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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 19 March 2014 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
Helen Rowe and Alice Riddell (Observers)

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

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

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

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. 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
19 MARCH 2014

Order of Business

1.	**Welcome and Housekeeping Arrangements**	
2.	**Apologies for Absence**	
3.	**Exclusion of Public and Press** To identify items where resolutions may be moved to exclude the press and public	
4.	**Declarations of Interest** Members to declare any interests they have in the business to be considered at the meeting	(Pages 1 - 4)
5.	**Minutes of Previous Meeting** To approve the minutes of the meeting of the Committee held on 15th January, 2014, and to note the Actions List	(Pages 5 - 20)
6.	**Public Questions and Petitions** To receive any questions or petitions from members of the public	
7.	**Sheffield Children's Hospital NHS Foundation Trust - Quality Accounts 2014/15** Report of John Reid, Director of Nursing and Clinical Operations	(Pages 21 - 66)
8.	**Public Health Investment 2014/15** Report of Jeremy Wight, Director of Public Health	(Pages 67 - 74)
9.	**Developing the Social Model of Public Health** Report of Chris Shaw, Director of Health Improvement	(Pages 75 - 92)
10.	**Update on Self Directed Support and Personalisation** To receive a briefing paper from Moira Wilson, Interim Director of Care and Support	(Pages 93 - 98)
11.	**Update on Progress in Implementing Plans for Improving Major Trauma Within Yorkshire and the Humber** To receive a briefing paper from Cathy Edwards, Head of Specialised Commissioning, NHS England	(Pages 99 - 104)
12.	**Date of Next Meeting** The next meeting of the Committee will be held on a date to be arranged	

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 15 January 2014, at St. Luke's Hospice

PRESENT: Councillors 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

Non-Council Members (Healthwatch Sheffield):-

Anne Ashby and Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Alice Riddell (Healthwatch Sheffield).

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 Councillor Sue Alston declared a personal interest in Agenda Item 7 – Sheffield Adult Safeguarding Partnership – Annual Report 2012/13 - as an employee of the Sheffield Teaching Hospitals NHS Foundation Trust.

4. MINUTES OF PREVIOUS MEETINGS

4.1 *Special Meeting on 5th November 2013*

The minutes of the special meeting of the Committee held on 5th November 2013, were approved as a correct record.

4.2 *20th November 2013*

The minutes of the meeting of the Committee held on 20th November 2013, were approved as a correct record, and the Committee noted the Actions Update attached to the minutes and, arising therefrom, it was reported that:-

(a) all the actions, as listed at 4.1(a) to (g), 8.5(c)(i) and 9.3(b), on the attached Actions Update, had been completed;

(b) responses had been sent by Councillors Mary Lea and Mazher Iqbal to questions relating to their respective Portfolio areas, to the questions raised

by Sylvia Parry; and

(c) the Policy and Improvement Officer would contact Sarah Burt, Senior Commissioning Manager, NHS Sheffield Clinical Commissioning Group (CCG), to chase up the information requested, (i) relating to the provision of a link to the modelling system used to compile the data in the report on Memory Management Services, to be shared with Councillor Martin Lawton and (ii) to clarify the request as to whether the CCG could encourage GPs to display posters in surgeries to encourage people to seek advice if they were experiencing memory problems.

5. PUBLIC QUESTIONS AND PETITIONS

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

5.2 The Chair reported that he had been contacted by several members of the public, asking the Committee to consider whether the new, privately funded Digital Autopsy Service, based in Sheffield, could be made more widely available in the future, through funding from either the NHS or the Government. He stated that arrangements were to be made for himself, the Deputy Chair (Councillor Roger Davison) and the Policy and Improvement Officer to discuss this issue with Linda Dale, Medico-Legal Centre Manager and Christopher Dorries, City Coroner, prior to formally considering the question at a future meeting of the Committee.

5.3 The Committee requested that information on the costs of undertaking both digital and physical autopsies be obtained prior to Members considering the questions.

6. SHEFFIELD ADULT SAFEGUARDING PARTNERSHIP - ANNUAL REPORT 2012/13

6.1 The Committee received a report of the Director of Business Strategy, Communities Portfolio, containing the Sheffield Adult Safeguarding Partnership Annual Report 2012/13, which provided an overview of Adult Safeguarding activity and information on the contribution individual partners had made towards Adult Safeguarding in the City.

6.2 In attendance for this item were Susan Fiennes, Independent Chair, Sheffield Adult Safeguarding Partnership, and Simon Richards, Head of Quality and Adult Safeguarding, Communities Portfolio.

6.3 Members of the Committee raised questions and the following responses were provided:-

- All alerts referred to the Council regarding Adult Safeguarding concerns were given serious consideration. All complaints were assessed, and in those cases where it was considered that there had been no actual abuse, whilst no further action was taken by the Council, the victims and/or complainants were directed to the appropriate groups/organisations who could provide the relevant support. Efforts were made to encourage anyone

who had contact with vulnerable adults to raise any concerns they had and, if it was not considered a safeguarding issue, officers were happy to discuss any other forms of support available. Representatives from all the Council's partners were trained to recognise any safeguarding issues.

- There was a significant connection between safeguarding and domestic abuse. The Partnership was aware of such a connection as the Lead for Domestic Abuse in the City was a member of the Safeguarding Adults Board.

- There was support available for alerters in that there was a policy to ensure that they were recognised and protected, and that there was a route for them to take any action they deemed necessary. There was a continuous process whereby people who had contact with vulnerable adults were educated and informed of what was acceptable or not in terms of the care of such people. Whilst every effort possible was made to encourage people to report any concerns, there was a strong reliance on people informing the Council of any issues.

- There was a feedback process whereby alerters were informed of where and how their concerns were considered. Training was offered, through the voluntary sector, to highlight the issues facing carers and family members in terms of the Home Care Service. The Quality and Adult Safeguarding Service, using what resources were available, continued to provide information and advice on what carers and family members should be aware of in terms of safeguarding. Communication was viewed as an active part of the Partnership's work.

- Statistics in terms of criminal prosecutions or cautions, as compared with other local authorities, were not available, but such information could be circulated to Members of the Committee. The Police would make a judgement in terms of whether they prosecuted or cautioned perpetrators, and there had been a number of recent cases where prosecutions had been made. A recent review of policy by the Crown Prosecution Service was likely to have an impact on the consideration given to evidence provided in terms of safeguarding cases. The Partnership had to have confidence in companies' recruitment processes in terms of the suitability of care workers appointed by them, and was also dependent on the standard of the companies contracted by the Council.

- It was not clear whether there was any specific training available for those people who had the Power of Attorney of relatives or friends receiving care so that they can be made aware of what they should or should not be doing in order to stop them being accused of making their relatives or friends vulnerable. It was believed that such people having the Power of Attorney would be provided with some basic advice on this issue when taking up the role, and there was also an expectance that such people would have some level of responsibility.

- The Safe Places Scheme was jointly funded by the Adult Safeguarding Partnership and Safer and Sustainable Communities, and comprised a number of 'safe places' in all areas of the City which provide a 'refuge' to vulnerable people who were feeling afraid or were lost or unwell. As part of the scheme, a part-time co-ordinator, based at Heeley City Farm, was employed to work with a dedicated group of service users to advertise and embed the Scheme. A number of staff and volunteers had been given education and support to provide vulnerable adults with the confidence to engage with the local and wider communities.

- An active Customer Forum was in operation in Sheffield. The Forum was led by service users and included people who were at risk of harm. The Forum was influential and was consulted on a broad range of safeguarding issues, a recent example of this being the consultation on the revised South Yorkshire safeguarding procedures.

- A number of actions had been taken, and procedures improved, following the Winterbourne View Care Home case, including an initial review, and an ongoing review of existing placements and consideration of contracting arrangements. A number of assurances had been made that safeguarding procedures had been improved after this case.

- The Partnership welcomed the views of Healthwatch Sheffield, and aimed to build up a relationship so that its views could be fed into the process. Simon Richards had met with Jason Bennett, Chief Officer, Healthwatch Sheffield, to discuss their views on adult safeguarding in the City and extended an invitation to meet with the Healthwatch Sheffield members on this Committee to discuss their views.

- It was appreciated that there was pressure on care workers in terms of their workloads, particularly when they were forced to spend more time with certain clients, which impacted on the time they could spend with others. If Members had any specific concerns, the Chair suggested that they be raised with Barbara Carlisle, Head of Strategic Commissioning and Partnership, Communities, and that a request be made of Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, to see if the Committee could have any involvement in the discussions with regard to the letting of contracts for Home Care Services. It was acknowledged that it was likely to be too late in the process, but that the question would still be raised.

- It was accepted that there was a need to raise awareness levels in connection with self-referrals which, at present, remained at a low level. Ideally, the best option would be to give people the confidence to make self-referrals, but, if this was not the case, they needed to be able to trust someone to make a referral on their behalf.

- The non-reporting of safeguarding issues relating to individuals with mental health problems was a priority for the Partnership, and representatives were

due to meet with the Social Care Trust this week to discuss their concerns.

- It was imperative that victims themselves who were reporting any safeguarding concerns, or any relatives or friends reporting concerns on the victims' behalf, were protected as part of the process. A Protection Plan and Strategy discussions took this into account. Although it could not be quantified with hard evidence, it was believed there were robust procedures to protect people raising safeguarding concerns.

- The Partnership needed to undertake more work to ensure that people most at risk were aware of the safeguarding process and to promote what safeguarding involved. There had recently been a major publicity campaign, raising awareness of the issues. The results of the Partnership's customer satisfaction survey had indicated that it was performing satisfactorily in this regard.

6.4 RESOLVED: That the Committee:-

(a) notes the information contained in the report now submitted, together with the responses to the questions raised;

(b) thanks Susan Fiennes and Simon Richards for attending the meeting and responding to the questions raised; and

(c) requests that:-

(i) the Chair writes to (i) the District Commander, South Yorkshire Police and Member of the Adult Safeguarding Executive Board, requesting a response in terms of why the number of criminal prosecutions for alleged perpetrators was so low and (ii) the Health and Social Care Trust, requesting a response from the Trust with regard to the low number of referrals from mental health, and to feedback to the Committee thereon;

(ii) the Sheffield Adult Safeguarding Partnership (i) looks into how it could maximise publicity in respect of the Safeguarding Adults Safe Places project, (ii) considers a specific piece of work, aimed at enhancing safeguarding training through the Council's contracting process, such as reviewing safeguarding processes and ensuring providers recruitment procedures were robust, and also to look at providers offering safeguarding training to people who use their services and (iii) provides a progress report to the Committee on a quarterly basis;

(iii) Susan Fiennes shares details of any steps taken to improve safeguarding procedures, in the light of the Winterbourne Care Home case, with Members of this Committee when available;

7. AN INTRODUCTION TO ST LUKE'S HOSPICE

7.1 Peter Hartland, Chief Executive, St Luke's Hospice, Sheffield, gave a presentation on the operation of St Luke's Hospice, referring to the care provided, the business model, the recent development of the new In Patient Centre and challenges for the future.

7.2 In attendance for this item were Peter Hartland, Chief Executive, Judith Park, Deputy Chief Executive, and Mark Harrington, Risk Management Co-ordinator, St Luke's Hospice.

7.3 Members of the Committee raised questions and the following responses were provided:-

- The nursing establishment at the Hospice comprised 71% qualified registered nurses, with the remainder being Health Care Assistants, who worked very closely with the registered nurses and received training and development, with a key focus on their caring skills and attitude. A dedicated consultant-led qualified medical team worked with the nursing team and other healthcare professionals to provide a full service for patients and families, both for in-patients and day patients at the Hospice, and in the community, where St Luke's provides 12 community Specialist Palliative Care Nurses for the City. Supporting teams of Hospitality and Housekeeping staff worked closely with the clinical teams and ensured that nutrition and cleanliness were addressed without compromising nursing time dedicated to patients. All these posts – medical, nursing, support and community – were funded by St Luke's.

- The annual funding requirement for the Hospice was £7.5 million, with just less than one-third of this amount (£2.34m in 2013/14) being funded by the Clinical Commissioning Group (CCG). St Luke's also had some separate arrangements with other parts of the NHS, in particular, the Post Graduate Deanery, which funded a portion of the salary costs of junior doctors on rotation at the Hospice (part of their training programme), and other more minor funding for particular projects from time to time. Other than this, the remaining £4.5m annually required to run St Luke's was raised through fundraising, supported by some limited investment income.

- The Hospice had to raise £4.5 million each year through fundraising. This comprised receipts from the charity shops, legacies, corporate partnerships, individual donors and funds raised from special community events. 75%-80% of this fundraising was generally deemed to be secure and, due to the success of the charity shops and the goodwill of donors, the Hospice had always been successful in achieving this level of funding. The Hospice could only hope that such funding could be achieved in the future, and would continue to work hard in publicising its excellent work and highlighting its fundraising activities.

- Whilst there had been an increase in engagement between GPs and the

Hospice Community Team over the last few years, and the Clinical Commissioning Group (CCG) had continued to emphasise the importance of end of life care to GPs, there was still a number of GPs who were not engaging with the Hospice or other palliative care services in the City. The CCG would continue to target such GPs.

- The Macmillan Cancer Care Charity differed from St Luke's in many ways, despite some misunderstanding by the public. Macmillan was a national, rather than local, charity. It concentrated on support for cancer, unlike St Luke's, which provided care for all life-limiting conditions, not just cancer. St Luke's provided ongoing, recurrent services to the people of Sheffield, and funded them for the long-term. Macmillan tended to focus more on providing initial funding for projects or initiatives, in the form of pump-priming, for some specific areas – using its charitable funds that had been generated nationally – and once the initial funding had ceased, these services, if they continued, were funded by either the statutory services or third sector. In most cases however, they would continue to carry a Macmillan badge once Macmillan's initial funding contribution had ended, which was a condition attached to Macmillan's participation.

7.4 RESOLVED: That the Committee:-

(a) notes the information reported as part of the presentation, together with the responses to the questions raised;

(b) requests that the Chair meets with Jackie Gladden, Senior Commissioning Manager, Long-Term Conditions and End of Life Care, Sheffield Clinical Commissioning Group, to discuss GP engagement with the Hospice; and

(c) (i) thanks Peter Hartland and his colleagues at the Hospice for hosting the meeting, arranging a visit of the new In Patient Centre and providing lunch and (ii) acknowledges the excellent work being carried out at the Hospice.

8. HOSPICE CARE IN SHEFFIELD

8.1 The Committee considered a report of Peter Hartland, Chief Executive, St Luke's Hospice, on the nature of hospice care in Sheffield. The report contained details on how such care was funded in terms of the charitable/donation-based nature of funding, and how the situation in Sheffield compared with the picture nationally.

8.2 In attendance for this item were Peter Hartland, Chief Executive, Judith Park, Deputy Chief Executive, and Mark Harrington, Risk Management Co-ordinator, St Luke's Hospice, and Jackie Gladden, Senior Commissioning Manager, Long-Term Conditions and End of Life Care, Sheffield Clinical Commissioning Group (CCG).

8.3 Jackie Gladden stated that the CCG valued the Hospice, both in terms of the provision of end of life care and, as a partner in the future development of these services in Sheffield. As well as providing an element of funding for the Hospice, the CCG also funded a number of other services, including the Home Care Nursing

Service, Continuing Health Care Service and the Macmillan Unit at Sheffield Teaching Hospitals, which provided 18 specialist palliative care beds in out-patient services. She added that the CCG would be meeting with the Hospice next week, to discuss its contract for the forthcoming financial year.

8.4 Members of the Committee raised questions and the following responses were provided:-

- Whereas the main hospitals in Sheffield were funded 100% by the NHS, the Hospice received less than a third of the £7.5 million funding required annually.

- Jackie Gladden offered to attend a future meeting of the Committee to talk to Members on the future of end of life care in the City.

- The CCG was not in a position to provide funding over and above the level it currently provided to the Hospice and, in terms of contingency, there was no legal requirement on the CCG to make up any shortfall suffered by the Hospice. The CCG did, however, have a responsibility to ensure care for all patients at the end of life, and should the Hospice not be able to provide its current service, the CCG would have to review the position, which would potentially mean that more patients would be cared for in hospital.

- The Hospice was generally ineligible for major National Lottery funding, mainly due to its physical location in a more prosperous area of the City.

- The term of the Hospice's contact with the CCG has historically been one year, but Peter Hartland stated that the CCG was to looking into the possibility of extending the next contract for a two year period.

8.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses to the questions raised; and

(b) requests that:-

(i) Jackie Gladden feeds back to (i) colleagues in the Clinical Commissioning Group, that the Committee strongly urges the CCG to consider longer-term contracting arrangements with the Hospice on the basis that the present one-year arrangement is not acceptable in terms of the Hospice's ability to plan its future finances and (ii) the Committee, following the contract negotiations between the Hospice and the CCG in late January, 2014;

(ii) arrangements be made for the Committee to look at the End of Life Care Strategy in the 2014/15 Municipal Year, and that this item includes feedback on the Department of Health's response to the report on the Liverpool care Pathway and any consequent actions in

Sheffield; and

(iii) the CCG should consider a contingency plan for the services provided by the Hospice should there be a substantial funding shortfall, which may include the availability of emergency short-term contingency funding to sustain services at the Hospice, if appropriate.

9. ADULT SOCIAL CARE PERFORMANCE - QUARTER 2 - 2013/14

9.1 The Committee received and noted a report of the Director of Care and Support, Communities Portfolio, on the Adult Social Care Performance – Quarter 2 – 2013/14, which summarised recent performance against the main Adult Social Care performance measures and demonstrated recent performance improvements in terms of reducing customer journey waiting times.

10. WORK PROGRAMME

10.1 The Committee received and noted its Work Programme 2013/14, as set out in the report of the Policy and Improvement Officer now submitted.

11. DATE OF NEXT MEETING

11.1 It was noted that the next meeting of the Committee would be held on Wednesday, 19th March 2014, at 10.00 am, in the Town Hall.

(NOTE: At the conclusion of the meeting, the Committee was taken on a brief visit of the Hospice's new In Patient Centre.)

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Healthier Communities & Adult Social Care Scrutiny Committee
Actions update for meeting on 19th March 2014

Action	Minutes	Update	RAG
Memory management Services – Development Options The Policy and Improvement Officer would contact Sarah Burt, Senior Commissioning Manager, NHS Sheffield Clinical Commissioning Group (CCG), to chase up the information requested, relating to (i) the provision of a link to the modelling system used to compile the data in the report on Memory Management Services, to be shared with Councillor Martin Lawton and	20th Nov 2013	**Complete** – DO contacted Sarah Burt regarding the data modelling system. A response has been received from Sarah Burt, Senior Commissioning Manager, CCG, as below, this was shared with Cllr Martin Lawton on 14/2/14. *"The model is all on disk. Essentially it models the impact of change on the health and social care system – we looked in particular at increasing diagnosis rate, intensive home care and care home in-reach and their effects on spend, admissions to hospital, admissions to care homes etc."* Sarah Burt has offered to meet with Cllr Lawton to discuss this in more detail.	
Memory management Services – Development Options 8.5 c (ii) to clarify the request, which was whether the CCG could encourage GP's to display posters in surgeries to encourage people to seek advice if they were experiencing memory problems.	20th Nov 2013	**Complete** – DO contacted Sarah Burt to clarify the request from the Committee A response has been received from Sarah Burt, Senior Commissioning Manager, CCG. A communication has gone out to all GPs via the CCG's GP Bulletin regarding this issue.	
Memory management Services – Development Options (iii) with regard to the proposed reduction in waiting times, to around six to eight weeks, the Chair writes to Ian Atkinson, Chief Officer of the Clinical Commissioning Group, requesting that consideration be given to whether the planned improvements can be introduced within 12 months, as opposed to the current 12-24 month timescale	20th Nov 2013	A letter has been sent to Ian Atkinson, Chief Officer of the Clinical Commissioning Group **Complete –** A letter of response has been received from Iain Atkinson and has been shared with the Committee.	

