Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 15 October 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 (Deputy Chair), Jenny Armstrong, Olivia Blake, John Campbell, Katie Condliffe, Qurban Hussain, Anne Murphy, Denise Reaney, Jackie Satur, Brian Webster, Philip Wood 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 Emily Standbrook-Shaw, Policy and Improvement Officer on 0114 27 35065 or email emily standbrook-shaw@sheffield.gov.uk

FACILITIES

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

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

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
15 OCTOBER 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 (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting

5. Minutes of Previous Meeting (Pages 5 - 12)
To approve the minutes of the meeting of the Committee held on 17th September, 2014, and to note the attached Actions Update

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

7. End of Life Care in Sheffield (Pages 13 - 42)
Report of Jackie Gladden, Senior Commissioning Manager, NHS Sheffield Clinical Commissioning Group

8. Sheffield Dementia Strategy and Commissioning Plan (Pages 43 - 54)
Report of Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group and Joe Fowler, Director of Commissioning, Communities, Sheffield City Council

9. Minor Oral Surgery Procurement (Pages 55 - 60)
Report of Emily Standbrook-Shaw, Policy and Improvement Officer

10. Work Programme 2014/15 (Pages 61 - 68)
Report of Emily Standbrook-Shaw, Policy and Improvement Officer

11. Adult Safeguarding Business Plan - Update (Pages 69 - 76)
Briefing paper from Simon Richards, Head of Quality and Safeguarding, Sheffield City Council, for information

12. Date of Next Meeting
The next meeting of the Committee will be held on

Wednesday, 17th December, 2014, at 10.00 am, in the Town Hall

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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.

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 Gillian Duckworth, Interim Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 17 September 2014

PRESENT: Councillors Mick Rooney (Chair), Sue Alston (Deputy Chair), Jenny Armstrong, Olivia Blake, Katie Condliffe, Qurban Hussain, Anne Murphy, Denise Reaney, Jackie Satur, Brian Webster, Philip Wood and Joyce Wright

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor John Campbell.

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 The Chair, Councillor Mick Rooney, declared a Disclosable Pecuniary Interest in Agenda Item 7 (Right First Time Programme Update) as a Non-executive member of the Sheffield Health and Social Care NHS Foundation Trust, but felt that his interest was not prejudicial in view of the nature of the presentation and chose to remain in the meeting during consideration of the item.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 23rd July 2014, were approved as a correct record. The Committee also noted the Action Update attached to the minutes and, arising from their consideration, the Chair, Councillor Mick Rooney, reported that the Child and Adolescent Mental Health Service (CAMHS) Working Group had produced a paper which had asked questions of the Commissioners, whose response had been reasonable, but was felt to be not as robust as it needed to be. As a consequence, he had discussed this with Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, who had referred this matter to the Sheffield Health and Wellbeing Board where it was agreed that some of the issues raised had not been addressed. In view of this, the Chair and Deputy Chair, Councillor Sue Alston, were to meet with Councillor Mary Lea, Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families, and Jayne Ludlam, Executive Director of Children, Young People and Families, to take this forward. The Chair also pointed out that a national review on CAMHS was taking place which mirrored this study.

5. PUBLIC QUESTIONS AND PETITIONS

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

6. RIGHT FIRST TIME PROGRAMME UPDATE

6.1 Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust, gave a presentation which updated the Committee on the Right First Time Programme. He explained what the Right First Time Programme was and outlined the vision behind it, emphasising the commitment to work together and across organisational boundaries. He went on to provide further detail in relation to developing integrated care in the community, transitional/intermediate care, urgent care and improving the physical needs of people with serious mental illness. The Committee were also updated on system oversight, and the impact and evaluation of Right First Time, together with comments on how the programme was to be moved forward. In conclusion, Kevan Taylor informed the Committee that a first draft of an evaluation report of the programme had revealed that the right things were being done, there was positive evidence of integration between the NHS and the Local Authority, and that Sheffield was different in that it was looking at the whole system, which made evaluation somewhat difficult to undertake. It should be noted that there were still high numbers of people being admitted into care homes and that demonstrating whether the programme was cost-effective presented a challenge.

6.2 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- People were encouraged to complain as this was an important way of identifying areas for improvement. Patient surveys had revealed high levels of satisfaction, but the need for balance was appreciated, particularly in situations where patients' home circumstances needed to be assessed.

- It was recognised that getting people out of hospital as quickly as possible was the right thing to do and was what people wanted. There had been an increase in community services to support patients in their homes.

- The bulk of responses to the patient satisfaction surveys were positive.

