home care model to be submitted for NHS Sheffield and Sheffield City Council approval in Dec 12, with view to new service model in place Oct 13	• *Equitable model of care for all patients with increased capacity and improved responsiveness*
Generalist (Primary) Care	Variation in management of EOLC patients across Primary Care: • Poor multidisciplinary team working in some practices • Not all EOLC patients identified on registers • Not all identified patients are assessed and managed appropriately • Lack of/poor communication with patients and carers regarding prognosis and choices available • Variation in access to case managers and community matrons by residential home patients • Inappropriate referrals for Continuing Health Care Fast Track funding	• Discuss with individual practices as part of facilitation team visits • 2011/12 Clinical Facilitation visits to all GP practices focused on increasing identification of patients in last year of life • 2012/13 Clinical Facilitation visits focusing on appropriate, multidisciplinary assessment and management of patients • EOLC clinical templates for GP practice systems developed and implemented • Communications training for 160 healthcare professionals established to improve quality and quantity of discussion regarding prognosis and choices • Protected Learning Initiative event held on EOLC for 200 GPs Sept 12	• Significant additional training planned for all GP practices on Advanced Care Planning • Fast Track team developing clarified criteria for referral	• Prevalence of patients on GP EOLC registers increased from 0.2% in 2010/11 to 0.37% in 2011/12 • 2/3rds of GPs who attended and evaluated PLI event said they would alter their practice as a result of attending
Specialist Condition Care Teams	• Variation in discharge support for EOLC patients which affects speed with which they are discharged and inappropriate referrals for Continuing Health Care Fast Track funding		• Fast Track team developing clarified criteria for referral • In the longer term, consider need for rapid discharge process	• *Improved speed of discharge and increased likelihood of dying at home/care home*
Specialist Condition Care	Variation in management of EOLC patients across Specialist Condition Teams – Inpatient, Outpatient and Community:	• EPCCS developed and 1000 patients entered onto EPCCS since Nov 11 (provides primary care with info on	• Further development of EPCCS to link to the Summary Care Record,	• Early indications suggest that EPCCS prompts a change in focus of

Teams	• Not all patients are identified when entering EOLC phase of condition • Lack of/poor communication with patients and carers regarding prognosis and choices available • Insufficient clarity over how care shared with Specialist Palliative Care Team and Primary Care • A change in the focus of treatment (from active to palliative) not routinely considered for EOLC patients • Variation in commencement/usage of EOLC advanced care plans • Lack of alternatives to inpatient management for some groups of patients • Variation in Specialist Condition Team management of patients within care homes • Variation in Specialist Condition Care Team input/development of advanced care plans • Use of EOLC pathway – patients put on too early or too late	patients's care plan including focus of treatment) • Evaluation of EPCCS currently being undertaken • Communications training for 160 healthcare professionals established to improve quality and quantity of discussion regarding prognosis and choices • New specifications have included an EOLC focus • Additional investment in EOLC Pathway Facilitator to improve appropriate usage of EOLC pathway • Specialist Palliative Care Team developing a strategy for EOLC within Secondary care	ensure provision of relevant information in A&E/MAU and roll out to more Specialist Condition Teams • Implementation of the AMBER care bundle (identifies patients' whose recovery is uncertain and prompts appropriate care/management) • Significant additional training planned for Secondary and Community Care on Advanced Care Planning	treatment and increased/improved discussion with patients • Improved communication and clarity between secondary and primary care and within secondary care • *Increase in number of EOLC discussions with patients/families and improved quality* • *Improved quality of care in last few days of life through EOLC Pathway* • *Good quality management of patients in their last year of life undertaken routinely by all Specialist Condition Teams*
Equipment	• Access to equipment at short notice to enable the patient to stay at/be discharged home (standard is 2 days from urgent request to delivery and 5 days for routine delivery) • Increased education on how to use the equipment and improved risk assessment and assessments of need for equipment		• Explore routine access to slide sheets, pads and urinals/bed pans/commodes for community nurses, carers and care homes • Consider need to increase number of beds and hoists at Sheffield Community Equipment Library Service • Consider adding to Last Offices Checklist and asking original referrers to contact SCELs • Improve estimated date of inpatient discharge and	• *Improved, timely provision of equipment for patients at home*