Public Question - Digital Autopsy 5.3 The Committee requested that information on the costs of undertaking both digital and physical autopsies be obtained prior to Members considering the questions.	15th January 2014	**Complete –** Linda Dale, Medico-Legal Centre Manager has provided this information as below: **The costs of Coroner's autopsies are laid down in statute.** • The cost of a standard Coroner's autopsy (physical) is £96.80 • The cost of an autopsy involving additional skills (physical) is £276.90. • Pathologists are in short supply and would be able to charge their own fee levels if a post-mortem was done privately. **Digital Autopsy** • There is limited availability of digital autopsies and providers (usually hospitals) charge their own fees. • IGene in Sheffield plan to charge £600 (£500 + VAT) for digital autopsy An email was sent to Committee Members on 25/2/14 giving an update on this issue.	
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 the Chair writes to (i) the District Commander, South Yorkshire Police and Member of the Adult Safeguarding Executive Board, requesting a response in terms of why the number of criminal prosecutions for alleged perpetrators was so low and	15th January 2014	**In progress –** a letter has been sent to Chief Superintendent David Hartley, Sheffield District Commander, South Yorkshire Police	
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 the Chair writes to (ii) the Social Care Trust, requesting a response from the Trust with regard to the low number of referrals from mental health, and to feedback to the Committee thereon;	15th January 2014	**In progress –** a letter has been sent to Kevan Taylor, Chief Executive, Sheffield Health & Social Care Trust	

Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 (ii) the Sheffield Adult Safeguarding Partnership (i) looks into how it could maximise publicity in respect of the Safeguarding Adults Safe Places project,	15th January 2014	**Complete** - Update from Simon Richards, Head of Quality & Safeguarding, Communities Publicity organised around forthcoming event on the 14th March. Plans are in place to work with Safe in Sheffield volunteers on a leaflet which can be made available to service users and their families promoting the scheme. There is a need to manage expectations to ensure the scheme is benefitting those people for which it was intended. Objectives are to consolidate the scheme within Learning Disabilities community and to expand this to cover adults with cognitive impairments including dementia and Alzheimer's. Later in the year will extend to cover adults with mental health issues. We will also look to improve communication within partner organisations so that front line staff are more aware of the scheme.	
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 the Sheffield Adult Safeguarding Partnership (ii) considers a specific piece of work, aimed at enhancing safeguarding training through the Council's contracting process, such as reviewing safeguarding processes and ensuring providers recruitment procedures were robust, and also to look at providers offering safeguarding training to people who use their services and	15th January 2014	**Complete** - Update from Simon Richards, Head of Quality & Safeguarding, Communities Safeguarding Adults office have been involved in recent evaluation of domiciliary care providers tenders around safeguarding and Mental Capacity Assessments (MCA). Contracts Team had training recently to support them to evaluate Deprivation of Liberty Safeguards (DOLS) and Mental Capacity Assessment compliance in contracted services – especially in care settings. This will be consolidated by working with the care homes and domiciliary provider forums	
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 the Sheffield Adult Safeguarding Partnership (iii) provides a progress report to the Committee on a quarterly basis;	15th January 2014	**Complete** – this has been added to the draft work programme for 2014-15. The first update would be July 2014.	

Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 (iiii) Susan Fiennes shares details of any steps taken to improve safeguarding procedures, in the light of the Winterbourne Care Home case, with Members of this Committee when available;	15th January 2014	Update not yet available.	
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 6.3 that a request be made of Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, to see if the Committee could have any involvement in the discussions with regard to the letting of contracts for Home Care Services. It was acknowledged that it was likely to be too late in the process, but that the question would still be raised.	15th January 2014	**In progress –** Cllr Mick Rooney & Cllr Mary Lea, Cabinet Member for Health, Care and Independent Living met on 26/2/14 to discuss this issue.	
St Luke's Hospice 8.4 (b) the committee, requests that the Chair meets with Jackie Gladden, Senior Commissioning Manager, Long-Term Conditions and End of Life Care, Sheffield Clinical Commissioning Group, to discuss GP engagement with the Hospice	15th January 2014	**Complete –** The Chair met with Jackie Gladden, Senior Commissioning Manager, Long-Term Conditions and End of Life Care and Dr Anthony Gore on 3/2/14. Dr Anthony Gore is the clinical lead on this area of work and one of the team of people who has been providing training and development to GP practices on end of life care. Jackie and Dr Gore updated the Chair in terms of the ongoing work in this area.	
Hospice Care in Sheffield 8.5 b (i) the committee, requests that, Jackie Gladden feeds back to (i) colleagues in the Clinical Commissioning Group, that the Committee strongly urges the CCG to consider longer-term contracting arrangements with the Hospice on the basis that the present one-year arrangement is not acceptable in terms of the Hospice's ability to plan its future finances and	15th January 2014	**Complete –** DO received an email from Jackie Gladden on 15/1/14 to confirm that this message has been passed on to relevant people at the CCG.	

Hospice Care in Sheffield (ii) requests that, Jackie Gladden feeds back to the Committee, following the contract negotiations between the Hospice and the CCG in late January, 2014;	15th January 2014	**Complete -** The Chief Executive of the CCG is writing to the scrutiny committee to update on this action.	
Hospice Care in Sheffield (iii) arrangements be made for the Committee to look at the End of Life Care Strategy in the 2014/15 Municipal Year, and that this item includes feedback on the Department of Health's response to the report on the Liverpool care Pathway and any consequent actions in Sheffield; and	15th January 2014	**Complete –** this has been added to the draft work programme for 2014/15. The Assistant Chief Executive of St Luke's Hospice has confirmed that the Hospice would welcome being part of any further discussion around the City's End of Life Strategy alongside the CCG.	
Hospice Care in Sheffield (iiii) the CCG should consider a contingency plan for the services provided by the Hospice should there be a substantial funding shortfall, which may include the availability of emergency short-term contingency funding to sustain services at the Hospice, if appropriate	15th January 2014	**Complete –** as above the Chief Executive of the CCG is writing to the scrutiny committee to update on this action.	

Briefing papers / items for information

An update on Self Directed Support and Personalisation including the Individual Service Fund Framework Agreement and Support Planning and Brokerage Framework Agreement. This request follows on from Eddie Sherwood and colleagues attending this Committee in April 2013 to present a report on Self Directed Support. A briefing paper from Moira Wilson, Interim Director of Care and Support has been circulated.

The national strategy for major trauma within the Yorkshire and Humber region Briefing Paper - Following the attendance of Iain Atkinson and Daniel Mason (Sheffield CCG) at this Scrutiny Committee in April 2013 the Committee, requested" that a further report on this issue be submitted to a meeting of the Committee in 12 months' time, focusing on the progress made with regard to the proposed improvements to rehabilitation services". Iain Atkinson advised that Major Trauma now falls under the remit of NHS England so this briefing paper has been produced by Cathy Edwards, Director of Commissioning (Interim), NHS England., the paper has been circulated.

Items for information

CCG Governing Body papers – a link to papers for the meeting on Thursday 6 February 2014 has been circulated.

Monitoring Advisory Board papers – minutes from the last meeting have been circulated.

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

Report of: Sheffield Children's Foundation Trust

Subject: Annual Quality Report 2013-14

Author of Report: John Reid, Director of Nursing,
Sheffield Children's Foundation Trust

Summary:

The report summarises the performance of the Trust in 2013-14 in relation to quality of care. It sets the quality priorities for 2014-15 in consultation with our families, governors and agency partners.

The report will form the quality section of the Trust Annual Report to our regulator, Monitor and a stand-alone document on the NHS Choices Website. It shows:

- The Trust has processes to provide assurance of safe quality standards
- There is a framework that supports identification of risk and poor patient experience and involves the Board and Governors in monitoring of action plans.
- Lapses in performance are known to the Board and investment of resources is appropriately targeted to resolve these.

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:

Review the report with the opportunity to question the author and the Trust on any aspect pertaining to accuracy, lack of inclusiveness or establishment of priorities.

Background Papers:

Detailed Requirements For Quality Reports 2013/14, Monitor.

http://www.monitor-nhsft.gov.uk/node/5912

Category of Report: OPEN

Sheffield Children's NHS
NHS Foundation Trust

Enc <>

DRAFT 1 REPORT TO THE TRUST BOARD OF DIRECTORS MEETING HELD ON 2014

Quality Report (Incorporating Quality Accounts) 2014

Trust objectives supported by this paper

- The paper supports the achievement of all Trust Objectives

Purpose of the paper

To summarise the performance of Trust in 2013-14 in relation to quality of care. To set the quality priorities for 2014-15 in consultation with our families, governors and agency partners.

The draft paper was consulted upon with all of our key stakeholders, as set out in the February Board schedule paper. The report will form the quality section of the Trust Annual Report to Monitor and a stand alone document on the NHS Choices Website.

Summary of key points

- The Trust has processes to provide assurance of safe quality standards
- There is a framework that supports identification of risk and poor patient experience and involves the Board and Governors in monitoring of action plans.
- Lapses in performance are known to the Board and investment of resources is appropriately targeted to resolve these.
- KPMG will provide an external audit opinion on the content and the assurance processes of the report.

Board Action required

Approval of the Quality Report

Author:	J Reid	**FOR APPROVAL**
Executive Sponsor:	J Reid	

SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST
QUALITY REPORT

1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

Sheffield Children's NHS Foundation Trust is a high quality provider of children's health care. We have responsibility for most aspects of child health care in Sheffield including hospital, community and mental health; and are a major provider of specialist hospital care for South Yorkshire and beyond. We are proud of the high satisfaction survey results that we obtain and the quality of care we provide. As a Foundation Trust we are able to use the surplus that we achieve each year to invest in children's care. Recent capital investments have included the building of a new children's hospital wing, two new operating theatres, replacement of our patient administration software, and provision of outpatient expansion at the Northern General Hospital.

We work with our partners to ensure children receive total care. Our health visitors and school nurses work with the local authority and GPs to ensure that children are kept healthy. Our community paediatricians, nurses and therapists work with families to minimise hospital stays. Our acute hospital services treat children locally when most needed and our specialist services are able to investigate and manage complex physical and mental health problems. Other than maternity services and GP services, we are able to offer a comprehensive child health service to our families. By specialising in this we routinely achieve some of the best standards in the country.

The Trust is far from complacent; we know we can always do better and the current economic climate has meant that even maintaining standards is a real challenge. The Mid Staffordshire Review has meant that NHS services are under scrutiny and its very culture is being questioned. We believe that our family centred approach has proved a safeguard against eroding standards and involvement of families in every aspect of children's care provides an inspiration to our staff.

The last year has seen great changes in the NHS. Sheffield Children's Foundation Trust will try to harness that change and use it to further improve the standards of care for children and young people.

The Quality Report set out below is accurate, to the best of my knowledge, and is a balanced and accurate reflection of the quality assurance processes, structures and outcomes in use at Sheffield Children's NHS FT.

I hope you will find the report informative and that it will encourage you to engage with our activities to improve children's health.

Signed

Mr Simon Morritt
Chief Executive

2 PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 Quality Improvement Priorities 2014-15

2.1.1 CONTINUE TO IMPLEMENT THE DEPT. OF HEALTH RESPONSE TO THE MID STAFFORDSHIRE PUBLIC ENQUIRY, 'PATIENTS FIRST AND FOREMOST'

Our reasons:

The NHS recommendations from the Mid Staffordshire Public Inquiry have been emerging over the last year and the Trust has responded to these. Like all public services, the Trust faces significant economic challenges and performance targets. Continued concentration on the Trust action plan is crucial to ensure that quality is not sacrificed in pursuit of these. Our Council of Governors see this safeguarding of quality as their key role and responsibility.

The Trust will be inspected on 6-8 May 2014 by over 30 CQC Inspectors. The CQC has significantly changed its inspection program to ensure that the public is confident that hospitals are fit for purpose. Professional and clinical staff, families who use services and CQC assessors will spend over three days examining how the trust works and how it has responded to the need for high quality care.

The Trust will:

- Pilot a children's nursing dependency assessment to provide evidence that our nursing establishments are sufficient for the needs of the families and children we care for.
- Show, at the entrance to each ward, the nursing staff numbers rostered and available to look after children on that shift.
- Extend our family surveys to our new-born high dependency ward and benchmark ourselves against other units. The survey will be published and an action plan produced to address any improvement needed.
- Fully implement a hospital out of hours model of senior children's nurses who are supernumerary and available to assist medical staff, advise nursing staff and coordinate patient care at night and weekends

2.1.2 REVIEW OUR CHILD AND ADOLESCENT PSYCHIATRY SERVICE TO ENSURE THAT IT HAS ADAPTED TO FIT WITH THE TYPE OF REFERRALS WE ARE RECEIVING.

Our reasons:

Our CAMHS service at Becton is one of the largest in the UK. It has four main Lodges and has been running for over three years. Since transferring from Oakwood at Northern General Hospital, we have seen a significant increase in referrals from all over the country.

The nature of the referrals has been changing with more young people who are exhibiting self-harming behaviours and require intensive support through episodes of severe emotional turbulence. CAMHS and its availability is a regular priority for our local authority Children and Young People's Scrutiny Committee.

With our commissioners, we will seek to understand what service we need, and how to ensure that it is meeting national standards for Child and Adolescent Mental Health care.

The Trust will:

- Demonstrate that the services are in accordance with the standards of the Royal College of Psychiatrists, Quality Network for Inpatient CAMHS (QNIC).
- Work with commissioners to ensure that local 16-18 yr old patients are accommodated, where needed, within the Becton Unit.
- Ensure that when young people are treated under the provisions of the Mental Health Act, they and their families have full access to information, advice and representation.

2.1.3 MINIMISE DISRUPTION TO OUR SERVICES FROM THE BUILDING OF THE NEW HOSPITAL WING

Our reasons:

The current building work is some of the most extensive in the Trust's history. Although it has the potential to fundamentally improve the experience of families, it has the potential to worsen their experience while we carry it out. Patient access has consistently been the single greatest source of negative family survey comment over the past 4 years.

The Trust will:

- Improve access by aiming to have most of the parking improvements in place by the end of 2015. This includes the multi-storey parking opposite the main entrance and the underground parking with direct lift access for disabled families.
- Shift significant numbers of outpatient clinics to the Northern General for the duration of the work.
- Set up a remote supplies depot to ensure that all supplies, pharmacy and laboratory deliveries are consolidated into as few goods vehicles as possible. Remaining deliveries and construction traffic will require to book on an online scheduling system to minimise conflict with patient traffic.

2.1.4 HOW PERFORMANCE WILL BE MONITORED

Progress on the above indicators will be monitored by reports to the Clinical Governance Committee and regular reports to the Trust Board. The Board will share its reports with the Council of Governors and its commissioners in NHS Sheffield and NHS England. All reports will be published on the Trust website.

2.1.5 PERFORMANCE ON QUALITY PRIORITIES 2013-14

The Trust set itself the following three areas of quality improvement for last year:

What we said.	What we did.
1. **Implement the Dept. of Health Response to the Mid Staffordshire Public Enquiry, 'Patients First and Foremost'**	The Trust published its response and has updated this regularly since. The response includes the strategy for responding to the national nursing issues raised. http://www.sheffieldchildrens.nhs.uk/about-us/statutory-declarations.htm
Review and define the culture of the organisation	The Trust has published its Trust Values following extensive stakeholder meetings. These values are based around five key points: **Committed to Excellence, Teamwork, Accountability,**

What we said.	What we did.
	Compassion and Integrity. These values are incorporated into everything we do and are set out on our website: http://www.sheffieldchildrens.nhs.uk/about-us/trust-values.htm
Assess nursing establishments against workload annually	All nursing establishments are reviewed annually with the senior department nurse and the appropriate Matron. The Trust has been recruiting against these establishments and benchmarks with other children's services.
Invest in Ward Sisters and Charge Nurses – Free up from other duties to provide a role model and visible ward presence.	Half of all Ward Managers were made supernumerary during 2013-14, with the second half due to change this year. Each post requires back-fill with a registered children's nurse to ensure that direct patient care is not affected.
Review and prioritise nurse training	All ward areas have identified a mandatory training program. Training weeks are combined with full or partial closure to allow deep cleaning and essential maintenance. Advanced Nursing Practice is being prioritised by supporting staff to undertake leadership training and skills training such as prescribing.
Involve governors and families in inspection and oversight of our services.	Governors have been involved in Adoption of the „15 Steps" approach: Challenge teams, including non-executive directors, staff, governors and patient groups go onto wards and departments. They use the toolkit to record observations and feed back to the department team. http://www.institute.nhs.uk/productives/15stepschallenge/15stepschallenge.html Governors are able to review anonymised complaints and our response each month against the Patients Association Template. Results will be used to inform future complaints responses.
2. Publish regular information on our quality performance and the experience of our families	We commission a wide ranging series of postal surveys carried out by Picker International. These surveys cover In Patient, Out Patient and A&E families. They survey over 800 families in each area, the results are published on our website and used to inform our care and investment. http://www.sheffieldchildrens.nhs.uk/patients-and-parents/patient-views.htm
Evaluate the experience of families in the community	The Trust has commissioned a new survey of families who come in contact with our Health Visitors. This survey has been welcomed and adopted by NHS England as a basis for national benchmarking in 2014-15. The survey results will form the basis for our improvement work.
Regularly evaluate experience of families in A&E using a child friendly derivative of the family and friends test.	The Trust has been allowing each family attending A&E to answer one of two questions: ○ Parents of children under 8 yr: Would you recommend this department to others? ○ Children over 8 yr: What could we do better? The results are available on our website but are overwhelmingly positive and in keeping with our annual A&E survey results. Link

What we said.	What we did.
Produce quality indicators for children and benchmark with similar health providers	The Trust has been reviewing its services against Quality Indicators that are agreed with our commissioners. The Scan tool is a child equivalent of the adult Safety Thermometer. Our results are available on our website and are regularly in excess of 95% achievement of the standards. Link
3. Minimise disruption to the public from our construction of the new hospital wing	The Trust and charity has kept the public aware of developments through media and web publicity. http://www.sheffieldchildrens.nhs.uk/about-us/hospital-redevelopment/ http://www.tchc.org.uk/our-appeal
Improve communication and signposting of access restrictions	The Trust has extensively updated our website setting out clearly the changes to access. http://www.sheffieldchildrens.nhs.uk/patients-and-parents/parking.htm All families receive a leaflet informing them of restrictions and suggesting alternatives to car transport. A Network of flat screen monitors has been installed in waiting areas. The monitors display advice on access and wayfinding.
Provide a park and ride solution for parents and families	To assist patients and their families, we have agreed a discounted park and ride scheme at the Q-Park Castlegate, near Ponds Forge. A free shuttle bus runs regularly between the car park and the hospital.
Control noise, dust and disruption to normal services	The Trust has worked closely with our Infection Control Dept. to plan all work in such a way that impact to patients is minimised. Trial work has been carried out in cooperation with surgeons and clincal scientists to ensure that vibration and noise will not pose a safety risk to services.
Manage services in the community, where possible	The Trust has employed a paediatrician to advise GPs on individual cases through a telephone clinic. The Trust has significantly expanded its Helena Home Nursing team. The Trust has negotiated a significant extension to the Sheffield Children's Hospital Clinic at the Northern General Hospital. This clinic is in a dedicated building and should divert traffic away from the main hospital site.

2.2 Statements of Assurance from the Board

2.2.1 GENERAL ASSURANCE

During 2013-14 Sheffield Children's NHS FT provided and/or sub-contracted 102[1] relevant health services.

Sheffield Children's NHS FT has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2013-14 represents 100% of the total income generated from the provision of relevant health services by Sheffield Children's NHS FT for 2013-14.