- The 3,500 Care Plans which had been commissioned, represented about a quarter of those required. This process was at a developmental stage and it would be two to three years before there was full coverage.

- In terms of evaluation, the Sheffield programme was one of ten national pilots on which the King's Fund would be undertaking an evaluation in the near future. It was proving difficult to establish cause and effect, but good joint assessments of care had been revealed.

- Under the NHS Choices scheme, GPs could refer patients to private services, but patients should not be paying for any extra care required, for instance if they had to stay in hospital longer than was expected.

- The Patient Advice and Liaison Service (PALS) continued to operate in Sheffield and had a presence at the local hospitals. Patient issues could also be raised through the Healthwatch Sheffield service.

- In relation to development areas, the Systems Referral Panel was running well in relation to engagement and work was being undertaken in relation to organisational development and ensuring that information systems were talking to each other.

- The availability of patient records was sometimes a problem caused by lack of information and there was also an issue around sharing information for some parts of the organisation.

- It was recognised that there was a need to publicise successes more.

- The need for home support, particularly in relation to elderly and isolated patients, was appreciated.

- It was accepted that access to information was an important tool in patient empowerment.

- The demonstration of cost-effectiveness was proving to be a challenge, with OPM (an independent research organisation and consultancy) having difficulty with this. It was felt that the Right First Time Programme would be shown to be cost-effective as funding was taken out of acute care and put into prevention, but this would take time.

6.3 RESOLVED: That the Committee:-

(a) thanks Kevan Taylor for his contribution to the meeting;

(b) notes the contents of the presentation and the responses to questions; and

(c) requests that an update on the Right First Time Programme be presented to a future meeting of the Committee in six months' time, to include details of patient feedback and progress on the communication and informatics workstreams.

7. CARE ACT 2014 - PROGRESS ON IMPLEMENTATION

7.1 The Committee received a report of the Interim Director of Care and Support which highlighted the reasons for the introduction of the Care Act 2014 (the Act), identified the actions which had taken place to support its implementation in Sheffield and described the implications of the Act for the people of Sheffield. The report was introduced by Luke Morton, Programme Manager, Communities.

7.2 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- There had been no major issues in implementation, with actions being undertaken to build on established best practice and ensure that the Council's practices aligned with the legislation. Consideration was being given to improving information and advice as this was not always as coherent or comprehensive as it might be.

- There would be financial implications associated with implementation, but a Department of Health impact assessment had indicated that there would be no net impact on local authorities.

- There would be no overall review of charging policy, but some parts of the Act involved discretionary decisions on issues such as carers' personal budgets.

- There would be a cap on care costs for those whose capital and income were above the charging thresholds and there were approximately 4,500 of those self-funders. The cap on care costs was £72,000.

- If the Local Authority had a responsibility, then the charging requirements would apply. There was a duty to meet care and support needs and a duty in emergency situations. The Act provided the force of law to support this so that if a local authority was not responding in an appropriate way, this could be taken to a Judicial Review.

- The Act had received cross-party support whilst going through Parliament, so its repeal by any change of Government was not expected. However, some of the limits may change.

- The capital allowance was to be increased to £118,000, which meant that people with assets, including houses, below that value would be eligible for support from the Council. There was also a deferred payment scheme whereby loans could be provided to pay for residential care, with a charge being put on the property.

- Some modelling had been undertaken to assess the impact of the Act on budgeting.

- There were specific rules on how property value was counted and the Financial Assessment Service were aware of the issue of people re-mortgaging their properties to avoid the capital limits.

7.3 RESOLVED: That the Committee:-

(a) thanks Luke Morton for this contribution to the meeting;

(b) notes the contents of the report and the responses to questions;

(c) welcomes the principles behind the Care Act 2014; and

(d) requests that:-

(i) a further report on the implementation of the Care Act 2014 be presented to a future meeting of the Committee after January 2015; and

(ii) a copy of the Council's Charging Policy be circulated to all Council Members, together with an explanation of why this was being done.

8. DRAFT WORK PROGRAMME 2014/15

8.1 The Committee received a report of the Policy and Improvement Officer which outlined the Committee's Draft Work Programme 2014/15.

