Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 20 November 2013 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, John Campbell, Katie Condliffe, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Martin Lawton, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright

Healthwatch Sheffield
Anne Ashby, Helen Rowe, Alice Riddell and Mike Smith (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 and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

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 Matthew Borland, Policy and Improvement Officer on 0114 27 35065 or email matthew.borland@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
20 NOVEMBER 2013

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 (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting

5. Minutes of Previous Meeting (Pages 5 - 10)
To approve the minutes of the meeting of the Committee held on 18 September, 2013

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

7. Right First Time Programme - Update (Pages 11 - 18)
Kevan Taylor, Chief Executive, Sheffield Health and Social Care Foundation Trust and Right First Time Programme Director and Zak McMurray, Joint Clinical Director, NHS Sheffield Clinical Commissioning Group, to report

8. Dementia Strategy Report (Pages 19 - 36)
Sarah Burt, Senior Commissioning Manager, NHS Sheffield Clinical Commissioning Group and Michelle Fearon, Service Director, Sheffield Health and Social Care NHS Foundation Trust

9. Memory Clinic Services (Pages 37 - 48)
Jason Rowlands, Director of Planning, Performance and Governance and Michelle Fearon, Service Director, Sheffield Health and Social Care NHS Foundation Trust, and Sarah Burt, Senior Commissioning Manager, NHS Sheffield Clinical Commissioning Group

10. Nutrition and Hydration Working Group (Pages 49 - 60)
Councillor Garry Weatherall, Chair of the Working Group, to report

11. Date of Next Meeting

The next meeting of the Committee will be held on Wednesday, 15th January, 2014, 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.

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

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in

land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

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

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously, 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 18 September 2013

PRESENT: Councillors Mick Rooney (Chair), Janet Bragg, Katie Condliffe, Roger Davison (Deputy Chair), Tony Downing, Adam Hurst, Martin Lawton, Jackie Satur, Diana Stimely, Garry Weatherall, Joyce Wright and Denise Reaney (Substitute Member)

Non-Council Members (Sheffield Healthwatch):-

Anne Ashby

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Sue Alston and Councillor Denise Reaney attended the meeting as the duly appointed substitute, and Helen Rowe (Sheffield Healthwatch).

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 17th July 2013, were approved as a correct record, subject to the amendment of item 6 - Sheffield Clinical Commissioning Group - Commissioning Intentions 2013/14, which was amended by the substitution of the word 'relationship' for the word 'role' in paragraph 6.6(c)(i) and, arising therefrom, it was reported that:-

(a) in the light of the refurbishment works at St Luke's Hospice being completed in October/November 2013, it was suggested that Members visit the Hospice in January 2014, and the Policy and Improvement Officer was requested to contact the Hospice to discuss a convenient date and time for the visit, and to inform Members accordingly;

(b) further to the Committee's request, at a previous meeting, for a response from Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, in connection with the Council's proposal to no longer provide, free of charge, individual small items of daily living equipment

costing less than £50, and regarding the setting aside of funds, for a hardship fund, to assist those who could not afford daily living equipment, a response had been received from Jan Sutton, Service Manager, Housing, Care and Support Service, indicating that, after further analysis of this proposal, it had become clear that it was not possible to make the anticipated savings on equipment under £50 and the proposal had not been implemented, and was currently under review; the Service was considering alternative ways to achieve the required savings within the Equipment and Adaptations budget and discussions had commenced with the Sheffield Community Equipment Learning Service (SCELS) to look at value for money; the Service was also looking at the Council's policy of equipment and adaptations to review whether this was fit for purpose;

(c) a response had been received from John Reid, Director of Nursing and Clinical Operations, Sheffield Children's Hospital Foundation Trust, indicating that the Asthma Audit would be repeated in November 2013, to pick up those children with acute exacerbations that resulted from upper viral infections, which generally did not start until winter, and that he would arrange for a copy of the Audit to be forwarded to the Policy and Improvement Officer, who would then forward it to Members;

(d) a response had still not been received to the letter sent to the Secretary of State for Health, expressing the Committee's concerns regarding the lack of a national framework and regulation for male circumcisions;

(e) it was agreed that the Policy and Improvement Officer would try and arrange a briefing session for Members and Sheffield Healthwatch representatives, in connection with the joint Yorkshire and Humber Health Overview and Scrutiny exercise on the review of adult congenital heart disease services;

(f) the Policy and Improvement Officer had recirculated the report containing an update on End of Life Care for Children provided by the NHS Care Commissioning Group, which had previously been sent to Members by Emily Standbrook-Shaw on 6th June, 2013, and it was agreed that no further action was required on this matter;

(g) the Policy and Improvement Officer would chase up a response from the Health and Wellbeing Board with regard to the contracts that have been let to voluntary and faith sector organisations around offering help and advice to patients with mental health, drug and alcohol problems;

(h) in the light of the confusion as to the precise nature of Councillor Adam Hurst's inquiry, relating to the Malnutrition Universal Screening Tool, Councillor Hurst indicated that he was prepared to let this matter rest;

(i) a discussion on communication issues between the Sheffield Teaching Hospitals Foundation Trust and Sheffield Healthwatch had taken place; and

(j) Tim Furness, Director of Business Planning and Partnerships, Sheffield

Clinical Commissioning Group (CCG) had forwarded the CCG's Communications Plan in terms of its commissioning intentions for 2014/15, outlining when the Group planned to involve the public and patients, to the Policy and Improvement Officer, who had subsequently circulated it to Members of the Committee; the full Communications Plan would not be available until October 2013, and the Policy and Improvement Officer would circulate this to Members of the Committee.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 There were no questions raised or petitions submitted by members of the public.

6. ADULT SOCIAL CARE LOCAL ACCOUNT 2012/13

6.1 The Executive Director, Communities, submitted a report on the progress made on the Adult Social Care Local Account 2012/13, and inviting feedback from Members on the approach being taken, along with the design, structure and content of the early stages of the first draft of the report.

6.2 Ben Arnold, Development Officer, Business Strategy, Communities, introduced the report and responded to questions from Members of the Committee as follows:-

- It was appreciated that some service users, particularly those who had no one to assist them, would find the questionnaire difficult to complete, due to its size and level of detail, but the Authority was bound by national guidelines in terms of its size and contents.

- Details of the budget in terms of the funding available with regard to helping people with learning difficulties find employment could not be provided at the meeting, but such details could be obtained and included in the final report.

- The annual report of the Complaints Team was to be published in October 2013, and the relevant details from the report, which would include the level of detail now requested, would be included in the final draft of the Local Account.

- The reason for the relatively high number of patients being discharged from hospital into care homes for them to recover, which resulted in more people being admitted on a permanent basis, was possibly due to the lack of preparatory work in terms of assessing patients' physical ability and their homes, in terms of relevant adaptations.

- It was accepted that there were too many graphs in the report and efforts would be made to look at whether the information could be portrayed in some other format.

6.3 The following comments were also made:-

- It would have been helpful to see the questionnaire so that the list of

questions could be seen.

- It would have been helpful to have the detailed information on complaints to enable Members to provide feedback. As well as the proposed information in terms of complaints, as detailed in the draft report, there should be further detail in terms of what action had been taken, how many complaints had been referred to the Ombudsman and comparable statistics with other local authorities.

- In terms of the graphs, it would be useful to include information to show why the Authority had performed well or poorly during certain years.

- More accompanying information was required in terms of the statistics regarding the number of patients being discharged from hospital into care homes for them to recover, which resulted in more people being admitted on a permanent basis, as the relatively high figures, as detailed in the graphs, during 2011/12 and 2012/13, contradicted what the Service was aiming to achieve in terms of intermediate care.

- The case studies need to be more visually attractive and interesting, whilst still being easy to read. There needs to be better arrangements in terms of planned discharges for patients leaving hospital and planning was required, at an early stage, in order to assess whether patients leaving hospital could be discharged to their homes, rather than care homes.

- Details of performance should be included in the report, whether good or bad, together with details of how the Service's budget had been allocated.

- There should be some reference in the report where decisions and policies had been made on a national level.

- The 'I statements' were welcomed, but would be better if they were linked to something, such as the four outcomes.

- There could possibly be too many comparables in terms of the graphs, and it may be preferable just to have two comparables, such as surrounding areas.

6.4 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the comments now made; and

(b) requests Ben Arnold to consider the suggestions now raised in terms of the contents and layout of the Adult Social Care Local Account 2012/13.

7. DATE OF NEXT MEETING

7.1 It was noted that the next meeting of the Committee would be held on Wednesday, 20th November 2013, at 10.00 am in the Town Hall.

(NOTE: Item 7 on the agenda – Memory Management Service Developments – Interim Report – was withdrawn from consideration on the grounds that Jason Rowlands, Director of Planning, Performance and Governance, Sheffield Health and Social Care NHS Foundation Trust, was unable to attend the meeting.)

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Report to Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee
20 November 2013

Report of: Kevan Taylor, Chief Executive and Lead Director for the Right First Time Programme

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Subject: Right First Time Programme Update

Author of Report: Steven Haigh, Right First Time Programme Manager

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Summary:
This section should briefly introduce the subject **and** summarise the key points of the report. It should explain the reason it is being presented to the Scrutiny Committee (e.g. the information presented has been requested by the Committee to enable it to scrutinise performance, etc.)

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	**X**
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to note the progress being made with the delivery of current RFT objectives; to provide views on the impact of the programme to date; and to consider the longer term objective building an enhanced model of primary care.

Background Papers:
This paper is supported by a more detailed summary of the Programme inputs delivered so far.

Category of Report: OPEN

Report of the Director of: Kevan Taylor, Chief Executive and Lead Director for the Right First Time Programme

Title of report: Right First Time Programme Update

1. Introduction

1.1 This briefing paper provides the Committee members with a summary overview of the progress made with the delivering the current Right First Time (RFT) Programme. This briefing paper supports the presentation that Kevan Taylor, Chief Executive and Lead Director for the RFT Programme will be sharing with the Committee.