2.2.2 AUDIT AND NATIONAL CONFIDENTIAL ENQUIRY ASSURANCE

During 2013-14, 20 national clinical audits and zero national confidential enquiries covered NHS services that Sheffield Children's NHS FT provides.

During 2013-14 Sheffield Children's NHS FT participated in 100% of national clinical audits which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sheffield Children's NHS FT participated in, and for which the data collection was completed during 2013-14 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits for which the Trust was Eligible	**% of eligible cases submitted**
MBRRACE-UK Perinatal Confidential Enquiry –	25%
RCP (UK IBD Audit) Inflammatory Bowel Disease	33%
CEM Asthma	100%
BTS National Asthma	100%
BTS Bronchiectasis	100%
BTS Paediatric Pneumonia (See BTS note in red)	**100%**
CE (CORP) RCPCH Child Health Audit Clinical Outcome Review Programme/Child Health Reviews-UK (CHR-UK)	100%
CEM Consultant sign off (Febrile under 1's and re-attenders)	100%

[1] Based upon the services specified in the NHS Provider Contract for 2013-14.

National Clinical Audits for which the Trust was Eligible	**% of eligible cases submitted**
TARN	100%
CE (CORP) RCoP National audit of Asthma Deaths	100% (No reportable deaths)
ICNARC Cardiac Arrest Procedures	100%
National Diabetes	100%
CEM Febrile Child	100%
MBRRACE-UK Perinatal Confidential Enquiry – Congenital Diaphragmatic Hernia	100%
POMH's National Audit for Schizophrenia / Antipsychotic Prescribing.	100%
PICANet (Paediatric Intensive Care Audit Network)	100%
NAP5: National Audit Project 5- Accidental Awareness During General Anaesthesia in the United Kingdom	100%
Neonatal Transport Group Annual Return 2013	100%
National Multicentre Evaluation of Lidocaine 5% Patch for Localised Neuropathic Pain in Children and Adolescents	100%
IBID: International Burns Injury Database	75%

2.2.2.1 National Audit and Confidential Enquiry Reviews

The reports of 6 national clinical audits were reviewed by the provider in 2013-14 and Sheffield Children's NHS FT took the following actions to improve the quality of healthcare provided.

CEM Febrile Child

The Trust is performing well and continues to improve in performance every year since 2010.

Although better than the national average, areas to address are, poor documentation of BP (68%) + Glasgow Coma Scale (86%). This may be helped by the introduction of a feverish child proforma.

1. Observations taken within 20mins of patients arrival in 73% of cases (SCH ED achieved this standard in 95% of cases in 2010) This may reflect the ever increasing attendances to ED year on year.
2. Appropriate safety net advice given to 86% of patients.

Action identified and / or implemented included:

- Results of audit have been communicated to A&E Team.
- Standards have been written for the role of the nurse coordinator including watching the triage time and opening up a 2nd triage when necessary.

CEM Consultant sign off (Febrile under 1's and re-attenders)

SCH has been compared nationally with all other A&Es and has shown higher proportion of "high risk" patients being seen first time by a consultant than elsewhere and also when combined with trainee doctors of ST4 or above assessments of these patients.

A separate cohort looked at SCH compared with stand -alone paediatric A&Es. SCH showed higher proportions than anywhere else of high risk patients being seen by a consultant.

Action identified and / or implemented included:

- A feverish child proforma has been developed and currently piloted to aid documentation, assessment and management of these patients.
- An evaluation of the impact of this proforma is planned once the Trust has piloted 60 proforma's.

2012 National Comparative Audit (NCA) of the labelling of samples for transfusion

Local findings:

1-3 There is a clear policy, including where and how to label samples as stated in the recommendations.
4. Samples are processed one at a time by hand no matter how many times a patient attends. Only one sample is collected as paediatric samples are precious and the Trust has an excellent safety record.
5. All staff are trained and competency assessed on labelling requirements for transfusion samples.
6. The Trust does not use an electronic system for patient identification.
7. All rejected samples are recorded and each incident is registered by Risk Management.

Actions in progress/completed:

- Trust has a better than average rejection rate implying that more samples are labelled correctly.
- We meet all standards except in extreme circumstances and all recommendations are already in place.
-

PICANet (Paediatric Intensive Care Audit Network) Annual Report 2013 ***(Data covering January 2010-December 2012).***

Local findings: *(extracted by Lead Local Clinician from published data)*

1. Despite a small rise in standardised mortality, Sheffield Children's Hospital PICU standardised mortality remains in line with national secular trends.

Actions: *(Generic actions from National Report)*

- No local actions identified.

NCAA (National Cardiac Arrest Audit) Report – June 2012-March 2013

Local findings:

1. Documentation relating to patient information and arrest details generally 100% complete
2. All inpatient arrests take place in Acute areas – Emergency Department, Paediatric Intensive Care Unit, and Emergency Admissions Unit.
3. 100% of patient that had an inpatient arrest survived resuscitation.
4. 62.5% of patients that had an arrest, while an inpatient, were discharged alive.

Actions:

- None identified.

POMH – Re-audit of prescribing Antipsychotics for Children and Adolescents (Topic 10b)

Audit results showed the following compliance

25/25/ (100%) of children and adolescents prescribed antipsychotic medication where there was an indication(s) for treatment with antipsychotic(s) had this documented in the clinical records.

21/22 (95%) of patients in each team for whom had the continuing need for antipsychotic medication reviewed in the past six months.

For all children and adolescents prescribed antipsychotic medication, the side effects of antipsychotics should be reviewed at least once every six months. This review should include, as appropriate, the assessment of body weight, blood pressure, blood glucose, plasma lipids and raised plasma prolactin, and examination for the presence of extrapyramidal side effects (EPS).

Body weight was recorded for 86% of patients
Blood glucose was recorded for 77% of patients
Plasma lipids was recorded for 68% of patients
Raised plasma prolactin was recorded for 82% of patients

Generally overall performance was above national average however the following improvements were identified

- To consolidate the current good medical practice
- To encourage the formal recording of extra pyramidal side effects using standardised questionnaires eg "AIMS".
- To explore the possibility of shared care protocol with GPs given that the audit highlighted that it applied only to 3 cases in CAMHS at the time of the audit who are already under the continued care of secondary care

2.2.2.2 Local Audit and Service Evaluations

The reports of 176 local clinical audits service evaluations were reviewed by the provider in 2013-14. The reports were reviewed by clinical teams. Examples of the actions taken or intend to be taken by the Trust to improve the quality of healthcare provided include:

Emergency Department (ED): CA651 Abdominal Pain
Findings:
Not all children have a comprehensive abdominal examination record.

Action identified and / or implemented included:

- Educating team about documentation of male examination
- Educating team about documentation of female pregnancy test and documentation of reason if not done
- Educating staff about the importance of urinalysis in all children with abdominal pain

.

CA634 Diabetic Ketoacidosis (DKA) management – Are we following the trust guidelines?
Findings:
90% of children have hourly observations recorded and accurate resuscitation fluid records.

Action identified and / or implemented included:

- Twice daily weights once transferred to the wards
- Input/output charts - need to have urine measured accurately.
- Cardiac monitoring to be documented

Child Protection: SE 651~2 Multiagency Pathway Sudden Unexpected Death in Infancy (SUDI) 6 year review

Findings:
Local risk factors associated with SUDI were identified and coincide with national risk factors.

Actions identified and / or implemented
There have been a number of initiatives aiming to reduce SIDS. These include:

- .
- A publicity campaign with posters raising awareness of the importance of safe sleeping sited in areas where families attend e.g. GP surgeries, hospitals, children's centres.
- Leaflets regarding safe sleep being given to all new parents.
- Midwives now routinely assessing where the newborn infant will sleep. Midwives directly question pregnant mothers as to where the baby will sleep and the baby's sleep environment is routinely checked prior to the baby's birth.
- Health visitors routinely discuss safe sleep at their first visit to the family when the infant is aged around four weeks.
- A Sheffield e learning package has been devised for all professionals who have contact with infants. This package has also now been adopted by areas outside Sheffield.
- A new smoking cessation programme for pregnant mothers has been introduced. Reducing smoking during pregnancy and beyond should reduce the risk of SIDS.

Pharmacy: CA363~2Re-audit of of prescribing errors and clinical interventions made for out-patients
Findings:

Pharmacists are making interventions to clarify prescriber's intentions and reduce the risk of harm to patients. 22% of inpatient prescriptions and 9% of all outpatient prescriptions had an intervention made by the pharmacist to reduce risk.

Actions identified and / or implemented

- Feedback audit results at level 3 medicines management training (& junior doctor induction) Include some audit results in prescribers training
- encourage use of addressographs to assist with accuracy
- encourage all staff who receive prescriptions to check name, date of birth, allergies etc.

Pharmacy: SE342 Pharmacy Department Patient satisfaction questionnaire
Findings:
Visitors to Pharmacy felt that Pharmacy staff on the whole were approachable and polite. Staff were scored as good/ excellent by 75% of patients

Actions identified and / or implemented

- Installation of a hand gel dispensary in the waiting area
- Toys/books to entertain patients/children
- Additional information signage
- Improve coverage of reception by staff

WAMH: CA627 Physical Monitoring of patients on ADHD (CG72 NICE)
Findings:
In ADHD clinic at Beighton CAMHS clinicians are recording physical observations both in the hand written notes (97%) and in the letter to the GP (100%).

In ADHD clinic, clinicians are plotting height and weight on a centile chart 47% of the time. Blood pressure is plotted 34% of the time.

Actions identified and / or implemented

- Addition to "When a diagnosis is made checklist" of taking physical observations and plotting them on a centile chart. Alteration of checklist and circulation to all clinicians.
- Centile measurements to be incorporated into the standard template for the GP letter.

Neonatal Surgical Unit: CA472 Newborn Screening in the Neonatal Surgical Unit
Findings: Some babies remain inpatients until beyond important milestones in newborn screening. Because they do not go through the usual system of discharge from a maternity unit, there is evidence of immunisations and 6 week developmental checks to be missed.

Actions identified and / or implemented

- Use of standard weekly form before Friday ward round to improve weekly checks
- Induction of new medical staff to the importance of all forms and of completing them fully

Histopathology: CA361 Auditing the association between neonatal necrotising enterocolitis/isolated intestinal perforation and placental pathology
Findings:
The audit results suggested that preterm babies showing acute chorioamnionitis with vasculitis and fetal inflammatory response in the placenta could be at increased risk of developing necrotising enterocolitis (NEC) or isolated spontaneous intestinal perforation (SIP).

Action identified and / or implemented included:

- A copy of the histology report of placentas of premature babies showing features of acute chorioamnionitis will be sent to the Neonatologist. To ensure regular frequent follow up.
- The cases of acute chorioamnionitis in preterm babies, especially if they show features of vasculitis, should be included in the discussion of cases at regular foeto-pathology meetings

Ears, Nose, and Throat Surgery (ENT): CA558 Prescribing in Paediatric Tonsillectomy
To ascertain whether departmental practice meets National guidelines, and whether the tonsillectomy techniques and complication rates compare with nationally audited figures.

Findings:
1. This three-cycle audit *(of which CA558 is the 3rd)* demonstrated a reduction in the prescription of antibiotics for paediatric tonsillectomy patients following an educational intervention.
2. There was a significant improvement in the prescription of intra-operative dexamethasone following an educational intervention.

Actions identified included:
- Local education regarding prescription of steroids and antibiotics

Note: This audit was presented at ENT-UK in September 2013, winning 1st Prize in the CAPAG Short Paper section.

Orthopaedic Surgery (Orthotics) SE295: Orthotic Patient Survey
To identify areas of satisfaction and areas where improvements need to be made. From this information an action plan will be formulated to implement procedures to improve the delivery of the Orthotic Service.

Findings:
1. Families felt that they were listened to and involved in the care of their child (97% and 95%).
2. 98% of families were happy with the standard of service given.
3. 70% of families were not informed of any delay in the clinic running time.

Actions identified included:
- Inform families of clinic delays

Anaesthetics: CA445 Anaesthetic Patient Survey
This was a re-audit of a project undertaken in 2010 as a lead up to a larger SEE project in the Theatres Department.

Findings:
1. 69% of patients remembered receiving an age appropriate information leaflet about their anaesthetic.
2. Above 90% of all families thought that the Nurses were professional/friendly (99%), Anaesthetist was professional/friendly (100%), and Surgeons (96%).
3. 100% of patients felt well looked after in the Anaesthetic Room (+9% from 2010).

4. The majority of parents were satisfied with their child's care (73% were extremely satisfied - +30% from 2010)

Actions identified included:

- Improve distribution of patient age-appropriate anaesthetic information leaflets.

Further examples of actions resulting from completed audits are available on the Trust Website or from the Clinical Governance Department.

2.2.3 CLINICAL RESEARCH

The number of our patients receiving NHS services provided or sub-contracted by Sheffield Children's NHS Foundation Trust (as well as family members and healthy volunteers) choosing to participate in our research is 1242. This has exceeded last years accrual figures by almost 200.

Research studies taking place at SCH NHS FT covers 5 of the 7 topic specific networks in the National Institute for Health Research (Medicines for Children, Cancer, Mental Health, Dementia and Neurodegenerative Diseases, and Diabetes) and studies within 8 specialty groups within the Comprehensive Local Research Networks (metabolic and endocrine, musculoskeletal, haematology, cardiovascular, ENT, Genetics, Infectious Disease, and Injuries and Emergencies.

Some examples of the research carried out in our Trust during the last year are:

2.2.3.1 KICk-OFF: A multi-centre, cluster randomised controlled trial comparing structured education (the KICk-OFF course) with standard care in 11-16 year olds with Type 1 Diabetes (T1DM) on intensive insulin therapy

The aim of this 5 year study was to assess whether the KICk-OFF structured education course improved biomedical and psychological outcomes in 11-16 year olds with type 1 diabetes. The study, funded by Diabetes UK and led by a team from our Trust, was a large randomised study which involved 31 UK NHS Paediatric Diabetes centres and 486 young people aged 11-16 years with type 1 diabetes.

In summary, for those children who took part in the trial, the KICk-OFF group reported improved overall quality of life at 6 and 12 months after participation in the course, with physical, psychosocial and social subscales being significantly improved after 6 months. The KICk-OFF group also reported improved diabetes related symptoms. The control group however reported greater confidence in managing their diabetes and greater adherence to treatment scores.

The study team concluded that participation in a KICk-OFF intensive structured education course is associated with significantly improved quality of life outcomes at 6 and 12 months and whilst overall HbA1c levels did not differ between control and intervention groups, those with the poorest diabetes control at the start of the study showed a significant improvement in their diabetes control after two years, which if maintained would reduce their risk of long-term complications such as eye and kidney disease.

2.2.3.2 Clinical Genetics Research

The Deciphering Developmental Delay (DDD) project.

DDD is a major national project led by colleagues in Cambridge. The study allows us to refer families who have a child with learning difficulties and/or other problems detected at birth for whom standard diagnostic tests have not given an answer. Sheffield Children's Hospital has managed to be one of the highest recruiting sites to this project. In part, this has been achieved by having research support staff based within the clinical genetics department. The project has already started to return results which we check in a service laboratory before seeing families. Access to new technology is a major asset for the families seen by the hospital. Once the DDD project closes in 2015, the NHS will have to make a decision regarding the provision of this technology for families. In the meantime we are making maximum use of this current opportunity.

Juvenile Huntington's Disease Research

Huntington's disease is a neurodegenerative condition which affects adults. In 5% of cases onset is under the age of 21 years and called juvenile Huntington's disease. Young people with this condition are often more severely affected than those who develop the condition in middle age. We are currently part of an international project studying Huntington's disease but more specifically the international working group on the juvenile form is led from our hospital. We have published a number of papers on the condition and are working on better methods of assessing the condition so that future interventions can be assessed; in addition we are hoping to develop a new national project to assess services for families affected by juvenile Huntington's disease.

2.2.4 USE OF THE CQUIN FRAMEWORK

A proportion of Sheffield Children's NHS FT income in 2013-14 was conditional upon achieving quality improvement and innovation goals agreed between Sheffield Children's NHS FT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2013-14 and for the following 12 month period are available online at *http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275*

The amount of income in 2012/13 conditional upon achieving quality improvement and innovation goals was £1.28M, the amount conditional upon achieving quality improvement in 2013-14 was £2.91M.

A more detailed commentary on our achievement against the CQUIN quality indicators is given below:

CQUINs for Specialist Services

Title	Description	Outcome
Implement safety thermometer	Achieve safety thermometer requirements set out by local commissioners	Achieved
Reduce unplanned	Out of network referrals PICU	Achieved

Title	Description	Outcome
PICU Transfers		
Prevent unplanned re-admission to PICU	To identify and reduce the unplanned readmissions within 48 hours	Achieved
Specialised Cancer – Access to and impact of CNS support on patient experience	To assess the impact of Clinical Nurse support (CNS) on the patients experience of their cancer journey	Achieved
Medical Genetics – improving triaging of patients at high risk of familial breast cancer	To ensure all high risk referrals are offered an appointment and to increase the proportion of new patient genetic appointments for unaffected patients at high risk of familial breast cancer.	Achieved
Haemophilia – joint scores in severe and moderate haemophilia A and B	The proportion of registered severe and moderate haemophilia A &B patients aged 4 and over who have had their joint score assessed by a trained Physio in last 12 months to meet target of 50%.	Achieved
Osteogenesis Imperfecta	Highly specialised services clinical outcome collaborative audit workshop and provider report.	Achieved
Ehlers Danlos Syndrome	Highly specialised services clinical outcome collaborative audit workshop and provider report.	Achieved
CAMHS Tier 4 – Improving Physical Healthcare and well-being of patients	Ensure children and young people admitted have appropriate Physical health care screening and interventions.	Achieved
CAMHS Teir 4 - CPA Standards	Ensure the care plan approach (CPA) process is effective and appropriately identifies unmet need.	Achieved
CAMHS Tier 4 – Optimising pathways	Understand the total care pathway and plan how they might work differently to optimise length of stay and improve outcomes.	Achieved

CQUINs for Core Services

Title	Description	Outcome
Patient experience – Improved access for parking	Parking is one of main reasons for complaints – implementation of a park and ride scheme to help alleviate problems	Achieved
Patient experience – A&E	Development and roll out of Family and Friends Test related question and follow up on suggested actions.	Achieved
Baby Friendly	To ensure that the Trust is prepared and able to deliver the requirements as per national scheme.	Achieved
Harm Free	The introduction of the SCAN tool within the Trust, input data, share data among Children's Trust Network.	Achieved
Early Warning Scores	To Develop and implement a single score approach to early warning on all wards.	Achieved
15 Steps challenge for clinic and outpatient settings	To help staff, patients and service users work together to identify improvements to enhance the patient or service user experience. To provide a way of understanding patients and service users first impressions more clearly.	Achieved
Referral to Sheffield Stop Smoking Service	120 referrals made from Health Visiting to stop smoking service	Achieved
Breast feeding Health Visiting	Health visiting service to ensure that at least 81.2% of mothers breast feeding at new birth visit should still be breast feeding after 6-8 weeks.	Achieved

2.2.5 REGISTRATION WITH THE CARE QUALITY COMMISSION

Sheffield Children's NHS FT is required to register with the Care Quality Commission and its current registration status is unconditional. The Care Quality Commission has not taken enforcement action against Sheffield Children's FT during 2013-14.

Sheffield Children's NHS FT has not participated in special reviews or investigations by the Care Quality Commission during 2013-14.

2.2.6 PERIODIC REVALIDATION OF MEDICAL STAFF

Medical revalidation is the process by which all doctors who are licensed with the General Medical Council (GMC) regularly demonstrate that they are up to date and fit to practise. Doctors will normally revalidate every five years. Revalidation is based on a local evaluation of doctors' practice through appraisal; its purpose is to affirm good practice.