			advanced care planning •	

Medication	Access to medication for patients at home
	• Delays in GP Collaborative obtaining emergency supplies of drugs 10pm – 7am
	• Collection of drugs at weekends/bank holidays (knowledge of which pharmacies with stock open/when, distance to an open pharmacy, leaving dying relative alone etc)
	• Administration of drugs (availability, training and confidence of nursing staff)
	• GP awareness of new formulary
	• Difficulties accessing specialist medications
		• Agreed a standard palliative care stock list for pharmacists and 4 Pharmacies with extended opening hours now hold this
		• Details of these pharmacies publicised on EOLC GP templates
		  • Protected Learning Initiative event held focused on prescribing
		  •
		  • 2012/13 Clinical Facilitation visits focusing on appropriate, multidisciplinary assessment and management of patients including pre-emptive prescribing
		• Raised awareness of new formulary within primary care and developed guidelines for particular drugs
			• Details of the pharmacies holding stock to be put onto Sheffield EOLC website	• Improved access to drugs in pharmacies, and at weekends/bank holidays, particularly in the north of the city
				• *Reduction in requests for GP Collaborative to prescribe/provide drugs through increase in pre-emptive prescribing*

Home Care	Variation in management of EOLC patients in care homes: • Different values, cultures and competencies across different groups of staff • Lack of adequate communication and handovers between staff and with GPs • Communication of prognosis with relatives of care home patients	• EOLC prioritised by Care Home Support Team for 2012/13 • 2 Care Home EOLC Facilitators and an additional Community Specialist Palliative Care Nurse for Care Homes appointed (1 year contracts) • Skills for Care EOLC training for care home managers and staff in place • Network arrangements for care home managers and staff revised and improved • EOLC Care planning information for Care Home GPs revised and improved	•	• *Staff with increased knowledge, understanding and confidence regarding EOLC management* • *Increased communication and discussion of EOLC with patients/families* • 25 Care Homes currently undertaking Skills for Care training
Other needs	Unable to find suitable place of care for ‘young’ pts whose needs are predominantly nursing rather than Specialist Palliative Care	• MND Stakeholder group considering what the needs of this group of patients are		• *Better understanding of actual needs to inform appropriate commissioning of services*

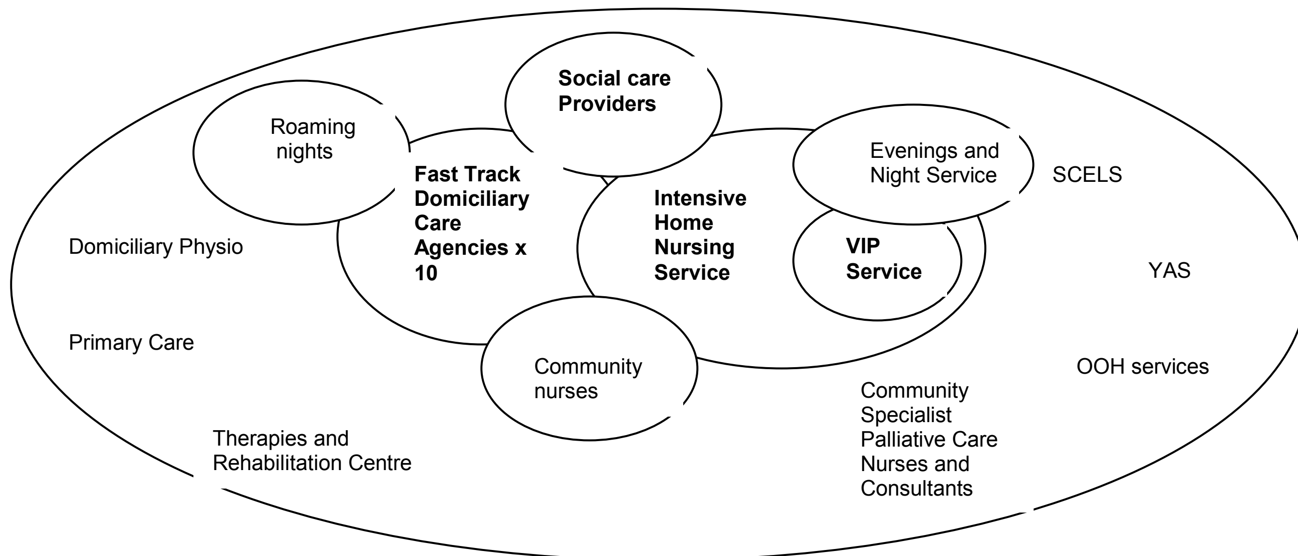
Appendix 2 Current versus New Model for EOL Home Care

Current Situation

Average number of deaths in Sheffield per year (based on 2008-10 data)

	Hospital	Home	Care Home	Hospice	Other
Percentage	**57**	**18.5**	**17.5**	**5**	**2**
Number	**2832**	**919**	**869**	**248**	**99**