2. Progress with the Right First Time Programme

2.1 As previously reported to Committee members the RFT Programme is half way through the second year of delivery. The attachment that is included with this paper highlights the progress made with each of the key project areas of the current programme. In terms of milestone management all planned inputs are on schedule.

2.2 There is some evidence that the inputs are impacting positively on:

- Service users experience. The Community Support Workers are having a real impact on keeping people well and at home.
- Care planning for those most at risk is putting the individual in the middle of a coordinated process
- We are now testing out how many people with complex discharge needs can be supported at home rather than being consigned to long term care
- We also know that in overall terms the number of beds occupied by people who do not have an acute need is improving, although the overall admission rate for emergencies is still climbing

2.3 The Programme has also brought a much more cohesive approach to managing system pressures.

2.4 There is also active and strong engagement with service users to support the development, delivery and evaluation of programme inputs. The Programme is supported by a very active Citizen Reference Group.

2.4 The challenge for the programme is now to be clear what needs to come next. To date it has focussed very clearly on the relatively short term goals of tighter system management. It now needs to build on this and develop the ambitions for an enhanced model of primary care that actively supports and maintains the health and wellbeing of those at risk.

3. Recommendation

3.1 The Committee is asked to note the progress being made with the delivery of current RFT objectives; to provide views on the impact of the programme to date; and to consider the longer term objective building an enhanced model of primary care.

APPENDIX 1

Right First Time Programme – Phase 2

1 INTEGRATED CARE TEAMS

In March 2013 the RFT Executive agreed the priorities for phase 2 of the programme (April 2013 – March 2014). For Project 1 the following were identified:

- The development and implementation of community based Health and Social Care Integrated Care Teams to support individuals at emerging or high risk of hospital admissions or long term care

- The introduction of a single holistic care planning approach with a target of delivering 2500 care plans within 2013 2014 (later revised to 3500 over a 12 month period commencing September 2013)

Care Planning

Commencing in September 2013, 3,500 of the individuals identified as at high risk of hospital admission from across the city will be offered a GP led care planning service. This will offer systematic integrated holistic care planning for a cohort of patients within the 30 – 70 risk score. GP Practices, Health and Social Care staff will work together to explore how we can work in a more co-ordinated way to provide earlier and targeted support to help people stay as healthy and independent as possible.

Care Planning will be a collaborative, patient centred, process. It will be led by GPs and the practice teams with a range of professionals involved as appropriate. This might include community nurses, mental health workers, specialist nurses, community support workers, social workers, palliative care, housing, VCF sector etc depending on the needs of the individual.

Integrated Care Team Development

A number of Locality/GP Association based workshops are taking place where Health and Social Care professionals are working through the practicalities of integrated working to support individuals with complex Health and Social Care needs based on population needs within a particular area of the city.

The purpose of the workshops is for GP practices, Health and Social care staff to work together to explore how we can work in a more co-ordinated way to provide earlier and targeted support to help people stay as healthy and independent as possible. The workshops are being attended by Local GPs, Practice Nurses, District Nurses, Social Workers, Therapists, Mental Health, pharmacy, patient representatives and the Voluntary and Community Sector.

Additional testing

In addition to the workshops a range of other pilots are taking place to test various elements of the future ICT model and the approach to care planning.

Community Support Workers

A number of Community Support Workers (CSW) funded by the CCG but employed by Sheffield City Council are linked to GP associations

The aim of the CSW role is:

- To support people with non-medical needs that impact on their wellbeing; specifically housing related issues, social care, loneliness and isolation
- To complete prevention and early intervention work with people GP Practices / District Nurses identify with a Combined Predictive Modelling score of 20-40 over 65 years old
- The above two aims combined should lead to a reduction and delay in the need for acute hospital services and social care packages.

Virtual Ward

As part of the overall approach to care planning a virtual ward model is being tested at two GP practices. This targets patients with a combined predictive score of 50 and above.

The virtual ward model aims to integrate primary, community and social care at micro (clinical level) and explore the cost effectiveness of this type of integrated, multidisciplinary care management in reducing emergency hospital admission for patients at moderate to high predictive risk.

The purpose of the virtual ward pilot was to develop an integrated multi professional approach to patient support and care in the community, to defer patients reaching crisis point and avoiding the need for admission to care, to streamline access to other professionals cross organisationally in order to deliver care planning and support in the timeliest manner and to optimise the health and wellbeing of the patient.

The VW is able to target those patients who are not known to mainstream services and/or who would be best supported by an intensive coordinated approach from the ICT.

Psychological Wellbeing Practitioners

The purpose of this pilot is to train a number of practitioners who work with people with physical health conditions as IAPT Psychological Wellbeing Practitioners (PWP), and testing an innovative model for integrating delivery of physical and mental health care.

The pilot has two aims:

1. To test whether this model improves access to talking therapies for people with physical health problems who also have common mental health problems such as anxiety and depression

2. To explore the contribution of IAPT PWP intervention skills to the facilitation of self management in people with long term conditions.

Medicines Optimisation Pilot

This project is a 6 month pilot of a domiciliary medicines service, jointly funded by health and social care, focusing on compliance, adherence and re-ablement for patients with long term conditions.

- To assess the impact of a domiciliary medicines service on patients, social services and GP practices.
- To inform the development of the Integrated Care Teams in relation to medicines/pharmacy input.

Community Nursing Expansion
Additional investment has been identified to expand the Community Nursing Service at weekends and evening to create a fully established 7 day 8am – 10pm service (in line with Active Recovery) from October 2013. This additional capacity will support additional first assessment and contact plus ensuring the active case management of care plans.

TRANSITIONAL CARE

In March 2013 the RFT Executive agreed the priorities for phase 2 of the programme (April 2013 – March 2014). For Project 2 the priority has been to develop effective and timely discharges from and flow through the acute hospitals and intermediate care provision across the city. The aim is to reduce the average length of stay in hospital and/or intermediate care and to maximise individuals potential to return home and live as independently as possible for as long as possible.

To achieve this aim several pieces of work are now in place. A summary of the different projects can be found below.

Active Recovery

Active Recovery has been developed from a model to align the Community Intermediate Care Service (CICS) and the Short Term Intervention Team (STIT). Active Recovery has been developed to provide an integrated health and social care response team to support core services in preventing inappropriate hospital admissions, facilitate discharges from hospital and intermediate care beds and enhance inter-disciplinary working. The first phase of Active Recovery went live on the 28th October 2013 when staff deployment were aligned and processes and systems were integrated to enable access into Active Recovery via a Single Point of Access.

New Reablement Pathway (expansion of intermediate care)

In order to support national policy to make sure people are given the best opportunity to remain at home and as independent as possible for as long as possible a new reablement pathway has been developed and went live on 16th September 2013 (replacing the Home of Choice schemes). It is hoped that by increasing the capacity in intermediate care services across the city we can reduce the numbers of people entering permanent care (nursing and residential). There has been an increase in the number of intermediate care beds already and more will be opening over the next few weeks. There has also been recruitment of extra therapy staff to meet the demands of the increased bed base. Work is ongoing to monitor this new pathway and examine the outcomes for people going through this route.

Development of the Single Point of Access (SPA)

It was agreed that the SPA should be developed to become a single and simplified pathway for both hospital discharges and provision of support to people in crisis. Bed bureau staff are now located in SPA at Lightwood and continuing to work to streamline processes. The District Nurse Line calls are also now handled through SPA and an additional 4 nurse advisors have been recruited to the team. Consultation has commenced to create core working hours of 08:00am-10:00pm 7 days a week. A key next step is to audit incoming calls (over Oct / Nov 13) to inform future development of the SPA offer (including potential linkage to social care, access to secondary care expert opinion and supporting developments to hospital discharge processes)

Access to Short Term Intervention Team (STIT) from Functional mental Illness (FMI) wards

A business case to develop a referral pathway from Sheffield Health and Social Care Trust (SHSC) Functional Mental Illness (FMI) beds into SCC Short Term Intervention Team (STIT) was submitted to and approved by the CCG in August 13. A small group to operationalise the new pathway has been established and the pathway opened 14th October 2013. To date 3 patients have been discharged with this support.

Extension of the Sheffield Community Equipment Loan Service (SCELS) Out of Hours provision

Since March 2012, SCELS has been funded on a non recurrent basis to provide a rapid response, out of hours service. Funding has paid for additional staffing hours, any equipment loaned has been from existing SCELS stock. Initially the OOH service was to support the Front Door Response Team at STH (facilitating admission avoidance), but as the FDRT function has developed over the past 18 months SCELS availability has been widened to 'referrers' from several teams within the overall RFT programme. Demand for this service has continued to rise month on month since commencement. An evaluation of the OOH service is planned for later this year.

Dementia Liaison

£190k was invested in 2012/13 as part of the dementia project. This has been used to:

1. Increase capacity for identifying patients in STH requiring rapid access to community dementia services in order to reduce delayed discharges
2. Increase capacity within Dementia Rapid Response teams in order to meet this increased demand
3. Increase capacity within the Memory Service in order assess additional number of patients identified as needing diagnostic assessment by Liaison Psychiatry services within STH

SERIOUS MENTAL ILLNESS & PHYSICAL HEALTH

Background

In March 2013 the RFT Executive agreed the priorities for phase 2 of the RFT programme (April 2013 – March 2014). This included a project focussing on patients with serious mental illness (SMI) and their physical health needs (Project 4).

The issue

People who suffer with a serious mental illness (schizophrenia, bi-polar or severe depression) can be especially vulnerable of becoming seriously ill with physical health conditions such as heart disease or diabetes. These problems can often go unrecognised and untreated. The aim of Project 4 is to make sure all organisations and service users work together to change this. The main aim is to improve the physical health of people with SMI so people stay well for longer, services are improved and fewer people end up in hospital or in long-term residential care.