In addition to the responsible officer all eight of the first tranche of doctors recommended for revalidation have been approved by the GMC.

2.2.7 INFORMATION ON THE QUALITY OF DATA

Sheffield Children's NHS FT submitted records during 2013-14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: xx.x% for admitted patient care; xx.x% for outpatient care; and xx.x% for accident and emergency care. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**

- which included the patient's valid General Practitioner Registration Code was: : xx.x% for admitted patient care; : xx.x% for outpatient care; and : xx.x% for accident and emergency care. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**

Sheffield Childrens NHS Foundation Trust Information Governance Assessment Report overall score for 2013-14 was : xx.x% this was graded xxxx. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**

Sheffield Children's NHS FT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) is described below:

A total of xxx Finished Consultant Episodes were scrutinized during the audit. The following services were reviewed in the sample:

- Xxx

(The results should not be extrapolated further than the actual sample audited)

Sheffield Children's NHS FT will be taking the following actions to improve data quality:

- XXX

A FURTHER AUDIT HAS NOT TAKEN PLACE SINCE THE ONE MENTIONED ABOVE – THEREFORE THIS CANNOT BE UPDATED AT PRESENT. THE CODING TEAM HAVE BEEN ASKED FOR DETAILS OF THE NEXT AUDIT.

2.2.8 INFORMATION ON THE QUALITY OF DATA

The following section sets out the data made available to Sheffield Children's NHS FT by the Health and Social Care Information Centre. The indicators below represent those relevant for the services provided by this trust. Most of the indicators specified are not relevant to a children's specialist trust and following agreement with commissioners, are not submitted as a data return. N.B. Where data is historical, this is to comply with the latest national data released by the HSCIC.

19. Patients readmitted to a hospital within 28 days of being discharged. (i) 0 to 14	
Unique Identifer:	P009013
Link:	http://nww.indicators.ic.nhs.uk/webview/
Source Data:	Source Data P00913

		National		
Financial Year	**%**	***Average (%)***	***Maximum (%)***	***Minimum (%)***
2010/11	11.9	*10.85*	*12.42*	*7.95*
2009/10	12.13	*10.64*	*12.21*	*8.55*
National data is based on the data for all acute specialist children's trusts (the category SCH comes under for this indicator).				

19. Patients readmitted to a hospital within 28 days of being discharged. (ii) 15 or over	
Unique Identifer:	P00904
Link:	http://nww.indicators.ic.nhs.uk/webview/
Source Data:	Source Data P00904

		National		
Financial Year	**%**	***Average (%)***	***Maximum (%)***	***Minimum (%)***
2010/11	10.75	*11.48*	*13.80*	*9.90*
2009/10	14.66	*12.27*	*15.13*	*8.84*
National data is based on the data for all acute specialist children's trusts (the category SCH comes under for this indicator).				

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

The Trust has a policy of giving safety net information to all parents telling them to contact the hospital if they have any concerns after discharge.

The Sheffield Children's NHS FT intends to take the following actions to improve this percentage and so the quality of its services, by:

Continuing to encourage families to contact our specialist services if they have any concerns but to review patterns to see if we can produce generic information leaflets that encompass common concerns.

21. Staff who would recommend the trust to their family or friends.	
Unique Identifer:	P01554
Link:	http://nhsstaffsurveys.com/cms/index.php?page=staff-survey-2011
Source Data:	Source Data P01554.1
	Source Data P01554.2

		National		
Year	%	Average (%)	Maximum (%)	Minimum (%)
2012	83	65	94	35
2011	84	65	96	33
National data is based on the data for all acute & acute specialist trusts (the category SCH comes under for this indicator).				

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

This represents an indicator of the high standards that our staff aspire to.

The Sheffield Children's NHS FT intends to take the following actions to improve this percentage and so the quality of its services, by:

To continue to work with our staff to maintain and improve the standards within our trust.

24. Rate of C.difficile infection.	
Unique Identifer:	P01557
Link:	http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/MandatorySurveillance/cdiffMandatoryReportingScheme/
Source Data:	Source Data P01557

		National		
Financial Year	Rate	Average	Maximum	Minimum
2011/12	12.2	20.6	51.6	0.0
2010/11	12.2	27.9	71.8	0.0
National data is based on the data for all trusts included in the indicator source data.				

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

The Trust has regularly reported low infection rates for C Difficile. This is due to the reduced susceptibility of children to this infection and to the high standards of infection control.

The Sheffield Children's NHS FT intends to take the following actions to improve this rate and so the quality of its services, by:

To continue to work with our staff to maintain and improve the standards within our trust.

25. Patient safety incidents and the percentage that resulted in severe harm or death.	
Unique Identifer:	P01558
Link:	http://www.nrls.npsa.nhs.uk/resources/
Source Data:	Source Data P01158.1
	Source Data P01158.2
	Source Data P01158.3

		National		
Period	**Rate per 100 patient admissions**	***Average***	***Maximum***	***Minimum***
Apr 12 -Sep 12	8.34	*7.5*	*24.88*	*1.37*
Oct 11 - Mar 12	10.04	*8.4*	*21.71*	*2.72*
National data is based on the data for all acute specialist trusts (the category SCH comes under for this indicator). The data available for April 2011 - September 2011 is not split at this level so would not be comparable with the more recent data.				

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

The Trust is close to average for this group but feels that the grouping itself should be restricted to specialist children's trusts to give a more accurate benchmark.

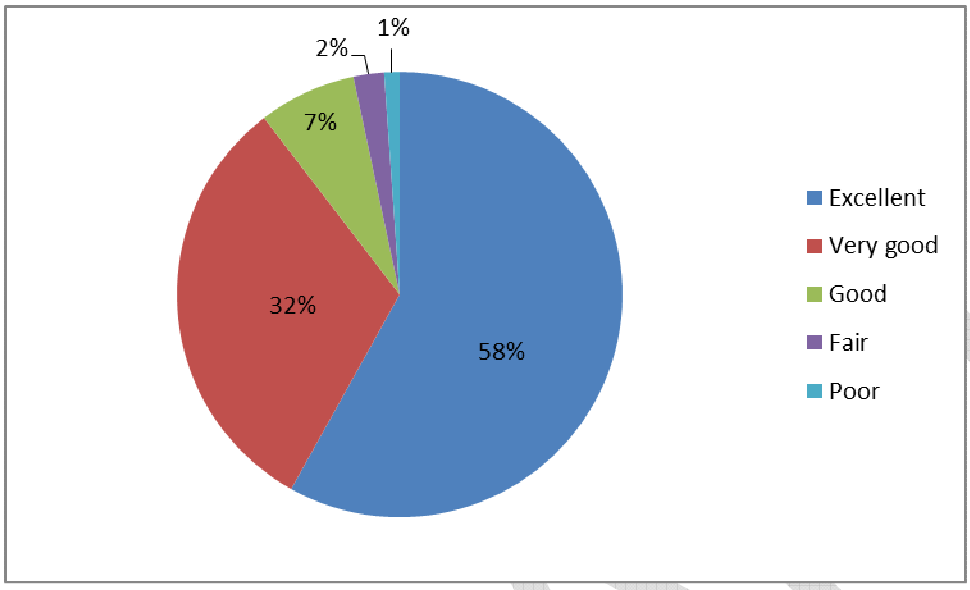
The Sheffield Children's NHS FT intends to take the following actions to improve this number and/or rate and so the quality of its services, by:

To be open with families and carry out root cause analysis on all such incidents, enabling learning from the outcomes reported.

2.3 Patient Experience

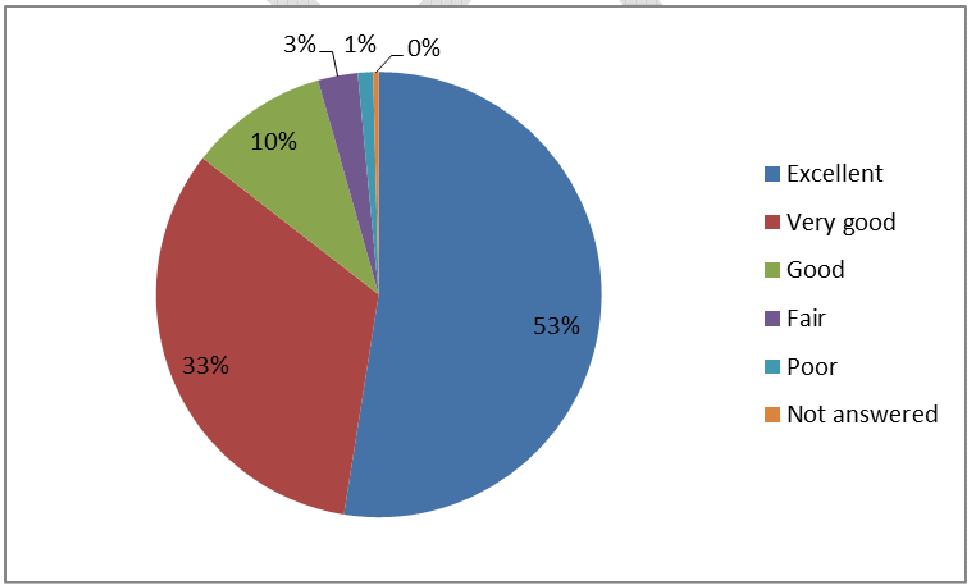
2.3.1 OUT-PATIENT SURVEY 2013-14

The 2013-14 Out-patient Survey of 850 families (31.9% response) showed that the majority of our clinic patients ranked their care well:



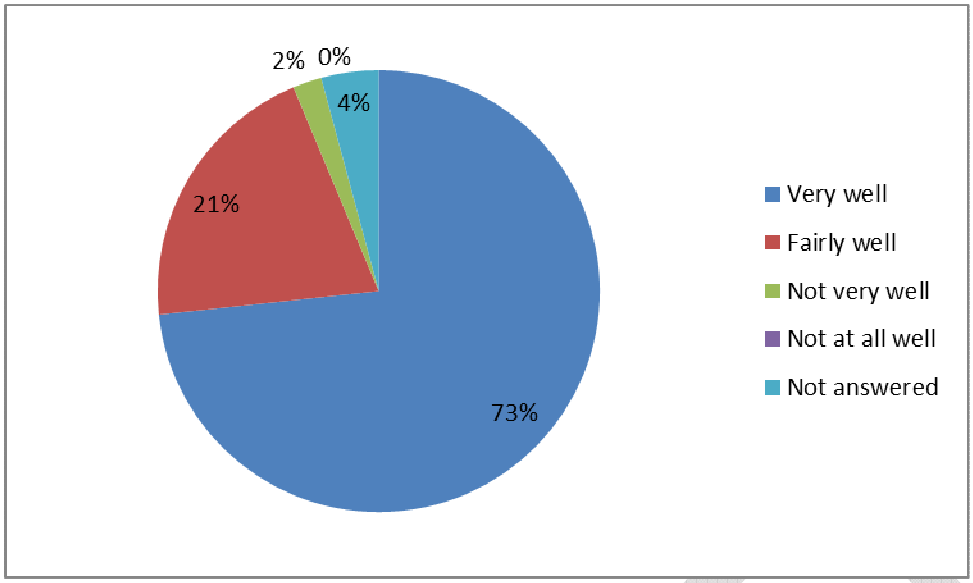
2.3.2 IN-PATIENT SURVEY 2013-14

The 2013-14 In-patient Survey of 850 families (32.7% response) showed that the majority of our ward children and parents ranked their care well:



2.3.3 A&E PATIENT SURVEY 2013-14

The 2013-14 A&E patient Survey of 850 families (30.3% response) showed that the majority of our patients ranked their care well:



All surveys demonstrated that the Trust was significantly better than their peers on many indicators and worse on very few. Chief problems were with access, car parking and the facilities. We intend that our building plan will improve all of these issues over the next three years.

Comments included:

- Excellent system being seen in an A & E clinic, thorough assessments and confidence in diagnosis and decision.
- The hospital staff were very supportive and made me feel I wasn't wasting their time because of my sons allergy.
- As the nurse was putting butterfly stitches on and then gluing the cut on her head I began to faint and felt sick and I kept apologising but the nurse talked me through it, telling me to take deep breaths as she carried on dealing with Xxxx's cut.
- The staff were very polite and understanding, my son's injury had occurred the day before and I hadn't realised how bad it was. The doctors said this was understandable and reassured me that I had done the right things.
- Yes, all I can say is the nurses at SCH and doctors are absolutely outstanding, they cannot do enough for us. They are fantastic!! A big Thank you to them all
- The resources toys on day care were excellent and well stocked. My daughter loved them. Occupied her mind. Also the porter who took us down did an amazing job. He had a laugh and a giggle with my daughter and was trying to relax us all. Thank you.
- Xxxxx was on emergency visit to SCH and had to have an operation. She stayed in 5 days. Despite all the stress and scare for a young child being in hospital, at the end she wanted to stay few more days! I believe that says it all, how she as been looked after. Every single person who has been involved in her treatment, from ward nurses, name removed doctors, theatre and recovery staff, everybody was highly professional and with care and empathy.

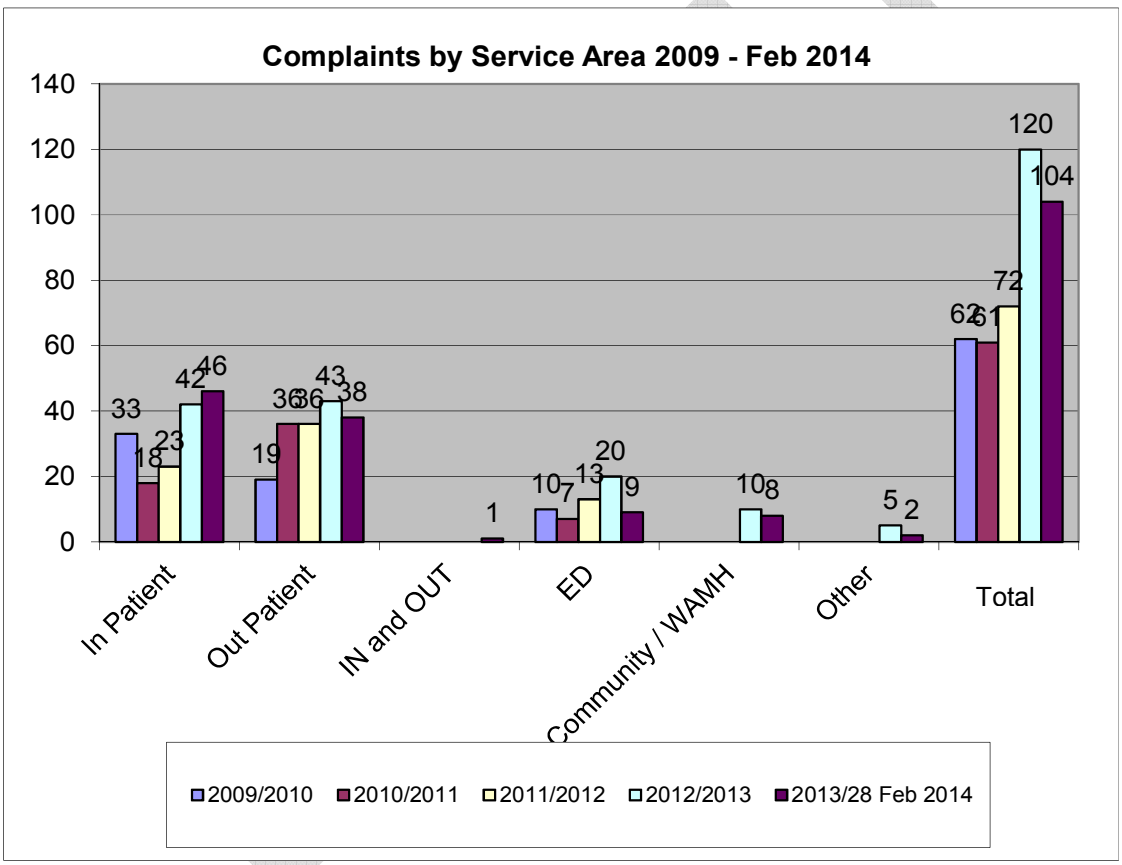
2.4 Complaints

During the financial year 2013-14, a total of 104 formal complaints were received as at 31 March 2013. The rate of complaints is set out in the following table:

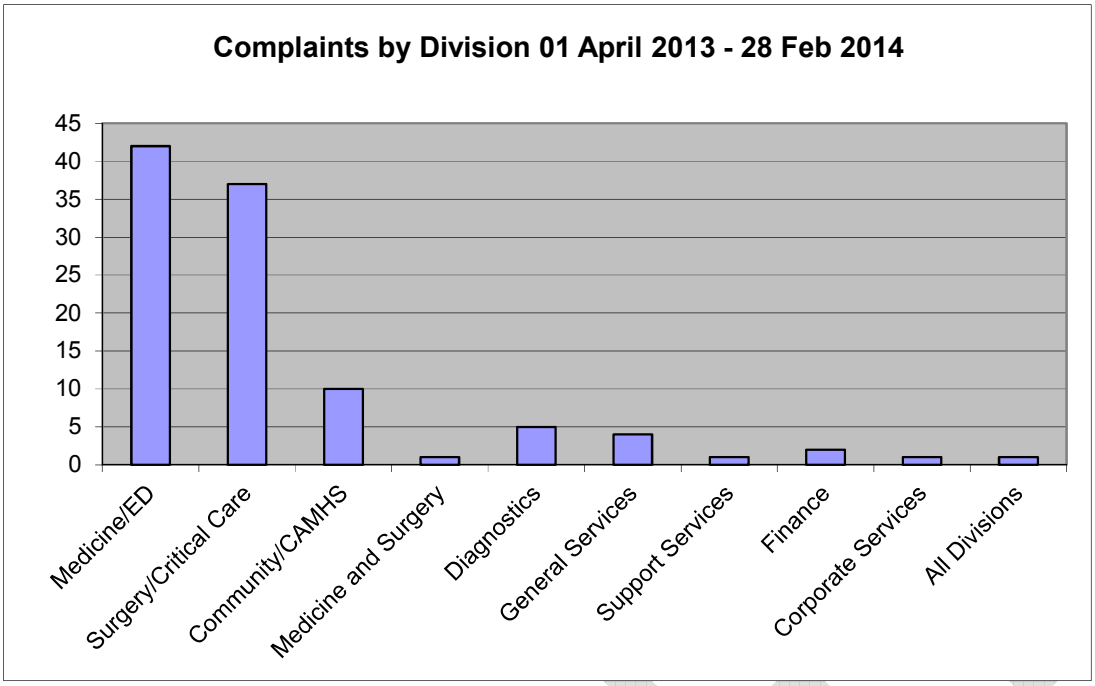
Year	Episodes of care	Complaints	No of complaints per 10,000 episodes
2004 - 2005	131,162	60	4.57
2012 - 2013	187,667	120	6.39
2013 - 2014	XXXXX	104	XXXXX

. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**

Further analysis shows the following are the main services receiving complaints:



. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**



. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**

2.4.1 REASON FOR THE COMPLAINT

Complaints are coded according to national coding descriptions:

Type of Complaint	No.
Care and treatment	43
Appointments/delay/cancellation	17
Attitude of staff	21
Transfer/admission arrangements	4
Lack of communication/information	10
Medical Records	1
Car parking	1
Breach of confidentiality	2
Privacy & dignity	1
Consent to treatment	2
Equipment	1
Other	1

. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**

In addition 2 complaints were also made to other health care organisations and the Trust is assisting these organizations in their responses.

The main types of complaint received in the 'care and treatment category are as follows:

. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**

Many of these complaints have several elements but there are recurrent themes that the complainants are not satisfied with:

. **CANNOT UPDATE UNTIL END OF FINANCIAL YEAR**

2.4.2 LEARNING FROM COMPLAINTS

Although there are some complaints which we cannot do anything about, we take the view that the need to make a complaint demonstrates a failure in communication of our services. If a child experiences known complications of a treatment then it should not come as a surprise to the family; if a family is subject to delays then these should be reasonable and the family should have a right to be warned about them.