Current Services



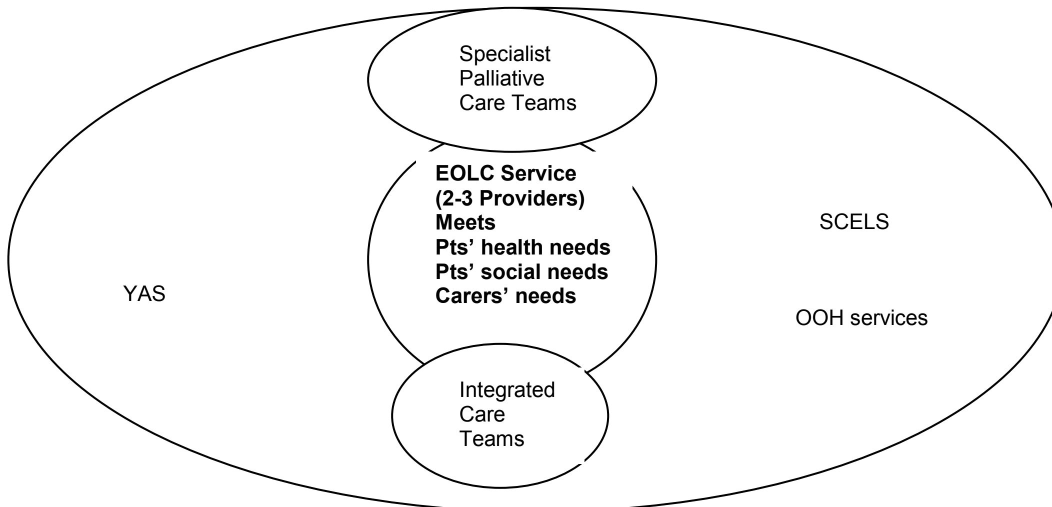
- Only 40% of patients who die each year are identified as being in their last year of life (75% of deaths are predictable). A large proportion of patients may either be accessing support that could be tailored more appropriately to their EOL needs or are not accessing any home care support
- Some patients receive a visiting service, some receive a sitting service and some receive a combination of both. This is based largely on which service the patient is referred to, the capacity of the sitting service and how these services are commissioned rather than on the needs of the patient
- There is minimal provision of EOL home care in the first 9 months of the last year of life, as a result patients are often admitted to hospital because of carer breakdown or crises which could be managed at home if additional support were available
- The needs of family carers in relation to supporting their loved one's wish to be cared for or die at home are not addressed (see above)
- Overlap/potential duplication between health and social care provision – most of the tasks undertaken by health providers support activities of daily living
- People with social care packages are means tested and may have to pay for care. Health care packages are free. Were more people identified as being in the last year of life, their care may transfer from social to health and therefore become free
- Current commissioning arrangements constrain some providers from meeting the patient/family carers needs e.g. health providers cannot meet family carer needs even if this means the patient is kept out of/discharged from hospital
- There is inequity of provision of EOL support to patients in care homes (particularly residential) and their own homes.

New Model

Ambitious average number of deaths in Sheffield per year (2013 onwards)

	Hospital	Home	Care Home	Hospice	Other
Percentage	**30**	**38**	**25**	**5**	**2**
Number	**1490**	**1888**	**1242**	**248**	**99**

New Service



Principles of New Model

- The model will provide practical care, reassurance, support, co-ordination and signposting to service users and their families
- The level and type of care will flex up and down based on their needs, not their length of prognosis
- The service is free to all on the basis that inability/refusal to pay will ultimately incur additional cost to the system (although the implications of this decision will be subject to detailed financial and risk modelling).
- The service will be provided by dedicated support workers who have additional skills and competencies relating to End of Life Care. It will also be expected to utilise (or sub contract) trained volunteers to support some aspects of provision.
- Each family will be allocated a consistent team of staff who will need to work in an integrated and collaborative manner with the Integrated Care Teams and (where necessary) members of the Specialist Palliative Care Teams in the city.
- In some circumstances, the service will act as an 'extra pair of hands with dedicated EOLC expertise' to an existing, long standing package of care and/or in the future to patients residing in residential and nursing homes in order to provide the additional EOL focused care whilst maintaining continuity with existing care providers.

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Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee

Report of: NHS Sheffield

Subject: Intermediate Care Facility Update

Author of Report: Tim Furness, Associate Director of Business Planning and Partnerships

Summary:

Following the review of Care4You resource centres in April 2012, the Scrutiny Committee asked NHS Sheffield to return in 6 months to report progress on developing a purpose built 120 bed Intermediate Care Facility.

The update is attached.

Type of item: The report author should tick the appropriate box

Briefing paper for the Scrutiny Committee	**x**

The Scrutiny Committee is being asked to:

Note and comment on the update.