People with SMI have a three-fold increased risk of premature death and a reduced life expectancy of 16 years for women and 20 years for men. Although suicide accounts for about 25% of these deaths, physical illnesses causes around 75% with cardiovascular disease (CVD) is the commonest cause of death and diabetes is a significant cause of increased morbidity and mortality.

The increased risk of mortality from CVD is most significant in younger people. Those under 50 with SMI are 3.6 times more likely to die of CVD than those without SMI. Meanwhile, those over 50 with SMI are still more than twice as likely to die of CVD, than those without

SMI. Over the last 20 years CVD mortality rates have fallen considerably in the general population, but these benefits have not been shared by people with SMI.

Progress
Project 4 has a number of workstreams in place to take this forward. A summary of the different projects can be found below:

(i) A SMI pilot project has been developed with 3 practices in the central locality to test out holistic goal based care planning for patients on the practice SMI register. The pilot commenced during October with a baseline audit followed by the implementation of the Annual Health Check (which is an approved intervention framework for patients with psychosis on antipsychotic medication) across the three practices. Resources have also been secured to appoint a Community Development Worker (CDW) to proactively support and help meet the physical health needs of people with SMI within the pilot practices.

(ii) The component parts of the Annual Health Check have now been included within the overall Care Planning template recommended for all GP practices across Sheffield. Discussions regarding the inclusion of drugs and alcohol assessment are also ongoing. In addition, exploratory discussions are underway looking at the possibility of integrating the Annual Health Check within the SHSC Care Programme Approach (CPA).

(iii) A 'Test for Change' Smoking Cessation/Improving Physical Health Project is being established within the locality served by East Glade Community Mental Health Team. The project will be led by the East Glade Team with support and broader involvement provided by RFT to:
- engage service users and staff in shaping the project
- agreeing the aims and objectives
- provide relevant data and provide in house training, intervention and evaluation.

(iv) An Involvement Plan survey is currently underway with relevant SMI user groups across the city. The results of which will be presented to the November Project 4 Steering Group. A workshop for user groups will then be held during the new year to describe how the recommendations will be addressed.

Report to Healthier Communities & Adult Social Care Scrutiny Committee

20th November 2013

Report of: Tim Furness, Director of Business Planning and Partnerships, Sheffield CCG

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Subject: Sheffield Dementia Strategy / Commissioning Plan

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Author of Report: Sarah Burt, Senior Commissioning Manager, Sheffield CCG

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Summary:

The enclosed information is being presented at the request of the Scrutiny Committee. The report discusses the dementia strategy and Sheffield Commissioning Plan

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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:

Please note for information

_____

Category of Report: OPEN

Report of the Director of Business Planning and Partnerships, Sheffield CCG

Sheffield Dementia Strategy and Commissioning Plan

1. Introduction/ Context

1.1 The following report is being presented at the request of the Committee following its meeting in May 2013. The committee requested a report on the "*Dementia Strategy: To outline the approach to dementia care across the City – including Continuing Health Care funding criteria and the role of bed based facilities in the strategy."*

In line with the increasing older population, the numbers of people predicted to have dementia is increasing each year. Following the publication of the national Dementia Strategy (2009) and the Prime Minister's Challenge (2012), there has been a greater focus on the commissioning of dementia services and the need to ensure dementia friendly environments.

In addition, with increasing focus within health and social care on the need to demonstrate value for money, quality and improved outcomes for people with dementia and their carers, continued commitment to a shared CCG and local authority approach to the commissioning and development of dementia services is essential.

2. The Dementia Strategy / Sheffield Commissioning Plan

2.1 There is a long history of a collaborative approach to the commissioning of dementia services in the city. Sheffield has had a Joint Health and Social Care Dementia Strategy since 2006/7 and a Joint Commissioning Plan which is refreshed every year to reflect the commissioning intentions of the CCG and City Council. The Sheffield Commissioning Plan for 2013/4 is enclosed (Appendix A).

The National Dementia Strategy https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf describes a number of key objectives including

- Improved public and professional awareness
- Early diagnosis and intervention
- Good quality information
- Access to care, support and advice following diagnosis
- Improved quality of care in hospital
- Living well with dementia in care homes
- Improved end of life care

Health and social care commissioners in Sheffield are working hard to ensure that people with dementia and their carers are able to live well with dementia. Since the National Dementia Strategy was published in 2009, Sheffield has made significant progress in all key objectives. Sheffield benchmarks well in England and Wales against key outcomes indicators eg it ranks second in England and Wales for its diagnosis rate. Early diagnosis and early intervention are key to improving outcomes.

Care Homes

With regard to care homes, the strategy's objective 11: Living Well with Dementia in Care Homes promotes improved quality of care for people in care homes through explicit leadership for dementia care, defining the care pathway, the commissioning of specialist in-reach services and through inspection regimes.

In Sheffield we are working hard to improve the quality of dementia care in care homes. Work in 13/14 has particularly focused on workforce development, better targeted care home support, the continued reduction in anti-psychotic medications and the promotion of meaningful activity for residents with cognitive impairment. Investment in the Local Enhanced Service for GPs also continues.

Sheffield has a range of care homes to meet the needs of people with dementia. It is widely accepted that there is a high percentage of people in residential and nursing homes who are cognitively impaired and therefore action to improve the quality of dementia care is not merely focused upon EMI care homes.

Other bed-based facilities

Recent commissioning changes to the intermediate care pathway have included commissioning input from the Senior Commissioning Manager for older adult mental health and dementia to ensure that the needs of people with dementia and their carers are fully considered. New pathways try to maximise the number of people who are able to be supported to return home following admission to hospital.

Continuing Health Care

The eligibility criteria for continuing healthcare are set out in the National Framework for Continuing Healthcare, which is published by the Department of Health. Eligibility for continuing healthcare is not determined by diagnosis of particular diseases or conditions. Eligibility is determined by assessing the individual's needs and determining whether the individual has a 'primary health need'.

Whether someone has a 'primary health need' is assessed by looking at all of their care needs and relating them to four key indicators:

• nature – this describes the characteristics and type of the individual's needs and the overall effect these needs have on the individual, including the type of interventions required to manage those needs

• complexity – this is about how the individual's needs present and interact and the level of skill required to monitor the symptoms, treat the condition and/or manage the care.

• intensity – this is the extent and severity of the individual's needs and the support needed to meet them, which includes the need for sustained/ongoing care

• unpredictability – this is about how hard it is to predict changes in an individual's needs that might create challenges in managing them, including the risks to the individual's health if adequate and timely care is not provided

Eligibility for continuing healthcare is subject to regular review

3 *What does this mean for the people of Sheffield?*

3.1 This report outlines the progress made to date to meet the objectives of the Dementia Strategy. Overall, Sheffield has made good progress and benchmarks well against key outcomes.

There continue to be areas that require further work in order to improve services for the people of Sheffield and we are currently working on the 14/15 commissioning plan to ensure that progress continues.

4. Recommendation

4.1 The committee is asked to note the enclosed for information

Sheffield Integrated Commissioning Plan for People with Dementia and their Carers 2013/14

April 2013

1.0 Purpose

1.1 This plan describes an integrated approach to commissioning services for people with dementia and their carers by NHS Sheffield and Sheffield City Council.

1.2 It summarises the needs identified in recent strategies, sets out a brief market analysis of current and potential service providers and proposes key areas for development.

1.3 Using a modelling exercise undertaken recently it identifies the financial implications of both the 'do nothing' scenario and the impact of priority interventions recommended in the National Dementia Strategy

1.4 It describes the commissioning principles for both health and social care that will determine the priority given to developing services both individually and jointly to achieve the objectives set out in the National Dementia Strategy by 2015 and the Prime Ministers Challenge (March 2012).

1.5 In a high-level commissioning plan it describes the workstreams that will deliver the priorities

2.0 Background

2.1 This section summarises the findings of the relevant local and national strategies and identifies the key areas for development.

2.2 In February 2009 the National Dementia Strategy was launched. It is a five year plan designed to transform the lives of people with dementia and their carers. The Strategy outlines 17 objectives to improve the quality of services for people with dementia and their carers

2.3 In September 2010 DH produced *"Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy"*. It describes what the Department of Health considers as its priorities for policy development in its role of enabler for continued progress in improving outcomes for people with dementia and their carers. It does not state what services should be planned, commissioned, provided and delivered. As highlighted in the National Dementia Strategy, the pace of implementation will vary depending on local circumstances and the level and development of services within each NHS and Local Authority area.

2.4 In March 2012 the Prime Minister launched a programme of work which aims to deliver major improvements in dementia care and research by 2015. The initiative builds on the achievements of the existing National Dementia Strategy and emphasises:

- Driving improvements in health and care
- Creating dementia friendly communities that understand how to help
- Better research

3.0 Needs Analysis

3.1 The 2010 Sheffield Health and Wellbeing Joint Strategic Needs Assessment acknowledges a major challenge is "…how to ensure that the growing number of older people maintain the best possible physical health and mental capital, and so preserve their independence and wellbeing." It also sets out the impact of an ageing population in terms of the increasing numbers of older people with dementia.

3.2 There are currently estimated to be 6,085 people with dementia in Sheffield. The table below shows how this is broken down by type of dementia and compares this to other localities in Yorkshire and Humberside.