Some of the complaints which were made include:

Examples of complaints

- Antibiotics not prescribed for a viral illness.
- Tests cancelled due to prior emergency admissions.
- Poor communication during long wait to be seen.
- Parental and patient disagreement with diagnosis.
- Delay in diagnosis.
- Dissatisfied with outcome of surgery.
- Incorrect information given in referral letter to another Trust.
- Poor planning of transfer to Leeds Hospital for surgery.
- Unhappy with the way in which General Office dealt with parent's travel claim
- Breach of confidentiality - Complainant could hear Support Worker discussing her on a telephone.
- Post-operative complication occurred which parent feels was not explained during the consent process.

The following describes some changes in practice as a result of lessons learnt following complaints:

- Relocate Waiting List Co-ordinator to be with the surgical secretaries to improve communication and relay of messages between clinical and administration staff.
- Information should be verified with parents before letters written - will do this in future.
- Patients will not be transferred to Leeds for PDA ligation unless an overnight bed is available post operatively. Main Embrace SOP amended to add day case PDA transfers to list of exclusions.
- General office will discuss with staff ways of making parents more aware of the possible financial help which can be offered in certain circumstances. Supervisor to liaise with PALS regarding a possible notice board outside the cashier's office.
- Staff member to undertake refresher course on Information Governance regarding patient confidentiality.
- One risk of a procedure was very low therefore not mentioned at the consent process. Following discussion at M&M meeting, parents will be warned about this potential complication in future.

2.4.3 REFERRALS TO THE OMBUDSMAN

During the last financial year, a total of 2 complainants referred their complaint to the Parliamentary and Health Services Ombudsman (PHSO).

Ref	Division	File to PHSO	Summary of Complaint	PHSO decision
COM50	Medicine	Feb 2012	Lack of information provided to parent on admission resulting in unexpected weekend inpatient stay while parent taught home care skills.	Parent awarded £500 in recognition of injustice of loss of confidence and upset and distress caused by handling of complaint. Action plan to be produced to avoid recurrence of failings. PHSO case now closed
COM82	Medicine	March 2012	Safeguarding procedures initiated due to persistent use of alternative remedies against medical advice.	PHSO dermatology expert produced report criticising the clinician's stance on the matter. The Trust challenged the report and the case has been transferred to the PHSO Complex Investigations Department for further work – awaiting response.
COM103	Surgery and Critical Care	December 2013	Alleged fractured caused whilst removing plaster cast.	Awaiting decision
COM252	CAMHS	October 2013	Patient seen by Sheffield CAMHS several years ago and discharged. Family moved away from Sheffield and was subject to 'grooming' by an older male. Complainant alleged that patient should not have been discharged by Sheffield CAMHS.	PHSO report – 'The care provided by the Trust was reasonable and there was no service failure'. Case closed
COM 50	Medicine	February 2012	Lack of information provided to family	Awaiting decision

2.5 Potential Serious Untoward Incidents

During the last financial year 2013-14, the Trust reported **9** Potential Serious Untoward Incidents.

- Breach of national Epilepsy Surgery Specification Model: epilepsy surgery undertaken on a patient aged five years, according to the specification model surgery on patients aged five years and under should be performed at one of the National Children's Epilepsy Surgery Services (CESS).

    - The Trust will in future adhere to the Epilepsy Surgery Specification Model.

- Unintended variation to a procedure: a surgical procedure was undertaken on a patient, the technique used was different from that consented.

    - The type of surgery to be undertaken to be documented in full, all relevant staff to be present at surgical team briefings.

- Failure to document full written consent for treatment: Removal of milk teeth to remove risk to a patient's airway during general anaesthetic, this had not been fully documented during the consent process.

    - Full written consent to be documented, consent audit to be undertaken.

- Young person attempted self-harm: A day patient left the hospital site and obtained and ingested a quantity of paracetemol from local shops.

    - Upgrading of site including anti-climb paint and additional cameras showing grounds. Meeting held with local police to strengthen joint organisation working arrangements.

- Communication issue: The Health Visitors were notified of a patient new to the city and requiring the offer of a new blood spot testing. This was not communicated within the team effectively and the offer was missed, although it was confirmed the test had been previously provided in the USA.

    - Blood Spot Protocol reviewed and amended, improved communication through various alerts put in place by Health Visiting and Child Health.

The following investigation reports have yet to be approved by the SCH Risk Management Committee:

- Breach of national Audiology targets. Waiting time for hearing tests unintentionally exceeded.

- Unintentional drug error and failure to notify coroner.

- Patient death following two previous A&E attendances..

- Accidental extubation of patient, whilst undertaking emergency stabilisation and transfer to regional intensive care unit.

Reports relating to the Serious Untoward Incidents are shared with the relevant Manager and Clinical Director or equivalent in addition to being presented at the Risk Management Committee. Following the Risk Management Committee and in order to facilitate organisational learning, the reports are discussed at each Directorate Board meeting with any recommendations being monitored through the Risk Management Committee.

All Potential Serious Untoward Incidents are subject to a root cause analysis and the result shared with the Risk and Audit Committee.

3 OTHER INFORMATION

The trust set a number of quality indicators to be monitored during 2013-14. Our performance is set out below:

3.1 Patient Safety

Patient Safety AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	PERFORMANCE 2011/12	ACHIEVEMENT 2012/13	ACHIEVEMENT 2013/14
Infection Control **Maintain levels of MRSA and C Difficile infection within Monitor Thresholds for best practice.**	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132045.pdf pp 64 and 68	MRSA: 0 Cases C Difficile: 3 Cases	MRSA 0 Cases C Difficile 8 Cases	MRSA 0 Cases C Difficile 4 Cases
Never Events **The Dept. of Health has published 25 Never Events for 2012-13. These are serious incidents that should never occur in a safe hospital.** **The Trust will do a gap analysis against these and report on progress quarterly.**	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132352.pdf	Nil events	Nil events	Nil events
Management of Aggression **Management of children and young people in Child and Adolescent Mental Health in a safe and secure environment.** **Staff should be trained to a national standard appropriate to the psychiatric speciality and risk assessment.** **Individual risk assessments**	http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/NHS_SMS_Workplace_Safety_Report_FINAL_MERGED.pdf p29	Violence and aggression incidents graded moderate: 149	24 Incidents	xx Incidents

Patient Safety AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	PERFORMANCE 2011/12	ACHIEVEMENT 2012/13	ACHIEVEMENT 2013/14
should be up to date.				

These initiatives all addressed key areas of child safety. Infection control is a high priority for acute hospitals and is a difficult area to control in children and neonates, who are particularly susceptible to infection. We have increased the time available to our Director of Infection Prevention and Control and Infection Control Nursing team, to ensure that there is a continuous onsite presence, 52 weeks per year.

The Trust is still within the safe level of 12 cases per year specified by Monitor for all trusts, since all were isolated cases. Monitor accepts that results below that level will fluctuate for reasons beyond the control of hospitals.

The DH Guidance on Never Events is designed to protect patients from the 25 events named by the guidance. Events that lead to death or severe harm include: wrong site surgery, wrongly prepared high-risk injectable medication, transfusion of ABO-incompatible blood components and misidentification of patients. I am pleased to record that there were no Never Events recorded by the Trust in that period.

Child and Adolescent Mental Health has seen an increase in the numbers of young people referred and an increase in the numbers of young people in crisis. This often manifests itself in violent behaviour, frequently directed at staff. The Trust has committed to reviewing the service design of CAMHS In patient care in conjunction with commissioners.

3.1.1.1 Proposed New Indicators 2014-15

- Compliance with CQC paediatric standards due for publication 31 March 2014. Three patient safety indicators to be selected.

3.2 Clinical Effectiveness

Clinical Effectiveness AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	PERFORMANCE 2011/12	ACHIEVEMENT 2012/13	ACHIEVEMENT 2013/14
Achieve compliance with agreed national standards for Safe and Sustainable Paediatric Neurosurgical Services	http://www.specialisedservices.nhs.uk/library/31/Developing_the_Model_of_Care.pdf	New Standard under national development	National standards still under development. Self assessment indicates compliance with provisional standards.	For update
Achieve compliance with agreed national standards for children's major trauma. As set out in the NHS Operating	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalass	New Standard under national development	Report indicates compliance with some areas for medium term improvement related to:	For update

Clinical Effectiveness AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	PERFORMANCE 2011/12	ACHIEVEMENT 2012/13	ACHIEVEMENT 2013/14
Framework.	et/dh_133585.pdf p76.		24 hr consultant presence in A&E., Rehabilitation space, data returns and proximity of core interventional radiology specialities. Peer Review 12 March 2013	
Achieve compliance with agreed national standards for best practice in children's diabetes	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133585.pdf p59.	New Standard under national development	Attainment of compliance. Peer Review 24 Feb 2012	For update

These indicators are based upon nationally identified patient quality indicators. The three areas impact on core services for families in Sheffield and South Yorkshire. The Safe and Sustainable Standards for Neurosciences and consequent peer assessment are still being agreed.

3.2.1.1 Proposed New Indicators 2014-15

- Compliance with CQC paediatric standards due for publication 31 March 2014. Three clinical effectiveness indicators to be selected.

3.3 Patient Experience

Patient Experience AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	PERFORMANCE 2011/12	ACHIEVEMENT 2012/13	ACHIEVEMENT 2013/14
Initiate 850 patient postal survey of experience in children's A&E **Tool should record child and parent experience**	No child specific national tool available Commission tool in conjunction with other hospital Children's Services	Not available – new survey	Completed Problem scores worse than peer average: Waiting area not clean Not enough for child's age group	Completed http://www.sheffieldchildrens.nhs.uk/Patient-views.htm No problem scores worse than peer average.

Patient Experience AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	PERFORMANCE 2011/12	ACHIEVEMENT 2012/13	ACHIEVEMENT 2013/14
			to do when waiting	
Complete an 11 bedded Home from Home for resident parents of children in Critical Care. **Work with the Sick Children's Trust to ensure that parents' needs are reflected in design.**	Poor performance against resident parent facilities scores: p3 http://www.sheffieldchildrens.nhs.uk/Downloads/Patient%20views/Inpatient%20Survey%20Results%202011%20pdf.pdf	Facilities for parents staying overnight rated as fair/poor 25%	The Home from Home was not available during the survey and accordingly the result remains at 28%. The facility is currently under construction and should be complete by 2013.	Completed November 2013
Ensure that family needs are reflected in design and working practices associated with new hospital Out-patient and In-Patient facilities being built from 2012 - 2015	No child specific national tool available	Patient surveys have reported on existing practices and facilities rather than what parents and children want.	University of Sheffield has been contracted to carry out focus group research this year with families and staff. Research findings will be published to advise new ways of working in late 2014.	University of Sheffield field work underway.

The Trust has largely based its capital building plan on family feedback. The needs expressed in the annual surveys have informed the access, way finding, clinic environment, ward facilities, resident parent facilities and working practices of the new hospital wing.

3.3.1.1 Proposed New Indicators 2014-15

- A&E Survey to be replaced with 2014 Neonatal Survey – target no problem scores greater than peer average.
- Home from Home target to be replaced with Health Visitor survey action plan based upon 2014 result – resurvey in 2015. – target no problem scores greater than peer average.

3.4 National Staff Attitude Survey

Introduction

3.4.1 SUMMARY OF PERFORMANCE

CANNOT UPDATE UNTIL END OF FINANCIAL YEAR

3.4.1.1 Response rate

2011		2012		2013	
Our Trust	National average	Our Trust	National average		
47%	53%	40%	52%		

3.4.1.2 Top five ranking scores[2]

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

[2] *These scores are the five key findings from the staff attitude survey where Sheffield Children's NHS Foundation Trust compares most favourably with other acute specialist trusts in England*

3.4.1.3 Bottom five ranking scores[3]

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

Question

2011		2012		2013	
Our Trust	National average	Our Trust	National average		

3.4.1.4 Key areas of improvement

ANNEX A. STATEMENT OF DIRECTORS RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the

[3] *These scores are the five key findings from the staff attitude survey where Sheffield Children's NHS Foundation Trust compares least favourably with other acute specialist trusts in England*

arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013-14;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2013 to June 2014
    - Papers relating to Quality reported to the Board over the period April 2013 to June 2014
    - Feedback from the commissioners dated
    - Feedback from governors dated
    - Feedback from Local Healthwatch organisations dated
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, entitled Risk Management Annual Report, April 2014
    - The In-patient survey 2013-14
    - The Outpatient Survey 2013-14
    - The national staff survey 2013-14
    - The A&E Survey 2013-14
    - The Head of Internal Audit's annual opinion over the trust's control environment dated
    - CQC Hospital Intelligent Monitoring dated

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

4 ANNEX B. CONSULTATION IN THE PREPARATION OF THE QUALITY REPORT

A number of staff, families and organisations were involved in the consultation process to produce this report and the Trust is grateful for the time and effort of all who have contributed. The final version has tried to accommodate the comments received or the minutes of the meetings at which it was discussed but it is accepted the production of the report is ultimately the responsibility of the Board of Directors.

4.1 Consulted Agencies or Groups:

4.1.1 SHEFFIELD CLINICAL COMMISSIONING GROUP

The first draft report was provided to NHS Sheffield on xxxx.

4.1.2 SHEFFIELD HEALTH WATCH

The first draft report was provided to Health Watch on xxxx and a meeting was held with key members of Health Watch and the Director of Nursing and Clinical Operations on xxxx . The following response was received:

4.1.3 YORKSHIRE OVERVIEW AND SCRUTINY COMMITTEE

The first draft report was provided to the South Yorkshire Oversight and Scrutiny Committee on xxxx. The Director of Nursing and Clinical Operations attended the Committee on xxxx. The following response was received:

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4.1.4 COUNCIL OF GOVERNORS SHEFFIELD CHILDREN'S NHS FT

The first draft report was provided to the Governors on xxxx. The draft was the subject of a discussion on xxxx between the Director of Clinical Operations and the Council. The attached is an extract from the minutes of the meeting.

Extract from the draft minutes of the Council of Governors meeting.
Draft Quality Report xxxx

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SHEFFIELD CITY COUNCIL

Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee 19th March 2014

Report of:	Director of Public Health
Date:	Wednesday 19th March 2014
Subject:	Public Health Investment 2014-15
Author of Report:	Director of Public Health

Summary:

The ring fenced public health grant increases from £29.6 to £30.7 million in 2014/15. The additional £1.1million, together with approximately £1.6million of savings on existing contracts and deletion of vacant public health posts makes approximately £3.9million of funding available for new projects in financial year 2014/15.

Approximately £23.5million is to be spent on continuing public health programmes already in place. Some of these are statutory. An additional £2.1million is to be spent in the communities and CYPF portfolios on programmes which were previously funded within the portfolios by revenue funding, but which are vulnerable due to a reduction in overall council resources.

Approximately £1.3million is being spent on a variety of new programmes including early intervention and prevention in children (with a mental health and wellbeing focus), promotion of physical activity (cycling and the Move More Strategy), improving standards of private rented sector housing and employment and health initiatives.

The Scrutiny committee is being asked to review the proposed use of the public health grant for 2014/15.

Category of Report: **OPEN**

Use of the Public Health Grant in 2014/15

Background and context

Public health responsibilities transferred from the NHS to local government in April 2013. At the same time, funding was transferred from the NHS to local authorities in the form of the Public Health Grant, in order to ensure that those authorities had the resources necessary to fulfil their new responsibilities. The purpose of this paper is to provide a summary of the planned use of the Grant in financial year 2014/15, as agreed by Cabinet in February and full Council in March.

The public health Grant is ring-fenced for public health purposes. It has been announced it will be ring fenced for a further year beyond the initial 2 years, ie for 2015/16. In future years the amount of the ring fenced Grant will be dependent on progress made in improving public health outcome framework (PHOF) indicators, though the exact way in which the amount of the public health Grant will be related to those indicators has not yet been determined.

A number of principles concerning the use of the Grant were agreed by EMT as follows.

The Grant would be used to support the City Council's Strategic Outcomes and the decision process would be aligned with all other budget decisions. Any savings made on programmes previously funded through the Grant, including savings released if services are decommissioned altogether, would not revert to Portfolio budgets. Any such savings would be considered as part of the overall unallocated PH Grant funding, and so become available to commission public health services to meet Members' priorities, which may be through other Portfolios or the DPH office. Overall, the Grant should be used to maximum public health benefit, which again could indicate transfer of public health resource between Portfolios.

Planned use of the Grant

Resources available
The Public Health Grant will increase from £29.665M in 2013/14 to £30.748M in 2014/15, an increase of £1.083M. It has been assumed that external income to support specific PH Programmes will continue at the same level in 2014/15 as in 2013/14. If this is not the case, the funding available for those specific programmes will have to be reduced on a pound for pound basis. Overall, the total amount assumed to be available to spend on PH Programmes, made up of the Grant and external income, in 14/15 is £31.721M, as shown in table 1.

Table 1

Available Resources	**£K**
Dept of Health Grant	30,748
Other external Income -	

Clinical commissioning group	200
Police and Crime Commissioner	551
Probation	80
SCC revenue funding for drugs and alcohol work	142
	31,721

Savings made

Savings to the value of £1.58M have been made on this year's spend on PH Programmes by a combination of reductions in contract values and a discontinuation of some programmes altogether, as shown in table 2. The recommissioning of drug and alcohol dependency treatment services, now in train, will release further savings in future years. DESMOND (diabetes education), and Community Dental Treatment have been paid for this year (2013/14) by the Council using the Grant, but in fact are NHS responsibilities, and will therefore not be paid for by SCC out of the Grant in future.

Table 2

Savings made on 13/14	£K		
	13/14	14/15	savings
Sexual health Sheffield Teaching Hospitals	5557	5337	220
Sexual Health - primary care	244	200	44
Drugs and alcohol treatment programmes	8080	7548	532
Children and young people substance misuse	413	383	30
Health Checks	600	500	100
Healthy Communities Programme	526	273	253
DESMOND	73	0	73
Community Dental Treatment	270	0	270
Sickle Cell and Thalassaemia support	58	0	58
Total			**1580**

Staffing and vacancies

There have been a number of vacancies in Public Health teams during the course of this year. Whilst a small number are now being recruited to, others are being held pending the outcome of restructuring (in Communities) and rationalisation of posts (in CYPF). Nevertheless it is clear that there are a number of posts which will not be recruited to and can be deleted from the establishment, thus releasing funding. Posts to be deleted include one health improvement principal post in CYPF, a consultant in public health and PA in the Communities portfolio, and an administrator post in DACT (Communities). In addition, the significant downscaling of the *Healthy Communities* team will also lead to a number of vacant posts being deleted, and a further reduction in staff costs. Overall this releases approximately £550K funding.

Cost pressures
Unavoidable cost pressures for 14/15 included an assumed 1% cost of living increase for staff, and the cost of drug prescribing associated with sexual health and contraceptive services, which this year has been paid for by the CCG, but which is SCC's responsibility and will have to be picked up in future years.

Considerations
In determining how the Grant should be used in 2014/15, the following factors were taken into consideration.

There are a small number of statutory obligations on the Council, that have to be funded from the Grant. These are the provision or commissioning of sexual health services, the health checks programme, the national child weighing and measuring programme (NCMP), and the provision of the 'core offer' of public health advice to NHS commissioners. This last is provided by Council employed public health staff. These costs are thus unavoidable.

In addition to this, there are some contractual commitments already entered into, that run through financial year 2014/15, such as the Carers' support and Carers' respite contracts.

There are also some programmes for which there is a very clear need, and the stopping of which would undoubtedly cause significant adverse health consequences. These include the drug and alcohol treatment programmes, weight management, and tobacco control programmes.