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Review of NHS Sheffield's Commitment to an Intermediate Care Facility

1. Introduction

This paper reviews the position with regard to the planned intermediate care facility, identifies the factors influencing progress, and proposes a timetable for reviewing requirements for a facility.

2. Background

In May 2008 the NHS Sheffield Board approved a strategic direction which described a new model of intermediate care in the city, to improve the organisation of services, to provide care at home in the first instance and where that is not possible, to provide care in a new community facility.

One component of the plan was a new single site 120 bedded unit intended to bring together the existing dispersed bed capacity, to provide intermediate care to patients either as a "step down" from acute hospital care or as a "step up" from their own homes, together with a day unit to replace the facilities at Nether Edge Hospital.

To test the concept, a 30 bedded prototype unit was established at Beech Hill in April 2009 focussing on 'step down' specialist Stroke and Ortho-medical rehabilitation. This enabled testing, evaluation and proof of concept of the proposed bedded facility. It is clear from clinician feedback that this model of care is effective in delivering high quality clinical support and confirms the benefits of commissioning a single site solution to provide specialist intermediate care.

Community 1st Sheffield Ltd (LIFT Co) has been instructed to search for a site in Sheffield suitable for the development of a new Intermediate Care Facility. The LIFT Co has undertaken a comprehensive search for an appropriate site. 21 options have been assessed, many of them several times, but NHS Sheffield CCG has yet to identify a site upon which to progress the 120 bedded facility. The key issues with unsuitable sites have been size, availability, access and public transport links.

These plans were made prior to the current NHS Reforms being proposed, and at a time when NHS Sheffield still had responsibility for providing community based health care.

The role and provision of intermediate care services is being re-examined within the Right First Time programme. There has been some consolidation of intermediate care beds with the closure of the Hazelhurst and Sevenfields resource centres, with replacement nursed capacity being commissioned within STH's provision of intermediate care.

3. Review

Given the above, and the anticipated establishment of NHS Sheffield Clinical Commissioning Group in April 2013, which will inherit responsibility for commissioning intermediate care, it is appropriate to formally review current plans for an intermediate care facility.

The review should address the following issues, in the light of the experience of the Right First time programme and the impact it makes on patient flows and demand for hospital care:

- Is the clinical model of inpatient step up and step down intermediate care still the right one?
- If so, how many beds are required, to meet current and future demand?
- Is the proposed model of one facility for the city still the best clinical model to meet patients' needs?
- In light of the number of sites identified and assessed so far, is one facility a practical aspiration?
- How should the CCG commission inpatient intermediate care? If a new facility is needed, who should be responsible for procuring the appropriate building or buildings, given the current exclusivity arrangements entered into by NHS Sheffield?

4. Timetable

This review should be informed by the outcome of the Right First Time work and experience of the operation of the new model of inpatient intermediate care commissioned following closure of the resource centres. To ensure that the benefits of both are realised and taken into account, the following timetable is proposed.

1. Manage transition for closure of resource centre beds to ensure that there are 123 nursed beds with consistent level of therapy input - complete by end of August 2012
2. Interim evaluation of the impact of transition arrangements in light of wider system flow delivered through RFT programme- by January 2013
3. Full review - June 2013

Therefore the full review would take place in June 2013, i.e. after 12 months operation of the new model.

Tim Furness
Associate Director of Business Planning and Partnerships
September 2012

Agenda Item 10

Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee

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Report of: NHS Sheffield

Subject: The Case for Decommissioning Grenoside Grange West Wing

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Author of Report: Tim Furness, Associate Director of Business Planning and Partnerships

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Summary:

This paper sets out the case for decommissioning Grenoside Grange West Wing. It seeks the Committee's views on the proposals.

Type of item: The report author should tick the appropriate box

Briefing paper for the Scrutiny Committee	**x**

The Scrutiny Committee is being asked to:

Provide views on proposals within the report.

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The Case for Decommissioning Grenoside Grange West Wing

Introduction

Grenoside Grange West Wing is commissioned to provide rehabilitation for people with dementia (primarily those discharged from STH).

NHS Sheffield CCG has identified, in the course of reviewing the effectiveness and efficiency of all the services we commission, that the outcomes achieved by West Wing could be improved, and savings made, by providing rehabilitation at home for those who can benefit, and with interim care in a care home for those who need interim care rather than rehabilitation.

This paper sets out the case for change, including examination of the outcomes achieved and the options for providing alternative care that will better meet people's needs. It's primary purpose is to explain the case and seek the views of stakeholders who may be affected by the change being considered, before the issue is considered by the Governing Body of the CCG.