Table 5: Numbers Predicted to have Late On-set Dementia by Sub-type – Yorkshire & Humber 2008 by Local Authority

Local Authority	Alzheimer's Disease	Vascular Dementia	Vascular Dementia & Alzheimer's Disease	Lewy Bodies	Frontotemporal Dementia	Parkinson's Dementia	Other
Barnsley	1,569	416	258	100	33	42	75
Bradford	3,070	812	503	195	65	81	146
Calderdale	1,402	370	229	88	29	37	67
Doncaster	2,102	560	346	135	45	57	100
East Riding	2,865	765	472	185	62	78	137
Hull	1,586	422	261	102	34	43	76
Kirklees	2,626	696	431	167	56	70	125
Leeds	5,064	1,343	832	323	108	135	241
NE Lincolnshire	1,216	322	200	78	26	32	58
North Lincolnshire	1,223	327	202	79	26	33	58
North Yorkshire	5,196	1,382	855	333	111	139	248
Rotherham	1,757	467	289	113	38	47	84
Sheffield	3,834	1,014	629	243	81	101	183
Wakefield	2,258	598	371	144	48	60	108
York	1,486	394	244	95	32	40	71
Yorkshire & Humber	37,254	9,887	6,122	2,380	793	994	1,776

Source: Dementia UK & POPPI

3.3 The 'Sheffield Dementia Health and Well Being Needs Assessment' makes a Number of key points:

- Given the rising numbers of people with dementia and the corresponding rising costs of caring for them, it is vital that addressing dementia is seen as a priority across the health and social care system.

- The data shows that Sheffield faces a substantial growth in the numbers of people with dementia in the next 15 years. The demographic pressure on older people's services is well documented. It is particularly notable within dementia. There are 750,000 people living with dementia in the UK now and by 2025 there will be over 1 million leading to one of the greatest challenges facing our ageing population.

- Sheffield is currently predicted to have 6494 (2012 data) people living with dementia and this is expected to rise to 7342 by 2020 and 9340 by 2030. The biggest increase will be in the people aged 85 and over which will nearly double over the same period.

- A relatively small number of people with dementia are from black and ethnic minority groups, but this will increase substantially in future years.

- Early diagnosis and intervention improves quality of life through enabling people with dementia to access suitable support services and delay or prevent premature and unnecessary admission to care homes.

- Evidence from Sheffield Teaching Hospitals Foundation Trust audit suggests that improving the experience of hospital care for people with dementia will assist in taking forward the reform agenda.

4.0 Market Analysis

4.1 An estimated £19m is spent on all independent sector care home provision for people with dementia. Of this £6.3m is spent on residents in specialist provision. The quality of care is variable and there are training, design and best practice issues for the care home sector.

4.2 The home support services also care for significant and increasing numbers of people with dementia in the community. An estimated £5.6m is spent in home support on people with dementia. Specialist home support provision available across the City with a final target of 5,000 hours of specialist provision per week.

4.3 Sheffield Health and Social Care Trust (SCHC) provide a range of services funded by both NHS Sheffield and Sheffield City Council:

- Assessment and diagnosis and treatment through the memory management service and community mental health teams (CMHTs)
- Specialist interventions
- Social care resource centre provision including respite and day support – costing approximately £3.2m
- Carer support – Carers Grant contribution £0.12m
- In patient assessment and treatment
- Intermediate care (Grenoside Grange)
- Nursing home care (Birch Avenue and Woodland View)

4.4 There is a significant investment by NHS Sheffield in the treatment of people with dementia in Sheffield Teaching Hospital Foundation Trust (STHT). It is very difficult to quantify the exact figure as patients are not always coded as having dementia but recent estimates suggest that people with dementia over 65 years of age currently occupy around 25% of hospital beds.[1]

4.5 The same research suggests that as well as an often difficult experience in hospital, poor outcomes for people with dementia and increased length of stay are costly for both health and social care. A new Call to Action to develop dementia friendly hospitals in 13/14 will build on the significant work which is already taking place at STH to improve the care of people with dementia and the experience of their carers.

4.6 The intermediate care arrangements are inconsistent but a major project, led by

[1] 'Counting the Cost – Caring for people with dementia on hospital wards' Alzheimer's Society, 2009

NHS Sheffield CCG is addressing the whole system of intermediate care, including the needs of people with dementia.

4.6 There is a range of services for people with dementia in the Third Sector. These are funded by both Sheffield City Council and NHS Sheffield. Over the past year these have been reviewed in the light of the Dementia Strategy to ensure continued fitness for purpose and best value. Plans are in place to either improve the fit or develop capacity to meet changing demand and the drive towards a more personalised support.

4.7 There is a lack of understanding about the demand for and role of specialist provision for people from our BME communities but the newly commissioned BME dementia cafes will help to clarify the amount and scope of support needed to ensure equality of provision.

4.8 The quality of care in care homes is varied. This is in part addressed through the multi-agency Quality in Care Homes Project. There remains a significant skill deficit in care homes in relation to dementia. The impact on the experience of residents is well evidenced. The cost impact for both health and social care is significant as people are placed in higher level care (including CHC funded placements) because their needs are not met in non-specialist and residential settings.

4.9 All commissioners and providers have identified the need for workforce development. All staff should be able to recognise and respond appropriately to people with dementia and develop strategies for managing challenging behaviour.

4.10 The current service configuration demonstrates a dependency on intensive care and support at the expense of lower level, earlier interventions. The National Dementia Strategy emphasises the need to shift the investment to reflect the changing focus.

5.0 Costing the Changes

5.1 Modelling work completed in 2011 and supported by CSED and YHIP[2] has identified the cost implications to the whole system of both a 'do nothing' scenario and the impact of key interventions. In summary, the model predicts the impact of the demographic changes will mean a combined additional cost to both health and social care of £3.5m by 2019

5.2 In contrast the model also predicts that through key interventions there is the potential for combined annual saving of £2.4m by 2015. The initiatives that are recommended to achieve this are:

- Increasing diagnosis rates to 70% of the estimated prevalence (currently 63.6%) through an efficient and effective memory service
- A mental health liaison service in the acute trust
- An in-reach team for care homes including a
- Reduction in the use of anti-psychotics
- Improve the understanding of the needs of people with dementia across the workforce

[2] This modelling work was led by Whole Systems Partnership on behalf of YHIP and CSED

5.3 The estimated savings are not spread equally across health and social care. The model predicts that for social care there will be a £200k increase compared to a £2.6 saving by health. These savings are net of any investment required to make the change. The model is calibrated to allow for the existing provision in Sheffield.

6.0 Agreed Priorities

6.1 The national consultation linked to the National Dementia Strategy sets the broad priorities for Sheffield. The way in which the services are finally delivered and the priorities for identifying which needs to change first will be the subject of consultation with a range of stakeholders. These include:

- People with dementia
- Carers
- Clinicians and practitioners
- Alzheimer's Society
- Providers of health and social care services

6.2 The key priorities areas for Sheffield in 2013-14 therefore are:

- Care at Home and in Care Homes
- Care in Hospital
- Early Diagnosis and Intervention
- Dementia Friendly communities and the development of a local Alliance
- Incorporating the voice of people with dementia into strategic planning

Though not the focus of a specific workstream the following areas will be addressed across the programme:

- Support for carers
- Reduction in the use of antipsychotic prescribing for people with dementia
- Information and advice
- Data quality and information management
- Research opportunities

6.3 The detail of the work to achieve these priorities is set out in **Appendix A**.

6.4 The main development during 2013-14 is the joint commissioning of the Dementia Information Advice and Support Service planned for October 2013. This is a jointly commissioned service responding to the call from people with dementia and their carers. It is intended to replace the current commissioned services with an enhanced model.

6.5 In addition, it is recognised that the Sheffield Dementia Programme will need to adapt to changing commissioning arrangements following the publication of the Health and Social Care Act (2012) and understand key links with e.g. the Health and Wellbeing Board and clinical networks.

6.6 It is acknowledged that there is significant overlap between the work of the dementia programme and the RFT programme and work is on-going to ensure that these connections are managed effectively.

6.7 There is increasing recognition of the impact of dementia and its effect on multi-morbidity, long term condition management and outcomes for patients. The importance of strong links to work in this area is required to ensure consistency and maximise effectiveness.

7.0 Measuring impact

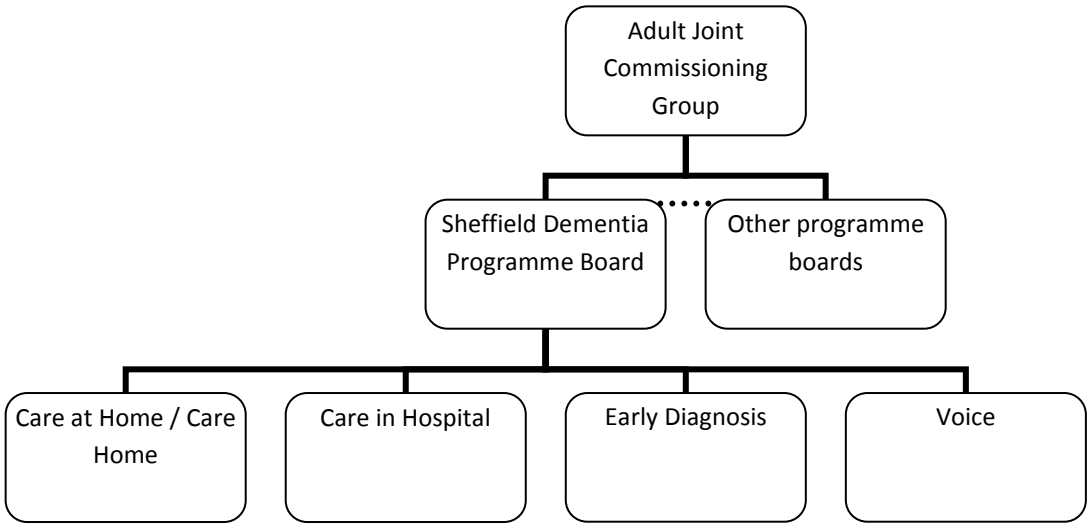
7.1 Each workstream will have a defined set of high level indicators to measure progress against the objectives

7.2 These will be available to the Programme Board on a routine basis.

8.0 Governance

8.1 A Programme Board, led by Health and Social Care Commissioners and including representatives from Sheffield Health and Social Care Foundation Trust, Sheffield Teaching Hospitals and the Alzheimer's Society, has been established to oversee and co-ordinate implementation of the transformation.