Elected members had reviewed the Healthy Communities Programme earlier in the year and determined a new balance of expenditure, with a more explicit focus on building social capital and a reduction in directly employed staff numbers. This was approved at Cabinet in October.

For other proposals, including proposals to continue existing programmes or to use Public Health Grant money to pay for programmes previously funded from within Portfolios, as well as any proposals for new activity, a simple cost effectiveness score was calculated. This took into account the amount of health benefit (number of people affected, extent of improvement in health, duration of effect), strength of evidence base, fit with members priorities, and cost. This was then used to inform (but not determine) the decision making.

Use of the Grant
It has been determined that the Grant will be used as shown in table 3. Overall, approximately £23.5M is to be spent on programmes continuing from this year, though the actual amount spent on each programme will not necessarily remain the same.

An additional £2.1M is to be spent in CYPF and Communities on programmes which prior to April 2013 were funded by the Portfolios themselves, bringing the total up to approximately £4.2M.

Approximately £1.1M is to be spent on a number of new programmes aimed at addressing the root causes of ill health, consistent with the social model of health

adopted by Cabinet. If the additional investment in existing programmes is added to this, it gives a total of approximately £1.3M worth of new activity. This represents the beginning of a re-shaping of the overall public health programme, consistent with the Council's ambition to 'do things differently' and become a public health driven organisation, whilst maintaining our efforts to improve the Public Health Outcomes Framework indicators and thus mitigate the risk of loss of PH Grant value in future years.

Table 3

Programmes continuing from previous years

Programme	Portfolio	£K	Notes
Sexual health services	CYPF	5,337	Statutory
SH - enhanced services	CYPF	200	Statutory
GUM and contraceptive services outside Sheffield	CYPF	170	Statutory
SH and contraceptive prescribing	CYPF	270	Statutory
CYP substance misuse services	CYPF	383	
Sexual Health outreach (SWWOP)	CYPF	56	
Support to Young Carers	CYPF	55	
School nursing	CYPF	1831	Includes statutory National Child Weighing and Measuring (NCMP) programme
Family Nurse Partnership	CYPF	160	
Community genetics awareness	CYPF	35	
Subtotal		**8,497**	
Tobacco control	Place	1,480	Contracts to be let for 3 yrs from April '14
Adult weight management	Place	685	Being re-specified and retendered during 14/15 with 3 year contracts
Children's weight management	Place	224	Being re-specified and retendered during 14/15 with 3 year contracts
Activity Sheffield	Place	400	Second year of two year commitment (13/14 & 14/15)
Upperthorpe Healthy Living Centre (food work)	Place	70	
Air quality monitoring (East End Quality of Life)	Place	55	
Subtotal		**2,914**	
DACT drug treatments	Comms	4,836	Programmes being retendered during the course of the year
DACT alcohol treatment	Comms	737	Programmes being retendered during the course of the year
DACT - Community pharmacies	Comms	321	
DACT - Police team for Drugs Intervention Programme	Comms	149	
Drug interventions programme	Comms	1,410	Contribution of £551K from Police and Crime Commissioner to this
Healthy Communities	Comms	273	
Social Capital'	Comms	290	
Health trainers	Comms	308	Contribution of £200K from Clinical Commissioning Group for this
Health champions	Comms	185	
Carers' support	Comms	210	Contracts let to Sept '15
Carers' respite	Comms	110	Contracts let to Sept '15

Substance misuse (residential rehabilitation)	Comms	350	
Hidden Harm - Safeguarding	Comms	40	
Mental ill health prevention	Comms	125	
Find and Stay in Employment - Bridge	Comms	50	
Employment Support - MH Problems – First step trust	Comms	106	
Mental Health Support to the Somali Community	Comms	73	
Support to Chinese Community – Kin Hom	Comms	55	
Magazine for Mental Health Service Users	Comms	20	
Advocacy for Older People with Mental Health Problems	Comms	34	
Infrastructure support to Third sector	Comms	61	
Private housing standards initiative	Comms	500	£175K increase over current budget
Subtotal		**10,243**	
Health Checks	DPHO	500	Statutory
Community infection prevention and control service	DPHO	90	Statutory
Occupational Health - SOHAS	DPHO	102	
Oral health promotion	DPHO	150	
Subtotal		**842**	
Subtotal, continuing activity		**22,496**	
Funding of programmes previously funded by Portfolios using mainstream revenue grant (with some contribution from PHG)			
Early years	CYPF	1950	£554K increase
Floating support	Comms	2275	£1,560K increase
New investment to address root causes of ill health, consistent with the 'social model'			
Early intervention and prevention (mental health and wellbeing)	CYPF	400	
CAMHS training capacity	CYPF	50	
Cycling opportunities	Place	50	
Move more	Place	55	
Cheap and illicit tobacco and alcohol enforcement activity	Place	97	
Eat well campaign	Place	100	
HENRY (Healthy Eating and Nutrition for the Really Young)	Place	60	
Employment and health work with young people	DPHO	200	
Employment and disability initiative	DPHO	80	
Subtotal new investment		**1092**	

DACT = Drug and alcohol commissioning team

DPHO = DPH office

SOHAS = Sheffield Occupational Health Advisory Service

Impact on Portfolio budgets
The allocations as proposed include additional sums for Portfolios, as follows.

For CYPF, there is an additional £554K funding for early years work, to replace funding that was previously available from within the Portfolio. In addition there is an additional £450K allocation for new initiatives (mental wellbeing and emotional resilience, and CAMHS training). This gives a total of £1004K.

For Place, there is an additional £362K, all on new initiatives.

For Communities, there is an additional £1560K approximately available for 'Floating support', again to replace funding that was previously available from within the Portfolio. (The total is £2275, but this includes approximately £710K of funding that was previously allocated to specific budget lines within that overall programme.) There is also an additional £175K for work on private sector housing, which will be used to secure new activity – i.e. it is not simply replacing Portfolio funding. The overall increase in funding to Communities is therefore £1740K approx..

Overall, of the approximately £3.9M funding available for new projects next year (of which £1.1M comes from the increase in the Grant, £2M comes from savings on existing budgets, and £0.8M comes from carry forward of unallocated spend this year), £2.1M would go to replace mainstream revenue funding within Portfolios, £340K would go on cost pressures of various sorts, and £1.3M would go on new programmes and initiatives.

Jeremy Wight
Director of Public Health
March 2014

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
19th March 2014

Report of: Dr Jeremy Wight (Director of Public Health)

Subject: Update Report on developing a Social Model of Health/ Health Communities Review

Author of Report: Chris Shaw (Head of Health Improvement)

Summary: Following the "call in" of the report "Developing the Social Model of Public Health" and the attendance of the Head of Health Improvement and Councillor Mary Lea at the extraordinary meeting on 5/11/2013, the Committee requested that a further report be given at their meeting in March 2014, as below:

Developing the Social Model of Public Health – a follow up report was requested to include an implementation plan, targets for the work and how outcomes will be measured

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	**X**
Briefing paper for the Scrutiny Committee	
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to consider the proposals and provide' views, comments and recommendations)

Background Papers:
Cabinet report October 2013 Developing a Social Model of Public Health

Category of Report: OPEN

Report of the Director of Public Health

Progress Report on Developing the Social Model of Public Health

1. Introduction/Context

1.1. Following the "“Developing the Social Model of Public Health" and the attendance of the Head of Health Improvement and Cllr Mary Lea at the extraordinary meeting on 5/11/2013, the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee requested that a further report be given at their meeting in March 2014, as below:

- **Developing the Social Model of Public Health –** a follow up report was requested to include an implementation plan, targets for the work and how outcomes will be measured.

2. Purpose of the Report

2.1 The Scrutiny Committee called in the Cabinet Report 'Developing a Social Model of Public Health'.

2.2 The original Report provided details of a Member Task and Finish Group who developed a Social Model of Public Health based on a Model of Risk by Labonte *(1993 Health Promotion and Empowerment: Practice Frameworks. Centre for Health Promotion, University of Toronto. Issues in Health Promotion no. 3)*

2.3 Members of the Scrutiny received a presentation detailing the rationale for the model, and the consequences of adopting the model in terms of the Task and Finish Group conclusions following their review of the Healthy Communities Programmes (Community based programmes working in the most deprived third of communities in the City).

2.4 Following the presentation some specific questions were asked, particularly around the implications of the Healthy Communities Review, and the introduction of commissioning specifically for Social Capital. This report provides 4 appendices which seek to answer the questions raised by providing:-

- A written progress update on the Healthy Communities Review (Appendix I)
- A definition and examples paper on Social Capital (Appendix II)
- A summary delivery structure (Appendix III)
- A Project Delivery chart with timelines (Appendix IV)

Members will note a full outcomes and measures document for social Capital commissioning has not been provided as this has not yet been completed. It will be commercially sensitive until the commissioning specification is published.

External Factors influencing scope and delivery

Sheffield Task and Finish Group on Building Community Resilience
Running parallel but connected to this is the work by Sheffield Executive Board led by Sharon Squires and Brendan Stone (SU) where City

Partners have signed up to the concept of developing resilience in the Cities Communities and a small group are to develop a Sheffield 'understanding' of the definition. Social Capital is clearly part of the 'must haves' for individual and community resilience and it is important the Social Capital Commissioning integrates into this thinking.

Integrating Health and Social Care.
The Integrating Health and Social Care programme led by Joe Fowler (Director of Commissioning SCC Communities) and Tim Furness (CCG) includes work to prevent the need for care, and the provision of care closer to home. The Healthy Communities programmes provide resource and support to individuals who may fall within the care envelope. As such there is a question as to whether the Healthy Communities resource should be part of this overall agenda.

Review of Grants and commissioned funding to the VCF Sector
This review is currently underway. Again it is important that the Healthy Communities and social capital commissioning are done in a way which integrates seamlessly with this review.

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

3.1 The aim of the Social model implementation is to ensure maximum health impact of Public Health investment. This model reflects the Members views that Public Health is affected by factors beyond individual behaviours and seeks to better integrate this community based public health work into existing City-wide support infrastructure.

4. Recommendation

4.1 The Committee is asked to consider the implementation, the Social Capital definitions, and future proposals and provide views and comments.

Dr Jeremy Wight
Director of Public Health

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IMPLEMENTATION UPDATE FOR SCRUTINY COMMITTEE REGARDING HEALTHY COMMUNITIES REVIEW AND SOCIAL CAPITAL COMMISSIONING

MARCH 2014

BACKGROUND

As part of the Members T +F Group on Public Health a Report was submitted to Cabinet in October which agreed the "Social Model 'of Public Health and also made recommendations regarding the future of the current Healthy Communities Programme.

The implementation of this element of the report was delegated, within the report to the Director of Public Health and the Director of Health, Care and Independent Living. A small officer group was charged with delivering on their behalf. This report provides an update on progress

HEALTHY COMMUNITIES REVIEW

Delivery has been broke into 3 components:-

- Internal delivery structure and external commissioning (Public Health lead)
- Contract Management (Communities Contracts and Partnership team lead)
- Engagement (Public Health lead)

Internal delivery structure and external commissioning

- Structure and funding boundary agreed
- Structure proposals agreed
- MER launched with staff and TU late March/Early April
- Already agreed to voluntary severance for some 2 staff through the SCC corporate scheme in the Communities Portfolio. Although there may be further applications for VER/VS compulsory redundancies will be minimal.
- Interviews commence w/c May 5th
- Completion by May 12th

Contract Management

- Waiver secured from procurement for 6 months
- Notice of 6 month contract extension provided to Current HC providers
- Champions and trainers extended with current providers for 6 months
- Contract deliverables agreed within the extensions
- PH Contract, all contract management will be undertaken by Communities Contracts and Partnership Team)
- Existing contract closedowns will be undertaken June – Sept 2014

Engagement

- **Current Provider Event held in December**
- **Wider provider event held in February, results disseminated**

SOCIAL CAPITAL COMMISSIONING

Internal delivery structure and external commissioning

- Commissioning Strategy to be drafted by May
- Work underway on how to measure outputs and outcomes + community impact
- Suggesting the commissioning is broken into 'lots' across the 7 localities,
- Suggesting smaller providers work within larger providers to deliver their role within these 'lots'

Contract Management

Awaiting drafting of commissioning strategy as above

Once Commissioning Strategy confirmed Contracts will work with Commercial Services and PH Management to procure new service

Engagement

Awaiting strategy draft to arrange procurement support / information session for potential providers

APPENDIX II

HEALTHY COMMUNITIES REVIEW

UPDATE TO SCRUTINY COMMITTEE 10TH MARCH 2014

DEFINING, AND COMMISSIONING FOR SOCIAL CAPITAL

SOCIAL CAPITAL

Health inequalities arise when some people have less access than others to resources that support health and well-being. There are many risk factors which contribute to health inequalities including poverty, low educational achievement, poor environment, and lack of self-esteem and hope. These can result in lower levels of physical and mental health, reduced well-being and shorter life expectancy. Developing social capital is one way to tackle the health inequalities that result from social isolation, low levels of support and low self-confidence.

What is Social capital?

(Taken from Office for National Statistics (ONS), the Office for Economic Co-operation and Development (OECD))

'networks together with shared norms, values and understandings that facilitate co-operation within or among groups' -

The degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate co-ordination and co-operation for mutual benefit (WHO 1997)

Key aspects of social capital are:

The pattern and intensity of networks among people and the shared values which arise from those networks.

Greater interaction between people which generates a greater sense of community spirit.

The main aspects of social capital include citizenship, 'neighbourliness', social networks and civic participation

Why develop social capital?

Social capital supports the development of protective health factors which result from strong networks, good levels of support and positive relationships which help to integrate individuals and communities. These benefits include:

Increased confidence and self-esteem.

A sense of connectedness and belonging.

The ability to bring about change in your own life or in your community.

There is evidence to show that increasing social capital results in better health, higher educational achievement, better employment outcomes, and lower crime rates.' ie housed, healthy, hired and happy

Different types of social capital

Can be described in terms of different types of networks:

(i) bonding social capital – describes closer connections between people and is characterised by strong bonds, for example, among family members or among members of the same ethnic group; it is good for 'getting by' in life

(ii) bridging social capital – describes more distant connections between people and is characterised by weaker, but more cross-cutting ties, for example, with business associates, acquaintances, friends from different ethnic groups, friends of friends, etc; it is good for 'getting ahead' in life

(iii) linking social capital – describes connections with people in positions of power and is characterised by relations between those within a hierarchy where there are differing levels of power; it is good for accessing support from formal institutions. It is different from bonding and bridging in that it is concerned with relations between people who are not on an equal footing. An example would be a social services agency dealing with an individual, for example, job searching at the Benefits Agency

Examples of Outcomes to increase social capital:

Bonding	Outcomes Increased confidence. An increased feeling of personal wellbeing
Bonding measures	More connections with family + ethnic group, carers, child support + close friends Feeling of safety/ Happiness / useful
Bridging	Outcomes An increase in participation/engagement in local community outside immediate network An increase in connecting and sharing -thoughts, ideas, conversation, food capabilities
Bridging measures	Number new acquaintances – newer ones, useful ones 'contacts' organisations Doing things for other people (befriending, mentoring), meeting joining local groups
Linking	Outcomes Positive outcomes from contact with agencies - Job Centre Plus, GP, Police, Active engagement in groups addressing local issues - health, environment, poverty, safety
Linking Measures	Reduction in reactive contact with statutory agencies including demand on health and social care Gaining - jobs, volunteering , accessing training, affordable finance, credit, reduced debt, level of active involvement

FUNCTIONS AND STRUCTURE OF FUTURE PUBLIC HEALTH, HEALTHY COMMUNITIES TEAM

With these changes, from May 2014 the service will be responsible for:

- Leading and developing the work in the Healthy Communities Programme areas covering working in the most deprived areas of Sheffield. Ensure the programme is linked with other interventions and priorities in the locality including other VCF funded interventions
- Locality based working leading the Health and Wellbeing agenda across 6 locality areas.
- Working with local members, Locality and Housing teams, GPs, local communities and community leaders to deliver public health outcomes.

- Whole time equivalent locality posts to have a role for a key area of work across the city
- Engaging communities in decisions about improving health and wellbeing in their communities.
- Ensure Health Trainers service is commissioned with continued investment in Public Health staff as a management and delivery hub to govern, manage and coordinate this service. Jointly funded with CCG.
- Lead the development and implementation commissioning strategy for Healthy Communities Programme, Health Trainers, Health Champions and Practice Champions.

SUMMARY

All of these elements outlined above mean that significant change in the structure is required to:

- Create a Public Health team that is able to provide the kind of strategic and operational support that the Council will need in the future in relation to Public Health locality working.
- Enable the management, development and delivery of the work of the Community Development and Health Programme, Health Trainers and the training and development of SCC staff
- To commission the Healthy Communities Programme, Health Trainers, Health Champions & Practice Champions to increase social capital.
- Reduce costs in the staffing budget to reinvest in root causes of poor health.

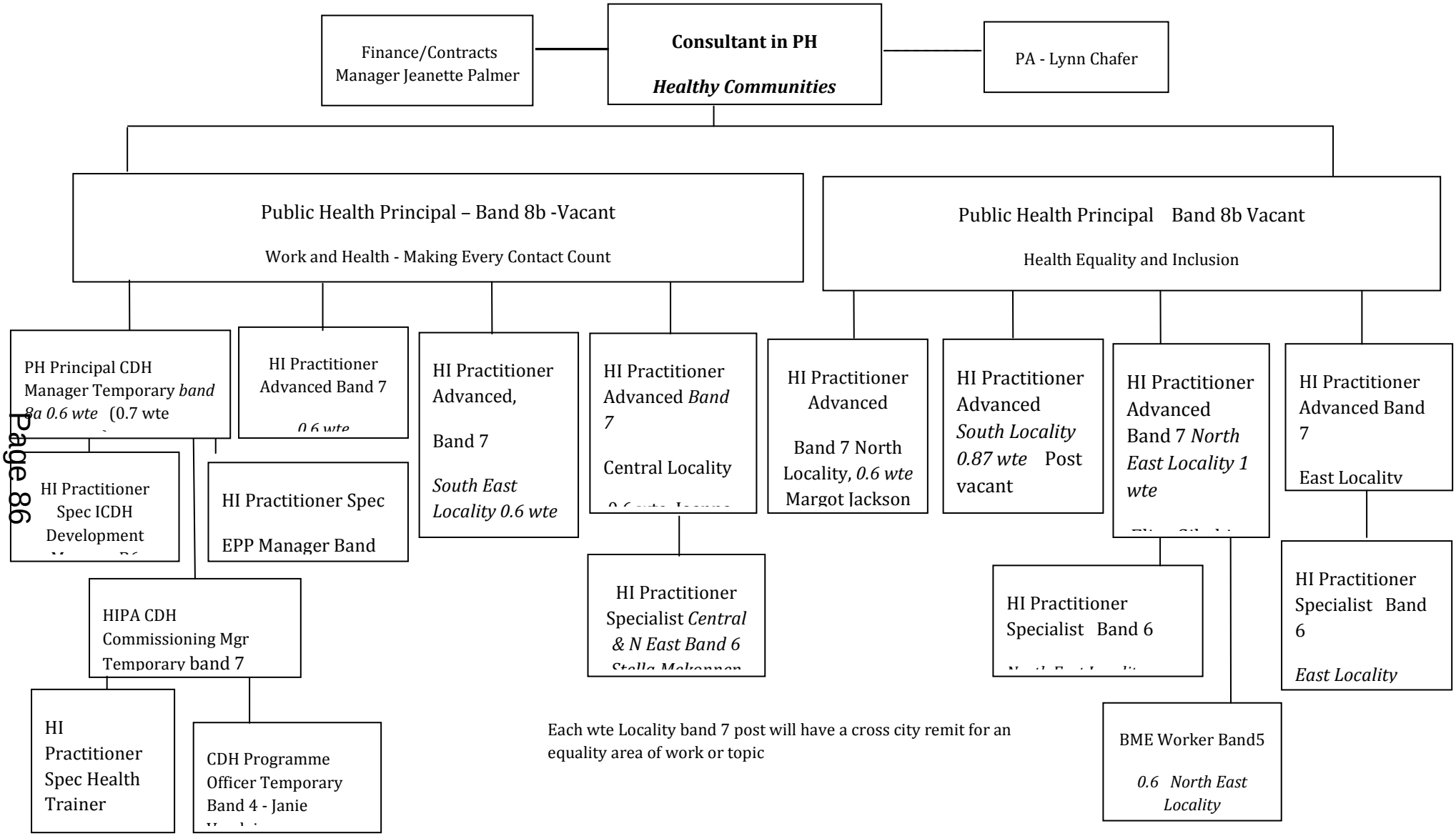
The structure attached in this document attempt to satisfy these aims.