The reasons for decommissioning the current service are:

- Few people go home after a stay at West Wing (and therefore few have achieved the intended outcome from the service) – due to a change in the type of clients who are referred
- The cost of care is several times that of interim care in a care home
- The length of stay is much longer than comparable care in a care home

There is one continuing care patient on West Wing for whom alternative provision must be made, bearing in mind the risks of moving long term patients. This paper sets out a proposal for alternative care, managing those risks.

The Case for Change

1. Although West Wing is formally commissioned to provide rehabilitation, over time it has changed to providing largely interim care. This is not a reflection of the quality of the care delivered or the abilities of the staff but reflects the change in the profile of the patients being referred. Patients are now much frailer and more complex and are therefore less suitable for rehabilitation and discharge home.
2. The cost per bed per week of £2,374 does not represent good value for money, when compared to other services providing similar care for people with dementia.
3. Patients have a long average length of stay and that the discharge destination is most frequently a care home. 2011 data (to 15/11/2011), shows only 11.1% of patients discharged from West Wing returned home.

An audit carried out in October 2012 of patients in West Wing showed that the care required could have been provided elsewhere at significantly reduced cost. The audit added to the already substantial evidence that West Wing provides interim rather than intermediate care. Typically, the patients that are transferred to West Wing from STH are already receiving significant care input at home and the likelihood of significant deterioration in the near future is high. Many have multiple co-morbidities and are

elderly and frail. Many people appear to be admitted with delirium superimposed on an underlying dementia and the hope on admission to West Wing is that if the delirium clears and the person is able to engage in therapies, that they may be able to return home. Unfortunately, this is not the case and the vast majority are ultimately admitted to a care home.

A small scale audit of eighteen patients discharged from an alternative provider commissioned from the independent sector in 2011 shows that five (27.8%) returned home and the average length of stay was 76 days. This service is provided at a fraction of the cost of West Wing.

Therefore it seems that the service is not achieving optimal rehabilitation outcomes, it has a longer than necessary length of stay (LoS), and high cost per bed per week and is largely providing expensive interim care rather than the intermediate care to enable people to go home that it is commissioned to provide. By comparison, other services in the city appear to be providing similar care at lower cost and with better outcomes.

How Could We Meet Patient Needs Differently?

Re-provision of the care provided to the approximately 40 patients a year discharged from West Wing, based on the mix of need for interim care and rehabilitation illustrated by people's destination on discharge from hospital, could consist of the following. **The figures in this table are illustrative and would be finalised during the contract negotiations that would follow a decision to change:**

Destination on discharge	**No. of pts**	**Re-provision – destination from STH**	**Cost (£) p.a.**
Care home	22	Care home via Home of Choice (HOC) * (see below)	68k
STH	8	HOC / Home	25k
Home	6	Home with CICS / STIT – mild to moderate dementia Home with therapeutic input via rapid response – moderate to severe dementia	Existing CICS/STIT services – no additional cost.
Died	4	(Assume HOC 6 wks)	12.5k
Other possible costs			
Potential investment to support discharge from STH to care homes (to be considered within the Right First Time project)			tbc
If 25% of HOC patients will be CHC eligible and will enter CHC early (based on WW av LoS)			41k

Cost of re-providing continuing care for one person (£) p.a.	100k yr 1, 60k subsequent yrs

Total cost of re-provision	**£246,500**

*Home of Choice

Home Of Choice is an initiative which was set up to allow STH to discharge patients into a nursing home – freeing up in-patient beds and reducing LoS. It was initially set up for people who were likely to be funded by Continuing Health Care and choose to go into a home but currently includes people who go on to be FNC or social care only.

From April to the end November 2011, there were 221 Home of Choice patients with a total LoS of 8,719 days (av LoS of 39.5 days). The cost is the contract rate of a maximum of £512.70 per week depending on the home and whether the person requires nursing / EMI placement.

Savings

Approximately £1.4M direct savings could be released through de-commissioning West Wing. Of this, approximately £250k would need to be re-invested to re-provide care and additional funding would be required to support the consultation process and any possible redundancy. Net savings achieved would contribute to the delivery of the joint savings target between SHSC and NHS Sheffield.

Continuing Care patient

West Wing currently provides continuing care for one elderly patient. She is frail but assessed to have sufficient insight to make a decision about future care arrangements. It is recognised that the impact of a move could be detrimental to her. To reduce the risks of a move, it is recommended that two staff from West Wing should remain with her to support her transition and ongoing care delivery in her new environment (on a supernumerary basis) for one year after a move.

Impact on staff

Although every effort will be made to re-deploy staff, there may be some redundancies. The funded establishment is 23.97 wte staff with further support infrastructure approximately equating to 5 wte.