8.2 The programme structure is set out below:



8.3 The Dementia Programme Board will report to the Adult Joint Commissioning Group on the progress of delivering the commissioning plan.

8.4 The programme board will meet on a six weekly basis to receive updates from the workstreams. The scope for each of the workstreams is set out in **Appendix A.**

8.5 The workstream leads will report progress against the plan including any emerging risks to delivery

8.6 The board will maintain an issues and risk long which will be updated as part of each board meeting.

Appendix A: 2013-14 Work Plan

Workstream	Objectives	Impact
Early Diagnosis and Intervention Lead: Sarah Burt	• Identify and diagnose people with dementia in Sheffield in a timely way in accordance with best practice • Initiate timely treatment as clinically appropriate • To ensure that the public, people with dementia and their carers in Sheffield receive the information, advice and support that they need, when they need it	• The number of people with a formal diagnosis of dementia and in touch with services will increase to 70% by 2015 • A delay in the time at which people with dementia are admitted to a care home and a prevention altogether of some admissions • An increase in the time people remain within early and mid stage dementia; • Increased involvement of community based health and social care services • Reduced potential for carer breakdown that results in hospital or care home admission
Care at Home / Care Home Lead: Howard Waddicor	• To provide people with dementia, and those who care for them, access to specialist advice and support • Improving the experience of people with dementia wherever they live • Reducing the use of antipsychotic medication	• Reduction in the number of people admitted to care homes • Reduce the number of people moving from a care home to a specialist EMI facility through improved management • Reduce the pressure on carers of people with dementia by offering a range of interventions • Reduction in number of admissions to general hospital or mental health inpatient facility through improved patient management; • Reduction in the prescribing of antipsychotic drugs due to improved skills in managing the behaviour of people with dementia; • People with dementia will have a greater choice of the services they need to help them live well with dementia

Workstream	Objectives	Impact
Care in Hospital Lead: Sarah Burt	• Ensure that people with dementia and their carers receive general hospital care (in Sheffield) in accordance with best practice • Move towards the creation of dementia friendly hospitals in Sheffield (Call to Action in 13/14) • Ensure community support services in Sheffield to enable people with dementia and their carers to be supported at home • Continued development of hospital liaison service to ensure timely and appropriate discharge • Case finding activity at STH incentivised by CQUIN (improvement of clinical coding of secondary diagnosis of dementia) • Improved carer support	• Reduction in length of stay through improved management of people with dementia who require hospital care; • Reduction in inappropriate general hospital admissions due to presence in A&E, assessment and diversion to community based services; • Increase in people with dementia diagnosed and referred to specialist services (health and social care); • Reduction in people with dementia going direct from general hospital to long term care through improved community support; • Avoidance of inappropriate mental health hospital admissions and some general hospital admissions; • Potential increase in use of community based services such as home care. • Increased compliance with RCP national dementia audit
Dementia Friendly Communities / development of a local alliance Leads: Julia Thompson/ Kath Horner	• Placing the dementia-friendly communities project into the mainstream of strategic partnership work by: • Integrating it into the workplan of the Dementia Programme Board • Widening the strategic focus for work on dementia across the city by connecting with partners and services which are not at the centre of planning or commissioning for people with dementia • Engaging with a specific communities in the city	• To enable people to live healthier, with or without dementia. • Provide alternatives to formal health and social care services to find ways of supporting people with dementia which are effective and preferable for them, especially in the early stages of dementia

Workstream	Objectives	Impact
Voice of People with Dementia and their Carers	• To build on the major involvement exercise in 2012 by further engaging with people dementia as part of the Alzheimer's Society Community Dementia Forum • Work specifically with people with dementia to understand their perspective • Develop mechanisms for supporting people with dementia to contribute to the design of support and developing a dementia friendly community in Sheffield	• To influence the way investment it used to support people with dementia to live well at home • Demonstrate to people with dementia that their opinions are valued and can influence the commissioning process • To better understand the full range of needs of carers of people with dementia and use this knowledge to shape support • To develop a better understanding of how to improve awareness of dementia in BME communities
Data and Information Management Leads: Howard Waddicor and Sarah Burt	• To develop a range of key performance indicators that help workstreams measure their effectiveness • To develop high level indicators that measure the success of the Dementia Programme in Sheffield • To develop a mechanism for capturing changes in the experience of people with dementia and the people who care for them • To develop a range of outcome measure for all health and social care services • To identify the costs of delivering support for people with dementia in health and social care	• The programme board will receive routine information about the progress of each workstream • An independent annual report to the programme board that gives an account of the experience of people with dementia and the people who care for them • Improved understanding of the value for money delivered by services to support people with dementia • Reduce the demand for high-cost, intensive support by identifying improved outcomes through early intervention

APPENDIX B: NICE Guidance 'Support for Commissioning Dementia Care' (April 2013)

Area of care	Commissioning impact	Estimated resource impact	Sheffield Commissioning Plan
Integrated care and service provision (see section 3)	Use a whole-systems approach to commissioning. Develop integrated health and social care needs assessments and commissioning plans. Integrate commissioning functions across health and social care where possible. Involve the public, people with dementia, their carers and families when commissioning services. Develop local multi-agency dementia partnerships. Use a long-term conditions approach to supporting people with dementia. Ensure that commissioning plans promote personalised care. Ensure that all health and social care professionals who may come into contact with people with dementia are aware of the condition and where people can access diagnosis. Commission multi-agency teams.	There may be costs for awareness raising training for staff, and developing skills, knowledge and continued professional development of health and social care professionals. There may be savings from more efficient systems and procedures, disinvestment from ineffective practice and having single assessment points and records leading to reduced duplication of duties and economies of scale.	Whole systems approach to commissioning already however work to do to improve integration of health and social care services. Included in CP 13/14 with significant link to RFT. Personalisation is a key feature of current CP. Workforce development included in CP.
Early identification, assessment and diagnosis (see section 5.1)	Agree a local target to increase the proportion of people with dementia who receive an early diagnosis. Commission a dementia diagnosis service. Ensure initial management of dementia includes information about the condition,	There may be additional costs resulting from a possible increase in the use of services that support people with dementia and their carers.	Local target for diagnosis agreed for 13/14 and 14/15. Sheffield already 2nd in England & Wales for diagnosis but ED remains a high priority in CP. CP includes commissioning of DIASS.

	and equal consideration of medical and social components of care. Develop a 'single point of information' on local dementia care and services.		
Promoting choice (see section 5.2.1)	Clearly define who is responsible for: Initiating a care plan Initiating a carers assessment The periodic review of the care plan, and review when a person's circumstances have changed Care coordination Supporting people to make advance care plans for end of life. Ensure there is access to independent advocacy services for vulnerable people with dementia	There may be additional resources required to support people with dementia and their carers to develop Advance Care Plans.	Care planning part of RFT plan for 13/14. 13/14 ARC research to promote resilience / carer support / self-care and management etc. Care co-ordination via ICTs. DIASS to support advanced planning. Commissioning links established to EoLC leads. Continuing use of personal budgets to support choice in social care
Promoting independence (see section 5.2.2)	Ask community and residential providers to demonstrate that they enable people with dementia to participate in leisure activities, maintain relationships and contribute to the local community. Invest in support for people to live independently with dementia.	There may be costs associated with adaptations to housing and the environment, meeting the needs of daily living and supporting people to participate in leisure activities and the community. However promoting independence may delay or reduce the need for avoidable residential care home costs and hospital admissions.	Joint CCG / SCC work to promote independence not specific to dementia. DFC and alliance work in CP. Links to ARC research to promote resilience. New non-recurrent investment re supporting people with dementia who live alone. New investment in cafes, dementia adviser etc.
Providing support (see section 5.2.3)	Have plans to increase access to behaviour and social interventions for people with dementia, which can reduce inappropriate use of antipsychotic drugs. Commission mental health liaison services in hospitals.	There may be potential savings resulting from a reduction in inappropriate use of anti-psychotic drugs and a reduction in secondary care costs (unplanned hospital admissions and length of stay in hospital).	On-going work to audit the use of AP rugs in primary and secondary care. Mental health liaison already commissioned in 12/13

		You may use the commissioning tool to estimate potential saving. Each 10% reduction in unplanned hospital admissions may save £14,000 per 100,000 populations. Additional investment in behavioural and social interventions may be required to support a reduction in the use of antipsychotic drugs.	Quality in Care Homes initiative will work with care home providers to develop best practice in supporting people without recourse to medication.
Palliative and end of life care (see section 5.2.4)	Make end of life care commissioners aware of the specific needs of people with dementia. Support primary care to identify people with dementia who should be added to primary care palliative care registers.	No additional costs anticipated.	Links already made to EoLC commissioners Work already on-going to support use of primary care palliative care registers. Recent LES care home audit shows significant improvement.
Support for carers (see section 5.3)	Ensure that carers assessments are routinely offered at the time of diagnosis. Commission a range of respite services for carers of people with dementia. Ensure local capacity in services that can provide emotional, psychological and social support to carers.	There may be costs to fund respite services and tailored interventions such as self-help, short-term psychotherapy or CBT. See costing work for NICE clinical guideline 42 for more information on costs.	DIASS, ARC research, carer support already part of MMS commissioned service.

Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Wednesday 20th November

Report of: Sheffield Health and Social Care NHS FT
Sheffield Clinical Commissioning Group

Subject: Memory Management Services development options

Author of Report: Jason Rowlands, Director of Planning, Performance and Governance, Sheffield Health and Social Care Trust
0114 226 3417

Summary:

This report outlines the plans being explored by Sheffield Clinical Commissioning Group (SCCG) and Sheffield Health and Social Care NHS FT (SHSC) to improve access to memory services for the people of Sheffield. This report is provided on behalf of both organisations.

It summarises the current position and outlines the areas being explored to inform future service development planning within Sheffield.

The development is being progressed jointly by the SCCG and SHSC. Together both organisations have delivered a range of improvements over previous years, and remain committed to ensuring future improvement remains a priority and are delivered upon.