-

IMPACT OF REDUCTION IN THE HEALTHY COMMUNITIES TEAM ESTABLISHMENT

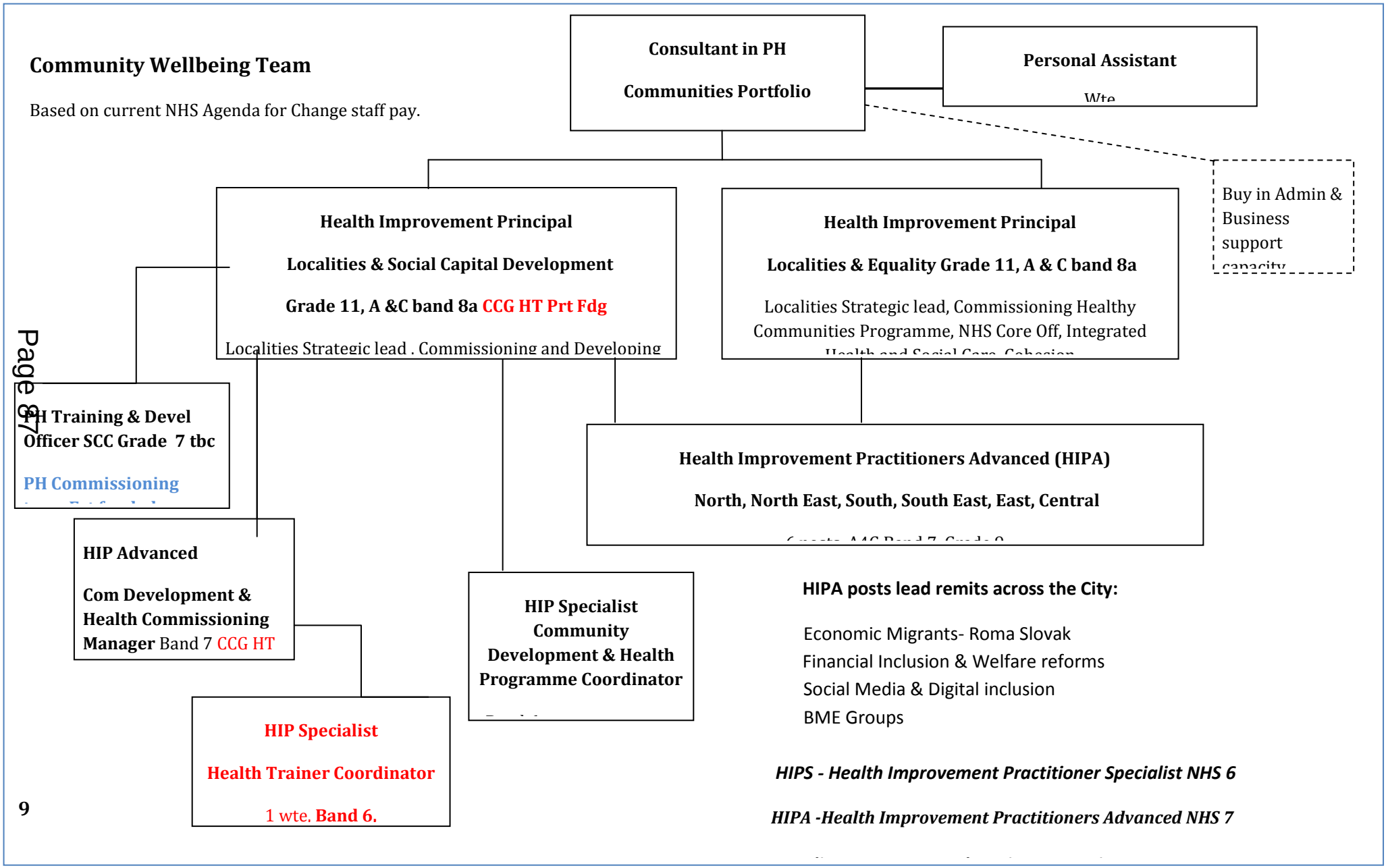
The reduction in HCP staff will mean that some work cannot continue and other areas of work will be reduced. The total number of staff in the establishment is 21. This will be reduced to 13 staff (including the new PH training post), the impact of this will be spread across the localities and partnership operation, but this proposal seeks to minimise this impact by using the existing commissioning capacity in Communities instead of internal capacity within the Healthy Communities team, creating some capacity in the key areas seen by the Task and Finish Group, and also retaining existing capacity in some key partnership areas such as the Health trainers and Health Champions.

Appendix 1- Healthy Communities Structure Current Establishment


Finance/Contracts Manager Jeanette Palmer
Consultant in PH
Healthy Communities
PA - Lynn Chafer
Public Health Principal – Band 8b -Vacant
Work and Health - Making Every Contact Count
Public Health Principal Band 8b Vacant
Health Equality and Inclusion
PH Principal CDH Manager Temporary band 8a 0.6 wte (0.7 wte
HI Practitioner Advanced Band 7
0.6 wte
HI Practitioner Advanced, Band 7
South East Locality 0.6 wte
HI Practitioner Advanced Band 7
Central Locality
HI Practitioner Advanced
Band 7 North Locality, 0.6 wte
Margot Jackson
HI Practitioner Advanced
South Locality 0.87 wte Post vacant
HI Practitioner Advanced Band 7 North East Locality 1 wte
HI Practitioner Advanced Band 7
East Locality
HI Practitioner Spec ICDH Development
HI Practitioner Spec
EPP Manager Band
HIPA CDH Commissioning Mgr Temporary band 7
HI Practitioner Specialist Central & N East Band 6
HI Practitioner Specialist Band 6
HI Practitioner Specialist Band 6
East Locality
HI Practitioner Spec Health Trainer
CDH Programme Officer Temporary Band 4 - Janie
Each wte Locality band 7 post will have a cross city remit for an equality area of work or topic
BME Worker Band5
0.6 North East Locality

Appendix 2

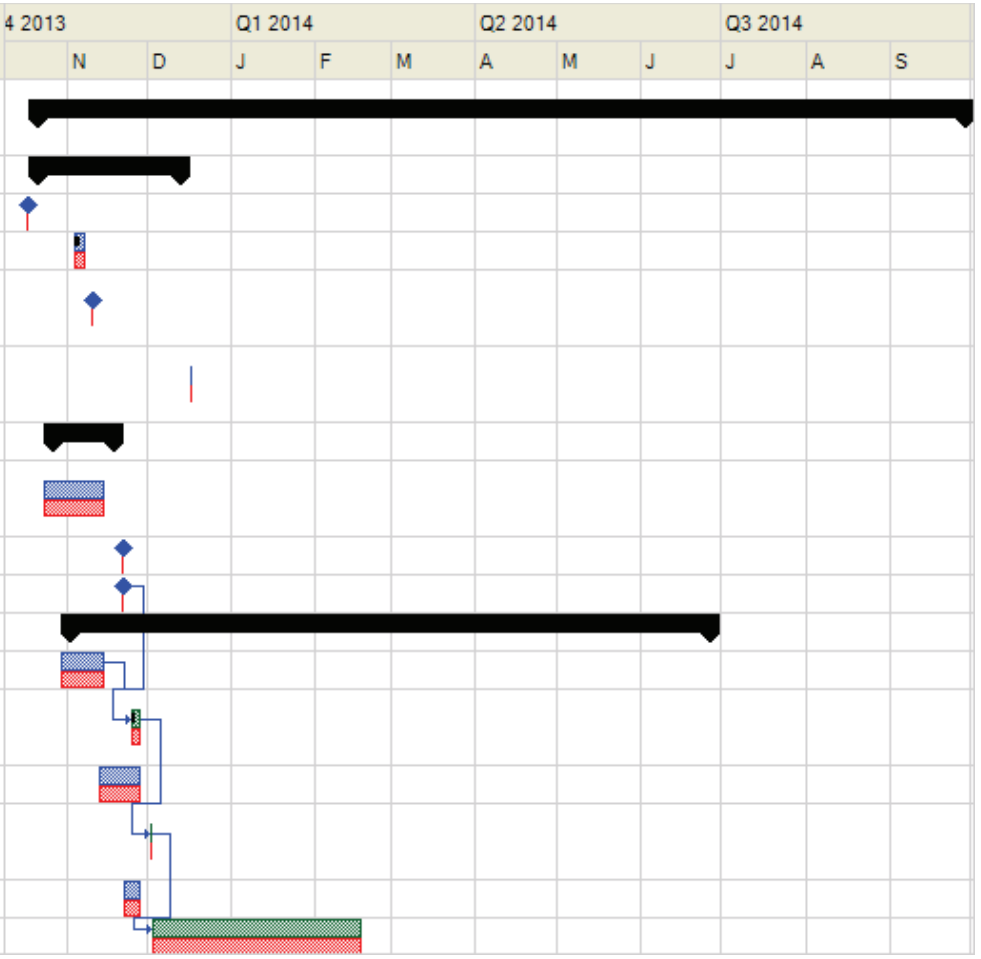
Proposed New Structure



PH001 : HCP Review

Development Officer (CDS) : Chris Hewitt

	Task	Start	End	%	Dur
1	**NEW STAFFING STRUCTURE - DESIGN & IMPLEMENTATION - Chris Nield**	18 Oct 2013	03 Oct 2014	1	251
2	**CCG Communications**	18 Oct 2013	17 Dec 2013	44	43
3	Covering email & Review to Tim Furness & Ted Turner	18 Oct 2013	18 Oct 2013	100	0
4	Plan for communicating with GPs	04 Nov 2013	08 Nov 2013	50	5
5	Discuss wider locality & resilience work with CCG mtg with Tim F & CS	11 Nov 2013	11 Nov 2013	100	0
6	Meeting with Ted Turner, Tim Furness & GPs by this date	17 Dec 2013	17 Dec 2013	0	1
7	**Finance Information**	24 Oct 2013	22 Nov 2013	0	22
8	Pension costs confirmed by HR - awaiting response from HR	24 Oct 2013	15 Nov 2013	0	17
9	Redundancy costs confirmed by HR	22 Nov 2013	22 Nov 2013	0	0
10	Establishment info from Finance revised & confirmed	22 Nov 2013	22 Nov 2013	0	0
11	**New Structure & MER**	30 Oct 2013	01 Jul 2014	2	175
12	CCG Core Offer clarification and input	30 Oct 2013	15 Nov 2013	0	13
13	1st draft of new HCP structure doc. - meetings with CS & NA	25 Nov 2013	29 Nov 2013	50	5
14	Draft MER & questions for HR from staff	13 Nov 2013	29 Nov 2013	0	13
15	Guidance from HR on dev/impl. - how much info needed each stage	02 Dec 2013	02 Dec 2013	0	1
16	Full structure complete for Members Nov	22 Nov 2013	29 Nov 2013	0	6
17	MER document	03 Dec 2013	18 Feb 2014	0	56



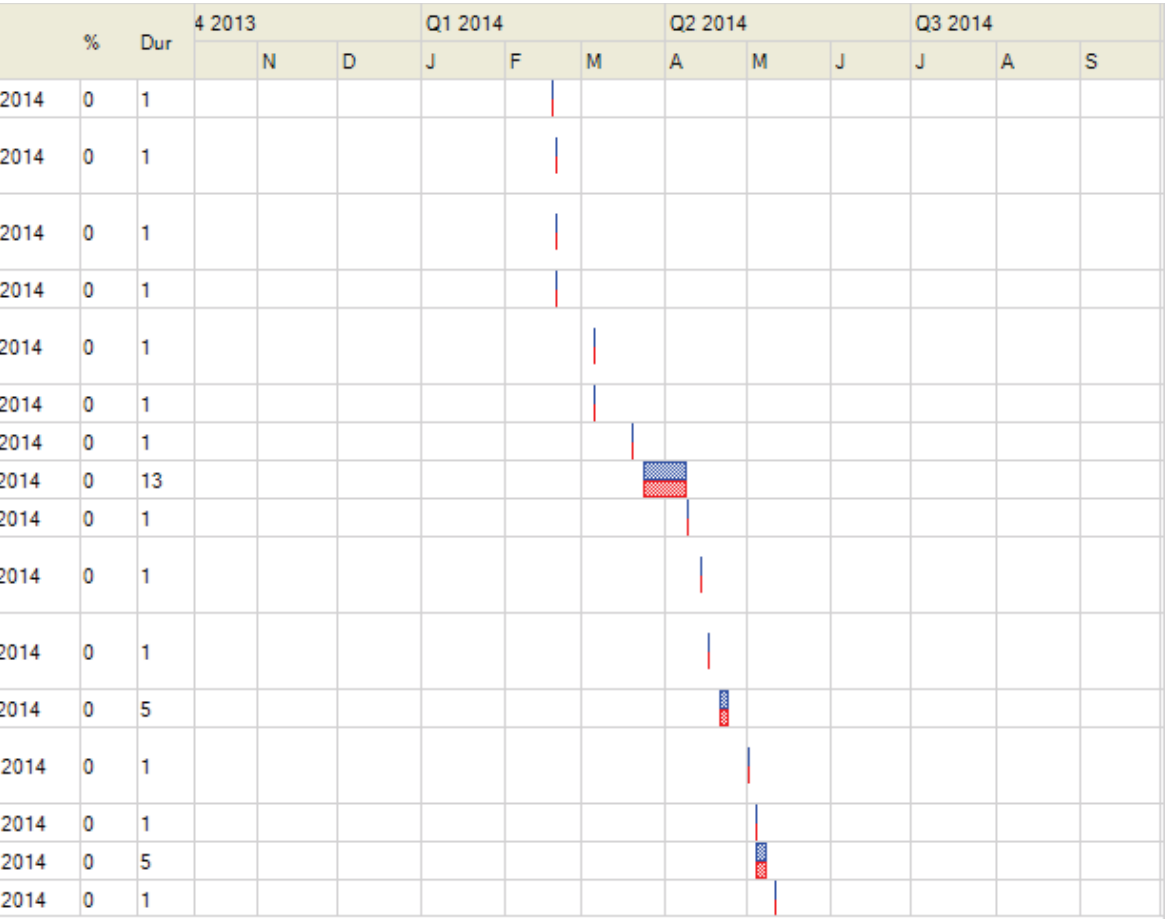
Task **Mllestone** **Baseline**

Progress **Summary** **Key Milestone/product**

PH001 : HCP Review

Development Officer (CDS) : Chris Hewitt

	Task	Start	End	%	Dur
18	Portfolio Trade Union Meeting to share MER	18 Feb 2014	18 Feb 2014	0	1
19	CN & HR to meet with TU reps - review MER and agree regular consult. sched.	20 Feb 2014	20 Feb 2014	0	1
20	Formal consult. period begins - presntation of MER proposal to staff - CN	20 Feb 2014	20 Feb 2014	0	1
21	VER/VS scheme launched & vuln. notices issues	20 Feb 2014	20 Feb 2014	0	1
22	Local Allocation Panel review new job descs and propose SCC grades	06 Mar 2014	06 Mar 2014	0	1
23	Closing date for quote requests	06 Mar 2014	06 Mar 2014	0	1
24	Closing date for VER/VS applications	20 Mar 2014	20 Mar 2014	0	1
25	Management consider VER/VS applications	24 Mar 2014	09 Apr 2014	0	13
26	VER/VS applications presented to Chief Officer Panel	09 Apr 2014	09 Apr 2014	0	1
27	Outcome of Chief Officer Panel communicated to relevant staff - termination letters issued	14 Apr 2014	14 Apr 2014	0	1
28	Corporate Grading Panel review new job descs and proposed grades	17 Apr 2014	17 Apr 2014	0	1
29	Outcome of Grading Panel communicated to staff	21 Apr 2014	25 Apr 2014	0	5
30	Job match apps in line with pooling proposals submitted to CN	02 May 2014	02 May 2014	0	1
31	Outcome of job match apps confimed by mngmnt	05 May 2014	05 May 2014	0	1
32	Recruitment process commences	05 May 2014	09 May 2014	0	5
33	MER sign off with TUs and consult. period ends	12 May 2014	12 May 2014	0	1

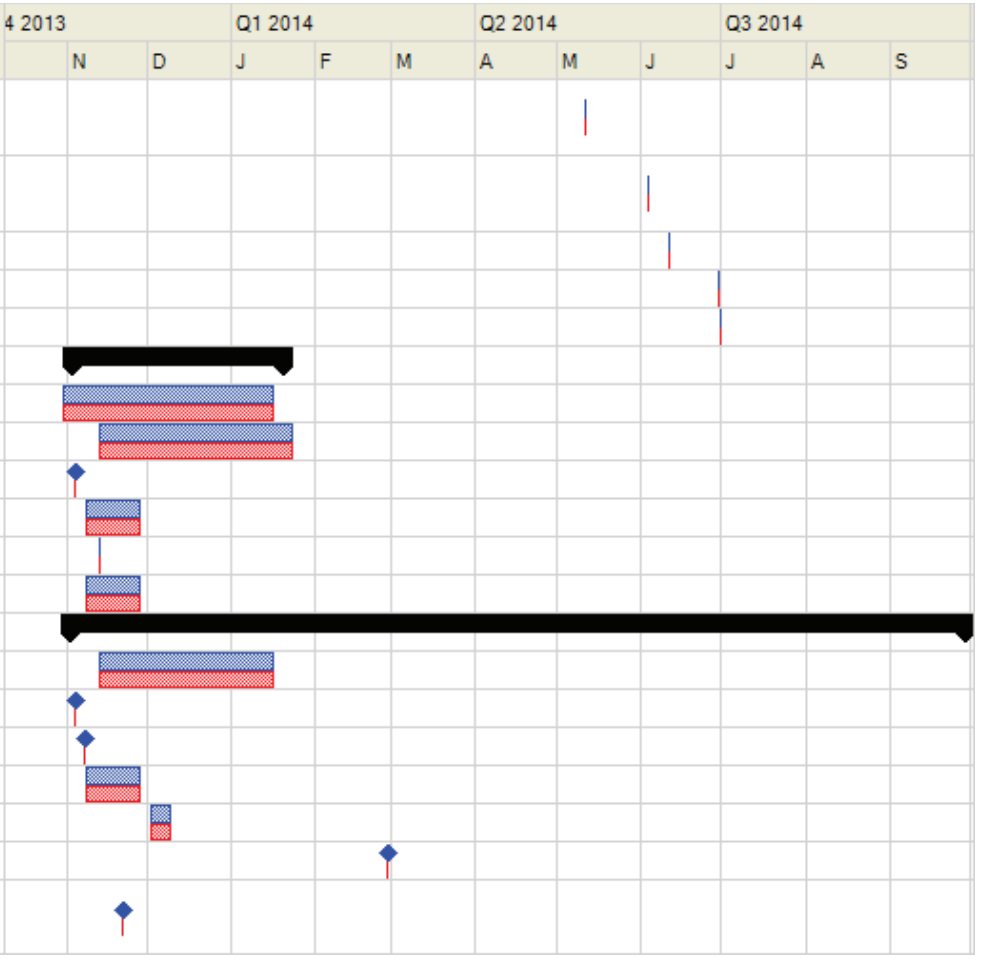


Task		**Mllestone**		**Baseline**	
Progress		**Summary**		**Key Milestone/product**	