Summary and Recommendation

West Wing is formally commissioned to provide intermediate care for people with dementia. It currently provides largely interim care for a small number of people. The cost of care is several times the cost of other interim care providers. The average length of stay is long. Most importantly, for most people a stay at West Wing does not appear to improve their chances of returning home after a stay in hospital, and delays their final discharge from healthcare to their eventual home (which, for many, is a care home).

It seems clear that West Wing does not provide good value for money and should be de-commissioned, with alternative care being provided as described.

Next Steps

The NHS Sheffield CCG will consider this proposal, following receipt of views from stakeholders about it. If it is decided to decommission West Wing, no current patients would be moved, but no new patients would be admitted, and the service would close once all existing patients have ended their period of care.

Tim Furness, Chief of Business Planning and Partnerships
Sarah Burt, Senior Commissioning Manager
NHS Sheffield CCG
7 November 2012

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Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee

21 November 2012

Report of: Richard Webb, Executive Director, Communities

Subject: **'How did we do?' – Sheffield's local account of adult social care services 2012**

Author of report: Howard Middleton, Development Manager – Planning and Performance, Communities 2735922

Summary: This report explains the national requirement for all councils to produce a local account of their adult social care services and provides Sheffield's draft local account for 2012.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	✓
Other	

The Scrutiny Committee is being asked to:

- Note the progress made in developing Sheffield's first local account of adult social care services
- Take the opportunity to comment on the draft local account
- Consider the role Committee members wish to play in the development of the local account for 2013

Category of Report: OPEN

Report of the Executive Director of Communities – Richard Webb

'How did we do?' – Sheffield's first local account of adult social care services

1. Introduction

1.1. From this year all councils must produce a local account of how their adult social care and support services are performing. This is essentially an annual report to the public, providing information on the performance of local social care services along with details about priorities and outcomes.

1.2. In the past, all councils had an annual performance assessment by the Care Quality Commission (CQC). The last of these assessments was in 2010 and it rated Sheffield as performing excellently. As the CQC no longer does its annual assessment, councils are expected to find other ways to test their performance.

1.3. The local account is part of this – we are also working with other councils in the region to challenge each other's performance and to share good practice.

1.4. We have produced Sheffield's local account with the help of service users and are sharing the working draft with other councils for their comments. We will publish the final local account in December.

2. Why do we need to produce a local account?

2.1. The Department of Health's framework for adult social care, published in 2011, confirmed the intention to open up information on adult social care and to make available more information on what councils achieve for local people. It identified 'local accounts' as one way of supporting a more detailed and meaningful dialogue between councils and communities.

2.2. There was very little guidance on the content and format of local accounts. Councils were expected to share a common approach but to be responsive to local needs and priorities.

2.3. Local accounts have now become part of the new approach to local government sector-led improvement. At the heart of this is the principle that every council should be responsible for its own improvement, and should identify its own needs through self-assessment.

3. Sheffield's approach

3.1. In Sheffield, we have a well-established network of service improvement and involvement forums. As part of our Quality Improvement Network (QIN), a Service Improvement Forum (for Care & Support: Adult Services) commissions an annual event called Quality Live to look at performance and progress during the year, reality check this from their own experiences and to prioritise areas of importance for the coming year. A sub-group of the QIN - the Readers' Group - quality assures leaflets, newsletters and other publications.

3.2. We have worked with members of the Readers Group to shape the local account. Their contributions on the content, language, presentation of information and style have been invaluable.

3.3. We have also played an active role in developing the region's approach to sector-led improvement. In February 2012, the Yorkshire and Humber Association of Directors of Adult Social Services (ADASS) developed its model for sector-led improvement, drawing on the experience of other regions and exploring the opportunities available.

3.4. The region's model has five stages –

- Stage 1 – self assessment
- Stage 2 – reality checks
- Stage 3 – independent desktop review
- Stage 4 – annual performance event
- Stage 5 – improvement activity

3.5. These five stages are being developed to form an annual cycle of improvement activity.

3.6. The local account is the key element in stage 1 – the self assessment. Councils across the region have agreed to share drafts of their local accounts this month for peer review and challenge.

4. Going forward

4.1. Most local accounts for 2012 will be published in December - January. We intend to have a relatively small number of printed copies and to publicise the local account on the council website.

4.2. Feedback on Sheffield's first local account will be vitally important in shaping future editions.

4.3. The region endorses the view that each local account should involve service users in its development. We will continue to use the annual Quality Live event to establish local priorities and feed back on performance, and we will co-produce the local account with the readers group. We will explore other tools and opportunities for people to engage, including social media. Healthwatch regulations due out in October will contribute to shaping its future role and involvement.