This report is provided at the request of the Committee.

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	**X**
Other	

The Scrutiny Committee is being asked to:

The Committee is asked to

- note the plans being explored and the proposed direction of travel to deliver improvements
- and provide comments and views regarding the proposed way forward.

Background Papers:
List any background documents (e.g. research studies, reports) used to write the report. Remember that by listing documents people could request a copy.

Category of Report: OPEN

Memory Management Service developments report.

1. Introduction/Context

1.1 During March 2013 Sheffield Health and Social Care NHS FT presented to the Scrutiny and Policy Development Committee its draft Quality Account.

1.2 During the review and discussion on the progress made across services, the Committee noted its concern regarding the waiting times experienced by people accessing Memory Service, when compared to other types of services provided.

1.3 The Committee asked the Trust to explore in conjunction with the Clinical Commissioning Group what steps could be taken to further reduce waiting times for memory management services, and to report on the Trust's initial thoughts on this issue.

1.4 The purpose of this report is to update the Committee on the progress made and for members to comment and on the solutions being explored and proposed.

2. Main body of report, matters for consideration, etc

An appendix is provided with more detailed information to support this summary

2.1 Background

2.2 Sheffield Clinical Commissioning Group (and the previous Sheffield Primary Care Trust) and Sheffield health and Social Care Trust have been working together over the last several years to improve experiences and access to Memory Services for the people of Sheffield.

2.3 The main strategies and plans that have been followed have been to

- Raise awareness across primary care and related services and improve signposting of people with possible problems to the right services
- Incentivise Sheffield Teaching Hospitals NHS FT, through the CQUIN scheme to identify, assess and refer people with possible memory problems to the relevant services
- Improve the effectiveness of current services available through the Care Trust.

2.4 These approaches have had considerable success. More people have been accessing services, and waiting times had improved. However, as we continue to identify more people who need services demand is increasing. Both the Commissioning Group and the Care Trust have been exploring how best to respond to this and deliver further improvements at the same time.

2.5 Development plans

2.6 Reviews undertaken of the current client group supported by the existing memory services suggests that most people receiving follow up support have non-complex problems and needs. They require ongoing monitoring and periodical re-assessments as required. However currently this client group is supported and re-assessed by the city wide specialist services when best practice evidence indicates that their needs can be effectively and appropriately provided for within primary care services.

2.7 A key area of focus has been how to improve capacity within primary care services to enable them to provide ongoing re-assessment support. Achieving this is expected to deliver the benefits of care closer to home and free up resources within the city wide specialist services for them to see more people.

2.8 The expectation is that this freed up capacity will allow the city wide service to see more people for their first initial assessment and diagnostic support needs, and to see them within more acceptable timescales.

2.9 The preferred approach to achieving this is based upon a hub and spoke model of care. This would consist of initial assessments being provided through a city wide specialist service, and ongoing support and monitoring of progress being provided in primary care. Key features would be;

- Care pathways within primary care, complementing the broader development of primary care services.
- Specialist nurse led support within primary care to work alongside and within primary care services.
- Further improvements to existing service models in respect of diagnostic testing support.

2.10 The expected outcomes are intended to be

- More people would be able to access assessment and diagnosis services quickly – which will improve people's experiences and the care outcomes of the support and treatment provided.
- Follow up care will be better integrated within the broader primary care provision resulting in more integrated care for the individual
- Follow up care and reviews will be provided more locally – resulting in better experiences for people and less inconvenience regarding travelling and disruption.

2.11 The resource implications of the proposed model are still being considered and evaluated. It is expected that some of the existing resources from the city wide model can be allocated to provide outreach support/ specialist community nurse input to the primary care pathway. Additional resource needs may be highlighted but this hasn't been determined at this stage.

3 What does this mean for the people of Sheffield?

3.1 This plan aims to ensure that people who are worried that they may be experiencing problems with their memory are able to access appropriate assessments, advice and support quickly. This is key to delivering effective care and providing positive experiences for people.

3.2 The plans being explored will result in future proposals for how improvements will be delivered. While this hasn't been finalised at this stage, the preferred option will mean that people in Sheffield will get their ongoing needs met more locally within their local primary care services if this is felt appropriate.

4. Recommendation

The Committee is asked to

- note the plans being explored and the proposed direction of travel to deliver improvements
- and provide comments and views regarding the proposed way forward.

Project Aim and Objectives

Aim

To provide a high quality service that can assess, diagnose and review people with dementia in Sheffield in a timely manner, the most appropriate setting and deliver the best value for money in achieving this aim.

Objective
It is proposed that this can best be delivered by:

- A hub and spoke model of care
- A single site location for the assessment and diagnostic elements of the service (hub)
- Provision of an 'outreach' service from the single site to enable assessment of patients admitted to STH (hub)
- Development of a memory service community provision that will undertake bi-annual review of patients within general practice (spokes)

Outcomes & Project Benefits

Quality Improvements

The proposal supports achievement of the following NHS Framework Outcomes:

- Domain 2,Enhancing the quality of life for people with long term conditions by;
  - Ensuring people with dementia get a timely diagnosis (aiming to deliver this within 6 weeks form referral), thus enabling people to cope better with their condition
  - Enabling independence and improving quality of life through effective review and improved community based presence
  - The proposal is modelled on the basis that 1,270 more people will be supported and, 4,500 people will receive ongoing follow up in a more community appropriate setting, and a waiting time to access services of 6 weeks.

- Domain 4, Ensuring people have a positive experience of care by;
  - Ensuring people experience an integrated care pathway that enables effective access minimises repetition providing specialist advice and interventions in appropriate settings

Resource Releasing

Re modelling of the current provision will require some re-alignment of resources (re-allocation of staff to community setting) and some investment to provide for the projected demand

Drivers

There are a number of drivers for the proposal which are a combination of local, regional and national agendas and priorities.

NICE guidelines and the NHS Outcomes framework require both commissioners and

providers to comply with specific criteria. There are 10 NICE quality standards relating to care for people with a dementia;

1. Training to ensure appropriately trained staff
2. Referred to Memory service
3. Client/carer info provided
4. Named care coordinator
5. Legal affairs discussed with patients/carers
6. Carer assessment undertaken
7. Non cognitive assessment and interventions where required
8. Access to liaison services
9. Palliative care planning
10. Respite access for carers

Delivering improved outcomes in line with the NHS Outcome framework.

The current memory service has historically been accredited by MSNAP (the national organisation that reviews memory services) as an excellent service. Locally the service is viewed as providing a high standard of care and treatment. It is recognised that the service locally has achieved much to improve waiting times and increase its capacity to see more people through improving pathways, systems and processes. However further improvements are required to respond to unmet need and future demands (see below).

Strategically within Sheffield there is a drive to integrate care pathways seamlessly across primary and secondary care, and to ensure care is delivered within primary care where appropriate.

Problem

Backgound - performance and developments

In 2012, there were 6,494 people predicted to have dementia (diagnosed and undiagnosed) in Sheffield. Of these, 4,130 have a diagnosis on the GP Quality Outcome Framework dementia register which means that Sheffield is now estimated to have diagnosed 63.6% of people with dementia. In 2011, Sheffield had 3,621 people with a diagnosis on the dementia register and was estimated to have diagnosed 56.7% of people with dementia. This therefore represents significant progress.

When compared to other Clinical Commissioning Groups in England and Wales, Sheffield now ranks 2nd for the diagnosis of dementia however, there is still some way to go and we continue to work to increase diagnosis rates. In 2013/14 a number of initiatives will help with this:

- Year 2 of the national dementia CQUIN for STH
- Increased diagnostic capacity in the SHSC memory service
- Specialist input to primary care to support case finding
- Public awareness campaigns – national and local
- Workforce development
- GP DES on case finding

Progress on the diagnosis of dementia in Sheffield is demonstrated by the steady growth in the proportion of people who have been diagnosed, as summarised in the table below.

Year	% Diagnosed	AS Ranking (England and Wales)
2006-2007	44.98	
2007-2008	47.58	
2008-2009	50.78	13th
2010	53.2	6th
2011	56.7	3rd
2012	63.6	2nd

From the England and Wales data for 2012, Yorkshire and Humber SHA has an average diagnosis rate of 48.6%. In South Yorkshire; Barnsley has 46.1%, Doncaster 53.7% and Rotherham 55.7%.

At the same time the Memory Services within the Care Trust have been increasing their ability to see and support more people each year. This has been achieved through a range of service and productivity improvements.

Year	Numbers assessed & diagnosed	Waiting times
2010-11	749	21.2 weeks
2011-12	876	14.5 weeks
2012-13	918	16.3 weeks

Over the last 3 year period the service has managed to see 22.5% more people to provide an assessment and diagnosis support service, and reduce waiting times by 23%.

However it remains the case that access arrangements need to improve both in terms of increasing the numbers of people supported and further reductions in waiting times. While currently the 2nd best performer in England regarding diagnosis rates and identifying people effectively, the evidence suggests that there are still 36% of people in Sheffield who haven't yet been identified by services. Looking ahead to the future, there are currently estimated to be 6,494 people with dementia in Sheffield and it is anticipated this will rise to 8,108 by 2025. This represents a 25% growth by 2025.