8.2 RESOLVED: That the Committee notes the Draft Work Programme as detailed in the report.

9. DATE OF NEXT MEETING

9.1 The next meeting of the Committee will be held on Wednesday, 15th October 2014, at 10.00 am in the Town Hall.

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Healthier Communities & Adult Social Care Scrutiny Committee
Actions update for meeting on 15th October 2014

Action	Minutes	Update	RAG
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13 The committee requests that, 6.4 (c.) (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	An update is not yet available.	
Child and Adolescent Mental Health Service (CAMHS) Working Group Report	10th April 2014	Meeting with Cabinet Member and Exec Director scheduled for November	
Learning Disability Service Petition 5.6 (c) (i) an update on the consultation process be presented to a future meeting of the Committee within 6 months	23rd July 2014	Scheduled for December meeting	
Nutrition and Hydration Working Group 10.2 (b) formally share the reports with the trusts	23rd July 2014	Reports shared, response requested for October	
Request from SHSCFT re request on how patients with specific needs are supported in hospital	23rd July 2014	Meeting with Governors requested – awaiting response	
Care Act 7.3 (a) ii Copy of Council's Charging Policy to be circulated to all Members	17th September 2014	Circulated 30th September 2014	

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

Report of: Idris Griffiths Chief Operating Officer NHS Sheffield CCG

Subject: **End of Life Care in Sheffield**

Author of Report: **Jackie Gladden, Senior Commissioning Manager, Sheffield CCG jackiegladden@nhs.net**

Summary:

The report provides an update on the issues raised at the meeting of scrutiny on 19th January 2014 and also seeks to answer the questions raised subsequent to that meeting

The report introduces the draft Sheffield End of Life Care Strategy for 2014 – 2019 and requests views from the committee.

It also provides an update on changes in national policy regarding End of Life Care and the work which is taking place locally to address this.

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

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

The Scrutiny Committee is being asked to:
Consider the draft Sheffield End of life Care Strategy and provide views and comments

Background Papers:

One Chance to get it Right - Leadership Alliance for the care of Dying people 2014
End of life Care Strategy Fourth Annual Report DH October 2012

Category of Report: OPEN

End of Life Care in Sheffield

1. Introduction/Context

This report is a follow up to the meeting of the scrutiny committee held on 19th January 2014 section and provides an update on the issues raised then.

At that meeting the CCG representative reported that a new End of Life Care Strategy would be drafted and Appendix 1 of this report is the draft strategy. Comments are invited from committee members.

It was also reported at the meeting that a response was awaited on the replacement for the Liverpool Care Pathway. This was published at the end of June, and the report gives information on the key standards and the local work which has taken place to respond to these.

A number of additional questions have also been raised by committee members, and these are addressed in the report.

2. Update on Issues raised by the Committee on 19th January 2014

2.1 Length of contract with St Luke's Hospice

The CCG noted the concerns raised by the committee in relation to the duration of contract previously offered to SLH, and have therefore agreed and signed a two-year contract with SLH, commencing 1st April 2014. In addition the contract value will remain at the same level as in 2013/14, despite other services being subject to a nationally mandated 1.5-1.8% reduction in funding. This level of funding will remain in place for the full two year contract period, regardless of any national guidance that is issued prior to the 2015/16 financial year.

2.2 Contingency Plan

The CCG has agreed with SLH a joint contingency plan to address issues that may arise as a result of any potential financial difficulties that SLH experience. This will include (but will not be limited to) establishing a process of joint financial monitoring (which will provide periodic assurance of financial sustainability), considering the availability of alternative provision across the city and establishing an agreement on

those services that may, in the event of financial failure, be preserved due to patient safety and equality reasons.

2.3 GP Engagement

The committee also raised concerns regarding GP engagement with the Hospice and this was the topic of discussion between the Scrutiny Committee chair and Dr Anthony Gore and Jackie Gladden on the 3rd of February. Dr Gore explained that whilst it was the South Yorkshire and Bassetlaw Area Team of NHS England who now directly commissioned primary care, the CCG still had a responsibility to support the maintenance and improvement of quality. The quality of End of Life Care provided by GPs continues to be a high priority for the CCG.

For the last two years an End of Life facilitation team has been offering support visits to GP practices. Improvements have already been made in the proportion of people who are on the palliative care register and therefore able to access end of life care, and care for these patients is discussed at a regular palliative care multidisciplinary team meeting. The CCG recognises that further work is needed to ensure consistent high quality across the city, and a training session for primary care on the topic of End of Life Care was held in May this year.

There will be further training for practices on the implications of the new guidance replacing the Liverpool Care Pathway.