4.4. We have developed a draft timetable to show how we plan to align local activity (L) with the agreed regional approach (R).

5. Draft timetable

L	Local account co-produced with service users	April - August
R	Regional sharing of performance information (year end)	June
R	Draft local accounts submitted for regional peer review	October
L	Draft local account submitted for Scrutiny comment	October - November
R	Reality checking	October - November
R	Desktop review	October - November
L	Local account sign off	November - December
R	Regional annual performance event (including endorsement of self assessments)	November - December
R	Local account published	December - January
R	Regional sharing of performance information (mid year)	December
R	Programme of peer reviews	January - March
R	Thematic buddying reviews	January - March
R	Sharing excellence	January – March

6. The Scrutiny Committee is being asked to:

- Note the progress made in developing Sheffield's first local account of adult social care services
- Take the opportunity to comment on the draft local account
- Consider the role Committee members wish to play in the development of the local account for 2013

Howard Middleton
Development Manager
October 2012

Report to the Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee
17 November 2012

Report of: **Emily Standbrook-Shaw**
Policy Officer (Scrutiny)
emily.standbrook@sheffield .gov.uk; 0114 27 35065

Date: 21 November 2012

Subject: **Work Programme and Cabinet Forward Plan**

The Committee's draft work programme is attached for consideration.

The Committee is asked to identify any further issues for inclusion in the work programme as agenda items, or in depth task and finish reviews.

To ensure that information coming to the Committee meets requirements, Members are requested to identify any specific approaches, lines of enquiry, witnesses etc that would assist the scrutiny process for items on the work programme.

The latest version of the Cabinet Forward Plan is also attached. Consideration of issues at an early stage in the development process gives scrutiny an opportunity to make recommendations to decision makers and maximises scrutiny's influence. The Committee is therefore requested to identify any issues from the Forward Plan for inclusion on a future agenda.

Recommendations:

That the Committee:

- Considers the work programme and Cabinet Forward Plan
- Identifies further issues for inclusion on the work programme

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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Draft Work Programme
Last updated 13 November 2012

What	Why	How	When
Intermediate Care	*As part of its review into the future of intermediate care resource centres, the Committee expressed concern about the length of time it is taking to find a suitable site for the planned intermediate care facility. An update was requested.*	Report	21st November 2012
Local Account	*To consider and comment on the Council's Local Account*	Report	21st November 2012
Birch Avenue/Woodland View	*Update as requested by the Committee at the September meeting.*	Report	21st November 2012
End of Life Care	*To consider progress on the End of Life Care Strategy – particularly around meeting the needs of the increasing number of people who choose to die at home.*	Report	21st November 2012
Child and Adolescent Mental Health Services	*To agree a terms of reference for a scrutiny task and finish exercise into waiting times for Tier 3 CAMHS*	Working Group	Ongoing

Nutrition and Hydration in Hospitals	*To consider support given to patients to eat and drink in hospitals, and to consider quality of food in hospitals*	Working Group	Ongoing
Adult Safeguarding	*To consider the annual safeguarding adults report and any issues arising from it.*	Report	16th January 2012
Experience of Care and Support – performance review	*To consider and comment on activity being undertaken to improve experience of care and support* including how the process of assembling Self Directed Support (SDS) plans could be streamlined in order to improve waiting times; The revised performance indictors upon which the effectiveness of the SDS service can be measured; and role and performance of the Equipments and Adaptations service and Occupational Therapy within the SDS service	Report	16th January 2012
Protocol for the Scrutiny of Health in Sheffield	*To refresh the protocol for the Scrutiny of health in Sheffield to reflect the changes to health and wellbeing structures in Sheffield brought about by the Health and Social Care Act 2012.*	Report	20th March 2012

Self Directed Support	*To consider progress made in rolling out personalised budgets*	Report	TBD
Anti Social Behaviour Review	*With a particular focus on impact of anti social behaviour for people with learning disabilities.*	TBD	TBD
Right First Time	*To consider the progress, future plans and outcomes from the Right First Time programme*	TBD	TBD
Quality Accounts	*To consider and comment on the annual quality accounts of NHS providers in the City, as required by the Department of Health*	TBD	TBD
Sheffield Food Plan	*To scrutinise progress of the Sheffield Food Plan*	TBD	TBD
Paediatric Cardiac Surgery	*To scrutinise outcomes for children in Yorkshire and the Humber following the decision to reconfigure children's heart surgery centres.*	Through the Yorkshire and Humber Joint Scrutiny Committee.	Ongoing