Current position

The following highlights a number of difficulties the service is experiencing/facing:

- Facing increasing waiting list from referral to assessment (16 weeks)(current wait is between 18 – 22 weeks)
- Duration of wait from assessment to diagnosis (6 – 8 weeks)
- Service located across two sites creates inequalities in access and unnecessary costs
- Projected increase in service demand

Sheffield is the 2nd best performer in England re diagnostic rates. However there is still a diagnosis gap of c. 37% in Sheffield with only 4,130 of those currently estimated to have dementia on GP Dementia registers, so we are not offering early treatment which would help people manage their disease and delay its onward progression. At consortium level, the following gives an indication of the cases to find currently:

Cases to find 2011	
Central	745
HASC	965
North	369
West	561

Diagnosis capacity required

An additional 1,2700 people will require specialist assessment by 2016 if we are to case-find the backlog and meet estimated growth in this population to that date. The Memory Service is currently funded to undertake 800 assessments per year and therefore needs to reconfigure capacity within its existing investment for the additional assessments as follows:

Table 1: Additional Diagnostic Capacity at Memory Service				
Memory Service	12/13	13/14	14/15	Total
Current Contract	930	930	930	2,790
Extra Required	59	65	100	219
Revised Total	989	995	1000	3,009

Follow-up

Previous reviews with the Memory Service, we have identified that 2,500 patients being followed up. Our assumption is that all of these are clinically appropriate to be transferred into primary care for follow up in 13/14

Assuming the above diagnosis demand this will impact on an increased demand for follow up appointments in primary care (of this population approximately 1,500 patients reside in nursing homes) requiring a phased increase in capacity

Table 2: Additional Review Capacity in Primary Care				
	13/14	14/15	15/16	Total
Number of patients	2,500	4,010	4,500	11,010
Number of reviews	5,000	8,020	9,000	22,020

Options Appraisal

1. **Do nothing**

Impact:

- Continue with secondary level care only, with variable connection to primary care services – failing to progress city wide vision for primary care based care and treatment.
- City wide modelling of demands/ needs arising from people with dementia has been previously undertaken. The costs of doing nothing to the local health community have been estimated (by 15/16) as:
    - An £830k increase in care home placements
    - An £880k increase in the costs of hospital admissions
    - A £200k increase in Community Mental Health Team contacts

2. Move to a single site and continue existing specialist service model/care pathway

Impact:

- Continue with secondary level care only, with variable connection to primary care services – failing to progress city wide vision for primary care based care and treatment.
- Does not provide the capacity to meet the demand/not effective use of resources

3. Move to a single site and undertake reviews in primary care

Impact:

- In line with city wide vision for primary care based care and treatment. Fits with MSNAP and Alzheimer's society recommendations
- Best value for money - Increase ability to meet demand/Improved use of resources
- Provide care closer to home

4. Move all provision to general practice

Impact

- Not adequate capacity or skill base within general practice to meet demand
- Not logistically viable to have mobile memory service covering general practice
- Does not provide in reach into teaching hospitals to facilitate assessment,

5. Invest in existing service model

Impact

- Would provide for increased capacity required
- However poor value for money
- failing to progress city wide vision for primary care based care and treatment

Preference

The above information highlights that in order to meet the increase in assessment (and subsequent review) demand the current service needs to re-configure to enable the current bottleneck of increased reviews to be addressed within general practice

Current position

(Hub building based provision)

Assessment	918
Diagnosis	918
Review Provision	2,500
(Spoke - primary care provision)	0
Review (nursing home patients)	300

Proposed Service

(The following calculations are estimates and need clarifying with additional demographic information)

(Hub building based provision)

Assessment	1250 (2014/15 to address waiting list)
Diagnosis	1250
(Spoke – primary care provision)	
Review	4,500
Review (nursing home provision)	0

Resource Required
(The following figures are estimates and require further clarification as they are dependent on clarification of demographic information)

Some flexibility of current resource and additional staff will be required to meet the demand over the next 5 years
Estimates on the projections highlighted above indicate an additional 5.3 WTE staff will be required

Solution Selection

Proposal:
Move to a single site and undertake reviews in primary care

Benefits:
The proposal highlights significant cumulative benefits to health and social care – totalling £1.6m over 5 years from the total health economy – if dementia care was redesigned. The benefits of the proposal includes;
early diagnosis, improved carer support, reviewed liaison psychiatry and improved rapid response functions, including in-reach to care homes. This development plan is focussing on the first step (early diagnosis) and we are not therefore suggesting that on its own it will therefore generate saved admissions.

Evidence
The dementia rationale is spelt out in the QOF Guidance for GMS Contract 2011/12.

Further information: NICE clinical guideline 42 (2006). Dementia. Supporting people with dementia and their carers http://guidance.nice.org.uk/CG42/NICEGuidance/pdf/English

Comparisons are drawn as well to services for people with Diabetes. 10 years ago all care for Diabetes Types I & II was mainly delivered in consultant led hospital based services, with people attending c.3 times per annum for review and check-up. Now it is all mainly community care delivered, supported by specialist nurse input when required.

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
20th November 2013

Report of: Nutrition & Hydration Working Group
Cllr Gary Weatherall, Working Group Chair

Subject: Nutrition & Hydration Working Group – Draft Report & Recommendations

Author of Report: Diane Owens, 0114 27 35065,
diane.owens@sheffield.gov.uk

Summary:
In November 2012, this Committee established the Nutrition and Hydration in Hospitals Working Group, to look at the quality of food in Sheffield's hospitals, as well as the support that people get to eat and drink whilst they are in hospital. The Committee agreed that the focus of this work would be on adults.

The Working Group has undertaken desk top research and site visits to inform this piece of work. A draft of the report has also been shared with representatives from Sheffield Teaching Hospitals NHS Foundation Trust.

The Working Group would now like to present the final draft report to this Scrutiny Committee for sign off along with the group's recommendations for further work in this area.

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: Working Group - draft Report and recommendations	**X**

The Scrutiny Committee is being asked to:

1 Sign off the Report which has been produced by the Nutrition & Hydration Working Group (Appendix A)
2 Consider the recommendations of the Working Group regarding further work in this area (page 3, section 4)

Background Papers:
Papers of the Nutrition and Hydration Working Group.

Category of Report: OPEN

Most reports to Scrutiny Committees should be openly available to the public. If a report is deemed to be 'closed', please add: **'Not for publication because it contains exempt information under Paragraph xx of Schedule 12A of the Local Government Act 1972 (as amended).'**

Nutrition & Hydration Working Group – Draft Report & Scrutiny Recommendations

1. Introduction/Context

1.1 The Nutrition & Hydration Working Group was established in November 2012 to look at the quality of food in Sheffield's hospitals, as well as the support that people get to eat and drink whilst they are in hospital. The Committee agreed that the focus of this work would be on adults.

1.2 The work undertaken to date has focussed on the Northern General Hospital.

1.3 The Working Group has undertaken desk top research and site visits to inform this piece of work and a final report and recommendations have now been drafted.

2. Matters for consideration

2.1 A draft of the report was shared with representatives from Sheffield Teaching Hospitals NHS Foundation Trust and the final draft is now being presented for sign off by this Scrutiny Committee (Appendix A).

2.2 The Working Group would like to recommend that further work is undertaken in this area, please see page 3, section 4 "Recommendations" for details.

2.3 In terms of capacity to support further work the Policy & Improvement Officer is able to support one Working Group (Task & Finish Group) per Scrutiny Committee. At present this Committee also has the Child and Adolescent Mental health Services (CAMHS) Working Group which is working on its final report.

3 What does this mean for the people of Sheffield?

3.1 High quality nutrition and hydration in Hospitals is an issue which is important for the health and well-being of the people of Sheffield.

4. Recommendations

4.1 That the Committee approve the final draft Report which has been produced by the Nutrition & Hydration Working Group.

4.2 That the services at the Northern General Hospital are reviewed in 12 months' time (November 2014 approx.). This would enable the Working Group (on behalf of the Committee) to identify if any of the recommendations from the Report have been adopted by the Trust. This work would also be relevant to the Trusts Quality Account which this Scrutiny committee responds to on an annual basis.

4.3 That on approval of the Report (relating to services at the Northern General Hospital) the Committee extends this piece of work to include observation visits to Weston Park, Royal Hallamshire and Jessops. This work could commence in early 2014 (once the "production kitchen food" system has been put in place). This piece of work could be carried out by the existing Working Group and would enable the group to see how the new service has embedded across the Trust. A report would be produced to outline any findings / recommendations.

4.4 The Working Group has also indicated they would be happy to undertake an observation visit to the Children's Hospital. An approach could be made to the Chair of the Children, Young People & Family Support Scrutiny Committee to update them on the work to date and to make an offer to undertake a visit to the Children's Hospital on their behalf. The findings would be included in the Report and would be fed back to both Scrutiny Committees.

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Appendix A

Report of the Nutrition and Hydration in Hospitals Working Group
Draft Findings and Recommendations v00.06

Version control

Version	Date	Author
V00.01	June 2013	Emily Strandbrook-Shaw
V00.02	September 2013	Amends made by the Working Group
V00.03	October 2013	Amends by Working Group following circulation with of V00.02
V00.04	5th November 2013	Amends by Working Group following circulation of v00.03
V00.05	7th November 2013	Comments from Chris Morley, NHS FT – corrections to titles.
V00.06	11th November 2013	Final amends by Working by Group – following a meeting with NHS FT.

1. Introduction

1.1 A public question was put to the Committee at its meeting on the 17th October 2012, raising concerns about the quality of hospital food in Sheffield. The Committee agreed to establish a working group to look at the quality of hospital food in Sheffield. The Committee agreed that the focus of this work would be on adults.

1.2 Members were appointed to the working group as follows:
Cllr Garry Weatherall (Chair)
Cllr Tony Downing
Cllr Joyce Wright
Cllr Janet Bragg
Cllr Roger Davison
Cllr Diana Stimely
Helen Rowe, Sheffield LINk Representative.

1.3 The working group has heard from the following people to date:

- Hotel Services Director, Sheffield Teaching Hospitals NHS Foundation Trust
- Head of Catering, Sheffield Teaching Hospitals NHS Foundation Trust
- Deputy Chief Nurse, Sheffield Teaching Hospitals NHS Foundation Trust

And made the following visits:

- Central Production Unit, Northern General Hospital

- Ward Vickers 4 – Northern General Hospital
- Hadfield 6 – Northern General Hospital

On these visits the Working Group spoke to staff and patients, observed mealtimes and meal preparation in action and sampled food.