3. Questions posed by the committee subsequent to the meeting on 19th January

3.1 What is the proportion of people that end their life in place of their choice?

The current information systems do not enable us to identify the place of death of choice for all Sheffield residents. We are currently planning an Electronic Palliative care Co-ordination System which would enable us to monitor this information. We do know that nationally around 70% would prefer to die at home and the latest data for Sheffield is as follows:-

Data from the National End of Life Care profile for Sheffield, based on ONS data, shows the following breakdown for place of death in Sheffield and England averages for the years 2010 - 2012

Place of death	Sheffield	England average
Percentage of deaths in hospital	53.84 %	50.71%
Percentage of deaths in own home	19.76%	21.54%
Percentage of deaths in hospice	4.45%	5.59%
Percentage of deaths in care home	19.45%	19.59%
Percentage of deaths other places	2.04%	2.12%

Please note that the numbers of people who die in hospital includes those who die in the Macmillan specialist palliative care unit. Since this is a 20 bedded unit, if the figures for deaths in this unit were counted as hospice beds, then the proportion dying in hospital would be considerably reduced.

3.2 How are people being supported to make their end of life plans, and how are these plans then shared with the relevant organisations?

Having an end of life plan which is shared with the main relevant organisations is key to ensuring that people receive the type of care, and in the appropriate place that they wish.

Every year there is a national Dying Matters week in May, which aims to encourage people to plan for their death. The CCG has supported this by issuing press releases, commissioning a transmission from Hallam FM organising sessions for staff in both the local authority and CCG, sections on the SCC and CCG websites, leaflets and poster distribution to GP practices and care homes, and poster and leaflet displays in public places. Wherever there are other chances to distribute the posters and leaflets, such as the CCG AGM, this opportunity is taken up. It is recognised that this is a major culture change will take a long time.

Training has been provided for GPs and healthcare staff in STH on communication skills to help them introduce the topic with patients and carers. We are doing work on providing an information manual to support practices in dealing with end of life care issues with people from Black, Asian and minority ethnic communities.

A template has been developed for use by primary care for an End of life care Plan and there has been training on the use of this template.

GPs write 'Special Notes' for patients who are at end of life, or have particular care needs, which are shared with the Out of Hours Services and the Yorkshire Ambulance Service. There is work going one a regional level to try to improve the consistency of the information provided in these notes.

There is currently in Sheffield an Electronic Palliative care Communication System whereby consultants in STH and St Luke's Hospice identify patients who are in their last year of life and record information regarding diagnosis, the patient's understanding of their diagnosis, prognosis and aims of treatment, key workers and contact details, foci of care (summary term for aims of treatment) and management plan recommendations for consideration by GPs. This information is then emailed in letter format to the relevant GP for them to consider adding the patient to their own practice EOLC register and implementing the management plan recommendations. This is working well, and the number of team's implementing this in STH is gradually increasing. We are, however, seeking to move to an Electronic Palliative Care Co-ordination System in line with national guidance. This will enable the sharing of plans between primary care, secondary care, St Luke's hospice, community nursing, OOH and the ambulance service. It also links with the work going on through the Integrated Commissioning in the access and information work stream.

3.3 What are the End of Life Care links to Right First Time – care homes inappropriately calling 999 at end of life? Are GPs covering the care homes ensuring that homes getting appropriate support – e.g. community nursing so people can remain in their 'home' at end of life should they choose.

The principles of Right First Time are clearly applicable to End of life Care, but the main links are in work to improve the discharge process.

Work is taking place between care homes and the GP Out of Hours service to improve access to appropriate emergency care. All care homes can ring the Out of Hours service directly rather than having to go through 111 or 999.

End of life care is a key component of the specification for the Locally Commissioned Service for GPs to provide additional support to care home residents. This specification has been revised this year and now places greater emphasis on End of Life Care, both in the planning stages, and in the quality of care in the last few days /hours of life. Training sessions have been organised for GPs undertaking the Care Homes Service for 9th October and 26th November and this will cover the GPs' responsibilities regarding End of Life care, and training in communication skills to improve the communication with the residents and their families regarding end of life plans

4 One Chance to Get it Right

4.1 Policy Background

The Liverpool Care Pathway was developed in the late 1990s by the Royal Liverpool University Hospital and Liverpool's Marie Curie Hospice initially for the care of terminally ill cancer patients, and then extended to all dying patients.

In 2009 and again in 2012 there was considerable concern in the media about the implementation of the pathway, and about financial incentives to NHS trusts to use the pathway. The government commissioned Dame Julia Neuberger to undertake a review of the pathway, and in July 2013 this review – More care, Less pathway, was published.

In response, the Secretary of State for health stated that all NHS hospitals should ensure that there was a named senior clinician responsible for patients care in their final hours and days, that there should be an end to financial incentives for hospitals to promote a certain type of care for dying patients, that the LCP should be phased out over the next 6-12 months and replaced with a more individual approach including a personalised care plan, and that the CQC would undertake a thematic review into end of life care and consider end of life care issues in their approach to inspections.