Cabinet Forward Plan of Key Decisions

12 Dec 2012 Cabinet	Revenue Budget and Capital Programme Monitoring 2012-13 (Month 6) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	4/12/12	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov.uk
12 Dec 2012 Cabinet	Securing and Sustaining Good Quality, Personalised Social Care Services for Adults (K)	Cabinet Member for Health, Care and Independent Living (Councillor Mary Lea) Healthier Communities and Adult Social Care Scrutiny Committee	Report of the Executive Director, Communities.	4/12/12	Communities Paul Brooke Tel: 0114 2736960 paul.brooke@sheffield.gov.uk
12 Dec 2012 9 Jan 2013 Cabinet Council	Changes to Council Tax Discounts for Second Homes and Empty Properties (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	4/12/12	Resources Jon West Tel: 014 2037762 jon.west@sheffield.gov.uk

12 Dec 2012 Cabinet	Disposal of land at Rother Valley Way	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	4/12/12	Resources Nigel Cunis Tel: 0114 2734120 nigel.cunis@sheffield.gov.uk
12 Dec 2012 Cabinet	Implementation of the Early Years Strategy (K)	Cabinet Member for Children, Young People and Families (Councillor Jackie Drayton) Children, Young People and Family Support Scrutiny Committee	Report of the Executive Director, Children, Young People and Families.	4/12/12	Children, Young People and Families Julie Dale Tel: 07794251181/01142930217 julie.dale@sheffield.gov.uk
12 Dec 2012 Cabinet	Wybourn Sites Disposal 1b	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Place.	4/12/12	Place Tamsin Auckland Tel: 0114 2052677 Tamsin.auckland@sheffield.gov.u k

12 Dec 2012 Cabinet	Implementing the Community Infrastructure Levy in Sheffield (K)	Cabinet Member for Business, Skills and Development (Councillor Leigh Bramall) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place.	4/12/12	Place Richard Holmes Tel: 2053387 richard.holmes@sheffield.gov.uk
12 Dec 2012 Cabinet	Future of Council Housing (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	4/12/12	Communities Vicky Kennedy Tel: 0114 2930241 vicky.kennedy@sheffield.gov.uk
12 Dec 2012 Cabinet	Community Covenant Annual Report and Action Plan (K)	Leader of the Council (Councillor Julie Dore) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	4/12/12	Resources Julie Bullen Tel: 01142736972 julie.bullen@sheffield.gov.uk

14 Dec 2012 Cabinet Member for Children, Young People and Families	Home to School Transport Policy (K)	Cabinet Member for Children, Young People and Families (Councillor Jackie Drayton) Children, Young People and Family Support Scrutiny Committee	Report of the Children, Young People and Families.	6/12/12	Children, Young People and Families John Bigley john.bigley@sheffield.gov.uk
16 Jan 2013 Cabinet	School Attendance Strategy (K)	Cabinet Member for Children, Young People and Families (Councillor Jackie Drayton) Children, Young People and Family Support Scrutiny Committee	Report of the Executive Director, Children, Young People and Families.	8/1/13	Children, Young People and Families Diane Dewick Tel: 0114 2506865 diane.dewick@sheffield.gov.uk
16 Jan 2013 Cabinet	Revenue Budget and Capital Programme Monitoring 2012-13 (Month 7) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	8/1/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov.uk

16 Jan 2013 Cabinet	Sheffield Development Framework:City Policies and Sites document and Proposals map - the Pre - submission version. (NOTE This item will be submitted to the City Council on 9th January, 2013.) (K)	Cabinet Member for Business, Skills and Development (Councillor Leigh Bramall) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place and other appropriate documents	7/1/13	Place Peter Rainford Tel: 0114 2735897 peter.rainford@sheffield.gov
16 Jan 2013 Cabinet	Re-let at Target Rent Consultation (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Executive Director, Communities.	8/1/13	Communities Liam Duggan Tel: 2930240 liam.duggan@sheffield.gov.uk
16 Jan 2013 Cabinet	Housing Revenue Account (HRA) Business Plan Update, HRA Budget and Rent Increase 2013/14 (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	7/1/13	Communities Liam Duggan Tel: 2930240 liam.duggan@sheffield.gov.uk

16 Jan 2013 Cabinet	The Future Delivery of Housing Repairs and Maintenance (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	8/1/13	Communities Jed Turner Tel: 27 34066 jed.turner@sheffield.gov.uk
13 Feb 2013 Cabinet	Housing Strategy 2013 -23	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Place.	5/2/13	Place Georgina Parkin Tel: 2736915 georgina.parkin@sheffield.gov.uk
13 Feb 2013 Cabinet	Revenue Budget and Capital Programme Monitoring 2012/13 (Month 8) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	5/2/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov.uk