PH001 : HCP Review

Development Officer (CDS) : Chris Hewitt

	Task	Start	End	%	Dur
34	Issue selection notice to unsuccess. staff - referrals to talent pool	12 May 2014	12 May 2014	0	1
35	Chief Officer Panel attended to present compulsary redundancies	04 Jun 2014	04 Jun 2014	0	1
36	Issue notice of dismissal notices to unsccssful staff	12 Jun 2014	12 Jun 2014	0	1
37	Staff leave organisation via VER/VS	30 Jun 2014	30 Jun 2014	0	1
38	New structure in place	01 Jul 2014	01 Jul 2014	0	1
39	**Locality Working & Social Capital - Develop Model**	31 Oct 2013	24 Jan 2014	0	62
40	Locality Structure - input from PLT VER & Consultation	31 Oct 2013	17 Jan 2014	0	57
41	Meeting with Housing & Locaility Leads	13 Nov 2013	24 Jan 2014	0	53
42	Meeting VAS & Vince Roberts	05 Nov 2013	05 Nov 2013	100	0
43	Meet with CCG - date to be agreed - check with CS	08 Nov 2013	29 Nov 2013	0	16
44	Finance approval needed for MER	13 Nov 2013	14 Nov 2013	0	2
45	Update to Cabinet Member & RW	08 Nov 2013	29 Nov 2013	0	16
46	**Social Capital Commissioning Strategy**	30 Oct 2013	03 Oct 2014	0	243
47	Reference to Task & Finish Group	13 Nov 2013	17 Jan 2014	0	48
48	Meet with VAS to discuss the model	05 Nov 2013	05 Nov 2013	100	0
49	Meet with Sharon Squires to discuss the model	08 Nov 2013	08 Nov 2013	100	0
50	Meet with Vince to discuss the model	08 Nov 2013	29 Nov 2013	0	16
51	Develop Commissioning Strategy	02 Dec 2013	10 Dec 2013	0	7
52	Commissioning event for potential providers	28 Feb 2014	28 Feb 2014	0	0
53	Meet with Commercial Services to discuss meeting with providers	22 Nov 2013	22 Nov 2013	100	0

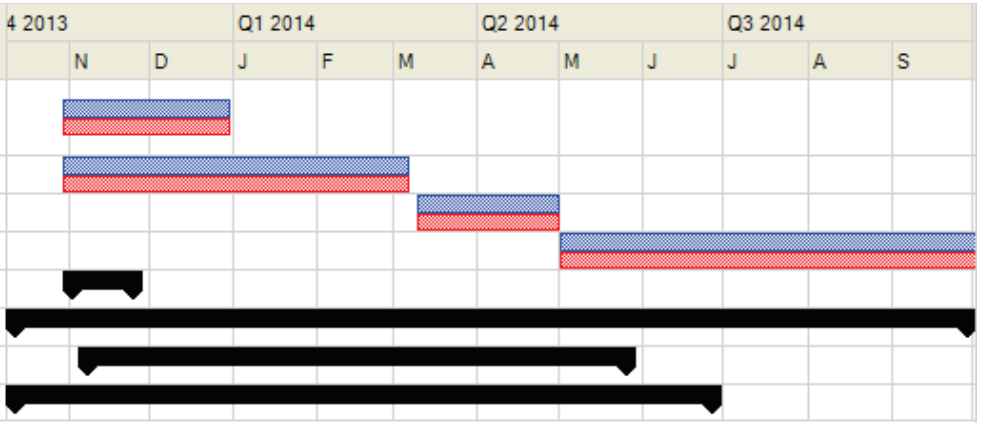


Task		**Mllestone**		**Baseline**	
Progress		**Summary**		**Key Milestone/product**	

PH001 : HCP Review

Development Officer (CDS) : Chris Hewitt

	Task	Start	End	%	Dur
54	Developing a commissioning model set up a meeting with Commercial Services (include NA)	30 Oct 2013	31 Dec 2013	0	45
55	Option appraisal for providers	30 Oct 2013	07 Mar 2014	0	93
56	Outcomes and commissioning methodology agreed	10 Mar 2014	02 May 2014	0	40
57	Commissioning process	02 May 2014	03 Oct 2014	0	111
58	**Branding**	30 Oct 2013	29 Nov 2013	0	23
60	**CONTRACT MANAGEMENT - Nicola Afzal**	09 Oct 2013	03 Oct 2014	0	258
69	**ENGAGEMENT - Chris Shaw**	05 Nov 2013	30 May 2014	0	149
83	**PROGRESS AGAINST REVIEW AREAS**	09 Oct 2013	01 Jul 2014	0	190



Task		**Mllestone**		**Baseline**	
Progress		**Summary**		**Key Milestone/product**	

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

Report of: Moira Wilson, Interim Director of Care and Support

Subject: Update on Self Directed Support and Personalisation

Author of Report: Luke Morton, Programme Manager

Summary:
This report provides an update on Self Directed Support and Personalisation identifying the work that is underway to improve practice and application of current polices and the implications of the current financial situation. In addition it updates the Committee on progress with the Individual Service Fund Framework Agreement and Support Planning and Brokerage Framework Agreement. The information presented has been requested by the Committee so it can review progress.

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:
The Committee is asked to note the information outlined and and provide views and comments.

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

Report of the Director of Care & Support

An update on Self Directed Support and Personalisation including the Individual Service Fund Framework Agreement and Support Planning and Brokerage Framework Agreement

1. Introduction/Context

1.1 In April of last year Eddie Sherwood, Director of Care and Support provided the Scrutiny Committee with an update on Self Directed Support and Personalisation, reminding the Committee of what SDS was, what had been achieved in Sheffield and the benefits of the approach.

1.2 The report also identified the challenges going forward for Self Directed Support, including the changing financial environment for the Council and what the next steps might be for personalisation. The focus here is an emphasis on quality and consistency and work to understand the implications of reducing budgets in Adult Social Care.

1.3 Specific pieces of work identified in the original report described plans to develop Framework Agreements for Individual Service Funds and Support Planning and Brokerage.

1.4 Scrutiny has subsequently asked for an update on Self Directed Support and Personalisation.

2. Update on Self Directed Support and Personalisation

2.1 Since the report in April of last year Adult Social Care has had to address a forecast budget overspend and a reduction in the overall budget available for Adult Social Care. This has required Adult Social Care to refine and update the way it operates Self Directed Support to address this issue.

2.2 The focus remains ensuring that our customers' unmet eligible social care needs are appropriately addressed and that they have choice and control over their care and support and social workers respond to individual circumstances.

2.3 We have updated our approach to Personalisation to reduce the time it takes to put in place support for our customers; reduce ongoing costs associated with assessment, support planning and reviews; reinforce our aim to promote independence; and ensure that we are fair and equitable in our approach for everyone. We have done this by simplifying the processes and associated forms, reducing hand-offs and tightening practice around our existing social care procedures. Improvements include:

- The introduction of a simplified Assessment Questionnaire (AQ) that keeps the key questions but is shorter and easier to use.
- An update of, and proposal to regularly review, the Resource Allocation System (RAS) to reflect the current available budget and the increasing number of people who need care and support.

- The role of the indicative budget is now as an internal reference for budgetary control for managers when agreeing a support plan rather than a fixed amount provided to plan up to.
- A simpler support plan template on Carefirst which has reduced inputting and makes the support plan approval process easier and quicker.

2.4 We have placed the social worker firmly back as the lead for the end to end process of assessment, support planning and ensuring support is in place and working to meet needs. Local targets for the numbers of customers supported by external support planners are no longer required. The social worker in the majority of cases will complete the needs assessment and support plan with a person, ideally in one visit, to ensure that the process happens quickly and easily. The social worker will encourage the person and their family to be as actively involved in their support planning as they are willing and able to be and will arrange for an external support planner if requested and as appropriate if, for example the person has no one who is able to help with support planning and needs help to work with their social worker.

2.5 A Personal Budget Support Service is being developed to replace the Framework Agreements for Individual Service Fund and Support Planning and Brokerage. This service will cover support planning, direct payment set-up including employing personal assistants , initial coaching on managing a direct payment and providing general advice and queries on personal budgets, direct payments and employing personal assistants. It will be paid for by the Council rather than via a customer's personal budget. The current timescale is implementation late summer; a tender will be issued during April.

2.6 We aim to help people to be as independent as possible; instead of money managers we will encourage informal support from family and friends to help manage a direct payment. We need to continue ensure direct payments are accessible to as many people as possible without incurring unnecessary administrative and monitoring overheads, but have removed the local target as we already performing well on this compared with other Councils . We will therefore provide help via a third party provider in the form of the Personal Budget Support Service to answer queries customers may have concerning their direct payment and help them become familiar with their responsibilities. We will provide clear guidance on when it is appropriate to provide a money manager to support a customer manage their direct payment. We will provide clear guidance on when it is appropriate to end a direct payment; namely where it is no longer in a customer's best interests or there is a risk of misuse of council money.

2.7 We have also tightened practice around our existing social care policies and procedures in order to ensure we are meeting needs, keeping our customers safe and managing our limited resources responsibly. As part of our annual review and reassessment process we are ensuring that our improved practice and processes are followed to ensure that customer's critical and substantial needs are met in a cost effective manner. Key areas include:

- We encourage people to be as independent as possible, looking first at what resources and support they have available to them then providing appropriate support for unmet critical and substantial needs where there is no one available to help.
- We have ceased the practice of gifting in support plans where people receive paid 'gifts' in return for support
- There is direct payment legislation that prevents family members who live in the same household being employed as a personal assistant. There are no legal restrictions on using a direct payment to pay other family members. It is not always in a person's best interests to employ someone where the relationship is primarily personal rather than contractual. We have therefore reviewed our practice in this area to ensure that alternatives are explored and reasons are given as to why employing a relative is the right option on a case by case basis.
- In line with our existing Mobility Strategy and Fairer Contributions Policy we have clarified that we pay for travel arrangements where the travel is necessary so that a person's critical and substantial eligible social care needs identified in their assessment can be met; the person does not have any other suitable travel resources available to them, financial or otherwise and the person is not able to travel safely without that assistance. We take account of a person's DLA mobility allowance as a resource to meet travel costs in their Support Plan and we expect a person's Motability vehicle to be used to cover transport arrangements in their Support Plan. The person pays for their petrol costs; these are not treated as Disability Related Expenditure (DRE).

2.8 People continue to have choice and control over their support. A person can still indicate their preferences in terms of times, how and who they want to help them with their care and support. We agree a person's Support Plan if their choice of provider is appropriate and cost effective. It doesn't have to be the 'cheapest', but where there are 'cheaper' suitable providers available we agree the person's choice only if there is additional value for the additional cost. If a person has a council arranged service the choice is limited to providers on our framework. Where a person has a direct payment and wants to choose, as opposed to needing, a provider that costs more, then we pay up to the general guideline rate that we pay for our contracted home care providers which is £13.00/hour. The person either pays the amount above that rate, or chooses an alternative more cost effective provider. We have clarified that a person can continue to vary their support arrangements in terms of providers and timings (how, when, where and by whom) but direct payment monies can only be spent on activities specified in the Support Plan.

2.9 To support the updates to processes and practice we have been developing clear information for staff, our partners and customers on what people can expect in terms of support and care going forward. There will be revised leaflets for:

- Getting your social care support
- Reviewing your social care support (to be sent to customer as part of their review from early March)
- Understanding Support Planning

- Managing your Direct Payment
- Employing Personal Assistants (update of current handbook).
- Getting a break for carers.
- Help with Travel Arrangements (released February 20th)

2.10 The Care and Support Leadership Team have responsibility for ensuring that refinements and improvements are implemented effectively and the benefits from them are seen. Cllr Mary Lea, Cabinet Member for Health, Care and Independent Living, has been kept up to date with progress to date and we have also involved our legal team on an ongoing basis regarding the updates we have made. We are actively involving customers, community groups and providers via recent budget consultations and adult social care conversations (Have your say events). We have a communication plan for customers, staff and providers and are collaborating with customers, Disability Sheffield, Age UK and 50+ in the production of customer factsheets.

2.11 Since the previous report in April 2013 the number of people with a personal budget has reduced from 63.1% to 61.1% and those with a direct payment have increased from 23.3% to 26.1%.

3 What does this mean for the people of Sheffield?

3.1 We will continue to promote self-directed support and personalisation for all our customers ensuring that they have choice and control over their care and support.

3.2 The Council has a responsibility to ensure that its resources are allocated fairly and equitably and we will work with people to make sure that their care and support meets their unmet eligible social care needs and is cost effective.

3.3 Processes will be quicker and simpler so that people get the support and care they need as quickly as possible

4. Recommendation

4.1 The Committee notes and comments on the changes that have taken place with regards to Self Directed Support and Personalisation

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

Report of: **Cathy Edwards, Director of Commissioning (Interim)**

Subject: Update on progress in implementing plans for improving major trauma within Yorkshire and the Humber

Author of Report: Sarah Halstead, Service Specialist, Trauma, Head and Neck Programme of Care, NHS England, South Yorkshire and Bassetlaw Area Team, sarah.halstead@nhs.net. (This report was produced in collaboration with colleagues at Sheffield Teaching Hospitals and Sheffield Children's Hospital).

Summary:

A paper setting out plans for improving the care for patients who have suffered major trauma in the Yorkshire & the Humber region was presented to the committee in April 2013. This paper presents progress made in implementing those plans and at the request of the Committee we have focussed on developments made to rehabilitation care following major trauma.

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

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

The Scrutiny Committee is being asked to:

Note the significant progress made in improving major trauma care in South Yorkshire and Bassetlaw and to acknowledge the further work that is underway to continue improvement.

Category of Report: OPEN

Report of the Director of Commissioning (Interim)

Update on Progress on Implementing Plans for Improving Major Trauma within Yorkshire and the Humber

1. Introduction/Context

1.1 **What is Major Trauma?**
Major trauma is used to describe serious and often multiple injury where a patient has less than 10% chance of survival, often described as 'life-changing' injuries, it includes: head injury, spinal injury, abdomen, chest, penetrating wound, gunshot, long bone amputation and injuries to the pelvis. The paramedic on the scene identifies the patient as having major trauma.

1.2 **How many people suffer major trauma on our region?**
The number of people across the region who experience major trauma is relatively small at around 660 cases per year, which equates to less than 0.2% of Emergency Department activity.

Nationally it has been estimated that 91% of hospitals will see less than one major trauma case per week and 75% of hospitals will see less than one case per fortnight. These are small numbers of patients who require specialist care.

1.3 **Plan for improving Major Trauma Care**
In 2011 NHS organisations in Yorkshire and the Humber agreed plans to ensure that all injured patients (adults and children) receive an excellent standard of care and safety, from time of injury to rehabilitation.

Evidence told us that better coordination of care and reducing variation in care would lead to saved lives and better outcomes for people who have suffered major trauma. This could be achieved through our acute hospitals, ambulance service and rehabilitation services working together as a whole system, with common protocols and agreements.

Our plan was to achieve the following:

- Save lives with an approximate 20% reduction in lives lost. In Y&H this equates to an additional 160 lives saved per year.
- Significantly improve chances of making a full recovery, reducing the chance of long term debilitation. 75% of patients are currently left with a significant disability following a major trauma.

1.4 This paper updates the Committee on progress to implement the plans. At the request of the Committee in April 2013 there is particular focus on actions to improve rehabilitation following Major Trauma.

2 Progress report

2.1 In December 2013 the national lead for Major Trauma announced that, as a direct result of improvement made in major trauma care across the country, there had been a 20% increase in lives saved following major trauma. It is difficult to precisely measure this improvement at a local level however it is believed that this increase is reflected in Yorkshire and the Humber. Additionally survival rates are likely to improve further as the new arrangements become more embedded. Further work on data is underway to confirm survival rates at a local level.

2.2 The Major Trauma Centres, Trauma Units and Ambulances have come together in South Yorkshire to implement change and where required invest resources to improve patient care. The following summarise some of the many improvements that are now in place:

- All patients (adults and children) are assessed at the roadside using a standard national approach.

- A paramedic in the ambulance control room coordinates the decision making about admission and transfers for patients injured throughout Yorkshire and the Humber.

- All patients with major trauma are taken directly to a Major Trauma Centre if they are within 45 minutes travel time. Where this is not the case they are taken to the nearest Trauma Unit for stabilisation prior to transfer on to the Major Trauma Centre.

- In South Yorkshire and Bassetlaw the Major Trauma Centres are the Northern General Hospital for adults and Sheffield Children's Hospital for children. Trauma Units are Barnsley Hospital, Rotherham Hospital, and Doncaster Royal Infirmary. Both Major Trauma Centres also receive cases from the North Derbyshire area too.

- The Northern General Hospital is receiving around 300 additional major trauma patients per year directly to the Emergency Department via ambulance service triage.

- Sheffield Children's Hospital was already receiving most patients directly from across the region so they have seen just a small rise in additional major trauma cases.

- All patients meeting ambulance service triage criteria are seen by a consultant lead trauma team.

- There is faster access to diagnostic imaging for all patients

- Improved care pathways and treatment are in place for all patients in particular those with severe bleeding, burns, spinal cord injuries, long bone and open fractures.

- Additional specialist nursing staff have been recruited to specifically care for patient with major trauma.

2.3 Work has progressed well to improve rehabilitation during the first stages of recovery from major trauma. These are summarised below:

2.3.1 For children:

- All children with major trauma are now assessed for their rehabilitation needs using the national major trauma rehabilitation prescription. This happens within the national standard of 72 hours of injury.

- A trauma and rehabilitation co-ordinator has been appointed to coordinate the care pathway for children with major trauma, from injury to rehabilitation.

- Dedicated consultant neurologist and a consultant in neuro-disability sessions are now in place for children with major trauma.

- Formal links have been developed with Tadworth Childrens Trust (the national specialised rehabilitation centre for children with highly complex rehabilitation needs)

- A directory of local services has been developed. This aids discharge and transition with therapists in the region and provide support as required

- Increased number of multi-disciplinary neurorehabilitation follow-up clinics.

- Education sessions for rehabilitation therapists from trauma units across the region.

2.3.2 For adults:

- 85% of adults with major trauma are now assessed for their rehabilitation needs using the national major trauma rehabilitation prescription within the national standard of 72 hours of injury. This is an improving position and the plan is to achieve 100% as soon as possible.

- A lead therapist for major trauma has been appointed at Sheffield Teaching Hospitals; he has responsibility for coordinating the rehabilitation of major trauma patients.

- A rehabilitation consultant dedicated to major trauma care has been appointed and will take up their post in February 2014.

- With the new rehabilitation consultant in post, Sheffield Teaching Hospitals will be able to meet the key national standards of a consultant signing the rehabilitation prescription within 72 hours, and for all major trauma patients to be reviewed in a multi-disciplinary meeting occurring weekly.

2.4 **Future plans for rehabilitation**

In April 2013 the South Yorkshire and Bassetlaw Major Trauma Operational Delivery Network was established. The purpose of the network is to bring together clinical teams from across the region to further improve care for patients with major trauma. The network will continue to improve the acute care for major trauma. However a key objective is to develop and implement a strategy for improving rehabilitation care following the initial acute phase following trauma. The operational delivery network would be happy to keep this Committee briefed of progress.

3 Recommendation

The committee is asked to note

- The significant progress made in improving major trauma care in South Yorkshire and Bassetlaw.
- Improved survival rates following major trauma.
- That further work that is underway and continued improvement to major trauma care is envisaged.

Sarah Halstead

3rd March 2014

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