2 Background

From the outset, the Working Group recognised the importance of high quality nutrition in hospitals. The group considered best practice advice.

In 2012, the Department of Health announced new standards setting out what patients should expect from hospital food. These will be assessed through the PLACE assessments – Patient Led Assessment of the Care Environment – which started in April 2013, and will be carried out annually by local people. Hospitals will be assessed on the following principles:

- Nutritious and appetising hospital food and drink is essential
- Patients get a choice from a varied menu – including meals suitable for religious needs.
- All patients should have access to fresh drinking water at all times, unless it contradicts clinical advice.
- Food and drink should be available at all times, not just planned mealtimes
- Hospitals should promote healthy diets to staff and visitors
- The Government Buying Standards for Food should be adopted as standard whenever possible.
- Hospitals should regularly evaluate their food service and act on feedback from patients
- The NHS as a whole should look for and reward excellence in hospital food.

These principles were useful as a framework for the group in considering how well we are performing in Sheffield.

2. Findings

Sheffield Teaching Hospitals NHS Foundation Trust

2.1 What does the performance information tell us?

Complaints information collected by STHFT between December 2011 and December 2012 show that out of 1359 complaints, only 25 related to food. Of the 25 complaints, 11 related to the quality of food, 8 related to the availability of food, and 6 related to assistance with eating or drinking.

The National Inpatient Survey for 2011 ranked STHFT as ‘about the same’ as other hospitals:

Quality of Food – 4.8/10
Choice of Food – 8.6/10
Help with eating – 7/10

STHFT's own inpatient survey asks the question 'If you need help with eating and drinking 'are you given the help that you need?'
80% of those questioned answered 'always' in February 2012, and 90% answered always in November 2012.

Between April 2012 and January 2013 STHFT received 196 comments about food from their website feedback and comment cards – 151 comments were positive, and 45 were negative.

The Care Quality Commission (CQC)
The Care Quality Commission carried out a nutrition inspection at the Northern General Hospital in March 2011. It found that the Northern General was meeting the required standards.

2.2 STHFT approach to food and mealtimes.

The Trust prepares meals for 4000 patients per day, at a cost of £6.86 per patient, across a number of hospital locations.

A bulk meal service has been in operation at the Northern General for some time, with this system planned to replace the plated meals service used across other hospitals as the necessary refurbishments take place.

The bulk meal service has distinct advantages over the plated meals service. Meals are prepared at the Central Production Unit on a cook chill basis, and then transferred to wards in trolleys to be served. This system provides choice at the point of service, choice in portion size to suit individuals, and improved presentation.

Typical menus consist of the following:

Breakfast
Continental

Lunch
Starter of fruit juice or soup
2 hot main dishes with vegetarian option
Choice of vegetables and potatoes/rice/pasta
2 cold choices – salad or sandwiches
Cold dessert

Evening meal
Fruit Juice
3 hot main choices
Hot desert

Wards can choose to alter meals to suit their patient needs and also their individual choices – e.g. cooked breakfast, soup and sandwiches for lunch.

Special dietary requirements are catered for – eg kosher, halal, fork mashable, smooth mashable and high protein. Snack boxes are available at all times, and the Central Production Unit can respond quickly to individual requests from wards.

For breakfast a cooked breakfast / eggs were available on request – but some patients did not seem to be aware of this

Different wards take different approaches to mealtimes and dining arrangements depending on the needs of their patient groups.

There is Trust wide recruitment of volunteers to assist with mealtimes – 77 volunteers across 8 wards were due to be in place by February 2013.

The Trust reported that the key mealtime challenge for, particularly frail elderly patients and those with dementia, is not in providing support for feeding, but in enticing patients with small appetites to eat. Families are encouraged to get involved at mealtimes – particularly on care of the elderly wards – and alternatives to heavy meals can be provided.

The Trust reported plans to develop ward accreditation for nutrition and hydration.

3 Observations from visits.

3.1 Central Production Unit

The group visited the Central Production Unit (CPU) at the Northern General Campus to tour the facility and sample meals**.**

The group were impressed by the facilities and production at the CPU. Catering staff reported that Government Buying Standards are adhered to, and that where possible the Trust uses local suppliers. This is not always possible however, due to the national NHS purchasing standards, which can be restrictive for smaller businesses. The group were aware that this challenge has been overcome by some Hospital Trusts, for example Scarborough

The group sampled a range of meals and were very impressed by the quality of the food. They also recognised the challenges implicit in catering for such large numbers of people every day, and their differing tastes and preferences. The group felt reassured that, contrary to anecdotal reports and ‘popular myth’, the quality of food provided to STHFT patients is good.

The group were especially pleased to note the CPU now prepare a range of freshly made soups, which are far more nutritional than the previous soup option which was dried and reconstituted with boiling water on the wards.

The group also recognised that these fresh soups are especially useful to tempt patients back into eating and can be made higher in calorific value by adding cream to them which can be requested.

3.2 Northern General – Vickers 4 and Hadfield 6

The group spoke to staff and patients on two wards at the Northern General, both catering for elderly patients. The patients the group spoke to were largely happy with the quality and choice at mealtimes.

The group were impressed with some of the systems wards had implemented to assist with nutrition and hydration:

- Magnet boards by patient's beds making nutrition needs and preferences clear – although the group observed these were not always being used.
- Information boards at the nurse's station detailing patient needs and preferences
- Recording and monitoring of patients food and fluid intake
- Fresh water available at all times

The group observed mealtimes in action, and did, on occasion feel that the benefits of the bulk meal service were not maximised – see below.

The wards reported a good relationship with the Catering Service, and were aware that they could make special requests as required.

Overall, the group observed mealtimes working well – and in line with the national NHS principles.

4. Recommendations

4.1 Ensuring the system works as intended.

4.1.1 Maximising the potential of the bulk meals system

The group were impressed with the system that STHFT has in place for mealtimes.

The group feels that the system provides adequate choice, and caters well for specialist requirements. The group were impressed with the quality of food provided by the Central Production Unit (which dispelled some of our misconceptions about hospital food!), and the flexibility of the catering service, which is able to respond to the majority of requests from wards.

The bulk trolley meals system is a big improvement on the plated meal service, and the group saw the potential this system has, in giving patients choice at the point of service, choice in portion size to suit individuals, and improved presentation and quality as the meal is plated just before serving.

However, the group felt there are perhaps some missed opportunities for maximising the impact of this system. Our ward observations showed different approaches on different wards. In some instances, meals were plated and distributed to patients, effectively re-creating the plated meals service – which limits the 'choice' element – both in terms of portion size and meal choice. The group recognises that the bulk meals system is

relatively new, and it will take time to be embedded across all sites, however feels that more could be made of the opportunities offered by this system. Plans to introduce nutrition and hydration accreditation for all wards may be a way of spreading best practice and ensuring that the system is working as well as it can across all sites and wards.

The group recommends that were possible, unless there are reasonable constraints e.g. restricted space on wards / risk of the spread of infection the wheeled trolley be taken into each individual bay. As this would provide more stimulation to patients' appetites and participation in meal times, as the patient would see their own meal being served.

4.1.2 Communication

The group were impressed by the flexibility of the catering service – meals can be provided outside of the normal schedule, individual requirements can be catered for, and snack boxes are readily available.

The group did think however, that more could be done to communicate the available services to patients. LINk had also observed that on their 'Enter and View' visits, patients were not aware that these options are available.

During the Observation visits, which involved speaking to patients, a number of patients that were asked about food/meals were not aware that they could meet with a member of the catering team to discuss their individual nutritional needs and that meals could be adjusted and planned to meet these needs (where it did not compromise the patients' health care and nutritional requirements). It appears wards do not take advantage of this service.

The group recognises that people in hospital may be feeling vulnerable, and unable to ask for things. The group therefore recommends that further work be undertaken to improve communication between ward staff and patients regarding the choices available to them, as from speaking to patients they were not always aware of these choices and so in turn the catering service were unable to meet these needs as they were unaware of them.

It was felt that wards need to be proactive in making patients aware of what is available, both in terms of choice and special dietary requirements. The Trust also needs to ensure that all staff are made aware of these options so they can be clearly communicated to patients, this includes non- ward based staff e.g. pre-operative assessment staff.

4.2 Making the most of our resources

4.2.1 The Central Production Unit

The group were impressed with the operation at the CPU at the Northern General, and the standard of food produced there. The CPU already supplies some of Sheffield Health and Social Care Trust units with meals and the group felt that over the mid to long term, there may be benefits

in looking to develop further the CPU as a provider of meals to other organisations.

There may be advantages to be had from such a set-up –

- Consistency across the Health and Social Care system in Sheffield
- Financial benefits through economies of scale
- Using Sheffield facilities rather than outsourcing to external companies – keeps money in Sheffield, and supports local suppliers used by STHFT.

4.2.2 Ward Flexibility

The group recognises that all wards are different, dealing with a diverse range of patient groups with a variety of needs. The group feels that wards should be given the autonomy to put in place systems that will help them to meet the needs of their patient groups. This is particularly important with frail elderly and dementia patients, who often have little appetite – and need to be encouraged to eat wherever possible. This might mean providing options other than meals.

Some examples given by staff on the wards included:

- Facilities for heating milk on the ward – eg microwaves and hobs – recognising that there might be health and safety issues and requirements.
- A snack cupboard on the wards – so patients can access treats and snacks at all times
- Cake in the afternoons - staff observed that for patients without large appetites, a cup of tea and slice of cake with visitors is an easy opportunity to increase calorie intake.

4.3 Support during mealtimes

4.3.1 The group observed that in some cases the meal had not been placed near enough for the patient to reach it, thus preventing the patient from being able to eat their meal without some difficulty.

Although the group are aware that all staff undergo formal training around supporting patients to reach and manage their meal, it recommends that further work continue to be done to reinforce this. Specifically through embedding best practice and monitoring on the wards. The group further recommends that consideration be given to having “Meal Time Co-ordinators” to support the embedding of this practice.

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