The response to the review was developed by the Leadership Alliance, a coalition of 21 national organisations, and published in June this year. .

https://www.gov.uk/government/publications/liverpool-care-pathway-review-response-to-recommendations

The new document sets out the approach which should be used in future in caring for dying people by health and care organisations and staff caring for dying people in England The approach should be applied irrespective of the place in which someone is dying and focuses on achieving five Priorities for care when it is thought that a person may die within the next few days or hours.

1. This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

The document also states that care should be

- compassionate;
- based on and tailored to the needs, wishes and preferences of the dying person, and, as appropriate, their family and those identified as important to them;
- includes regular and effective communication between the dying person and their family and health and care staff and between health and care staff themselves;
- involves assessment of the person's condition whenever that condition changes and
- Timely and appropriate responses to those changes;
- is led by a senior responsible doctor and a lead responsible nurse, who can access support from specialist palliative care services when needed; and
- is delivered by doctors, nurses, carers and others who have high professional standards and the skills, knowledge and experience needed to care for dying people and their families properly.

4.2 Local Action

In Sheffield the CCG did not provide financial incentives for use of the LCP.

In Sheffield there was a Sheffield Pathway which was based on the Liverpool Care Pathway. Clear guidance has been given to staff in community, acute and primary care that the Sheffield Care Pathway is no longer used.

Sheffield Teaching Hospitals set up a group to address the requirements and St Luke's Hospice has also worked on developing appropriate documentation. The CCG is working with both organisations to seek a process which can be used throughout Sheffield, and further updates will be provided at the Scrutiny meeting on 15th October.

5 Draft Strategy

The CCG has revised its End of Life Care Strategy in the light of changing needs and the publication of new policies and this is attached as Appendix 1. We are currently consulting on the strategy and would very much welcome views, particularly on the priorities for further action which are detailed in section 7.4 in the strategy.

4. Recommendation

4.1 The Committee is asked to consider the strategy proposals and provide views and comments,

4.2 The Committee is asked to note the responses to its previous points and subsequent questions, and the people presenting will be happy to provide more details if required.

Appendix 1 Draft Strategy for End of Life Care

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Sheffield's End of Life Care Strategy

Draft 2014 - 2017

Date:
Date at CCG Board
Sponsor Director:

CONTENTS

1. SUMMARY

Sheffield's End of Life Care Strategy sets out the local vision for end of life care which is personalised, well co-ordinated and enables real choice for patients. The Strategy utilises the local Baseline Review[1], -[2], local research including views of local patients and carers, [3] NICE Quality Standards for End of Life Care, One Chance to get it Right[4] and themes from the National End of Life Care Strategy and its Annual Reports. [5]. It details the current understanding of need, service provision and the future plans to commission integrated end of life care for all patients with active, progressive and advanced disease, irrespective of their diagnosis.

In Sheffield there is a range of high quality specialist and generalist end of life care services. However the uses of the end of life care best practice tools is variable and around 54% of deaths currently occur in hospital and 19.5% in care homes. This is in contrast to national research that has shown that between 50 and 70% of people would prefer to die at home.

Acknowledging this, Sheffield's End of Life Care Strategy outlines a plan to realise the local vision for end of life care through commissioning integrated end of life care services which embed best practice, and working closely with all providers contributing to care in Sheffield. This includes seeking the best experience possible for both patient and carers in the palliative period and in the last few days and hours of life, regardless of where the death occurs. As far as clinically possible, the aim is to deliver real choice for patients.

1

[1] Baseline Review of Services in Sheffield for End of Life Care March 2008

2

3 Healthy Ambitions – NHS Yorkshire & Humber http://www.healthyambitions.co.uk/index.html

4 Once Chance to get it Right Leadership Alliance for the care of Dying People 2014

5 National End of Life Care Strategy Department of Health July 2008

2. INTRODUCTION

Sheffield's End of Life Care Strategy is guided by the themes in the National End of Life Care Strategy and the subsequent annual reports to the strategy[6] It has been developed in partnership with providers, service users and carers, and it updates the End of Life Care Strategy 2008 developed by the End of Life Commissioning Group.

End of life care was initially prioritised in the 2007/08 NHS Operating Framework[7], which identified the need to undertake baseline reviews. This was reinforced by the National End of Life Care Programme Commissioning Tool kit. This Strategy utilises Sheffield's comprehensive baseline review and findings from a number of research projects to outline the current understanding of need, service provision and Sheffield's current position. The Strategy articulates the vision to commission integrated end of life care for all patients with advanced disease, irrespective of their diagnosis.

The strategy is principally about care for adults, although it is recognised that work needs to be carried out on transition issues, where young people cared for by the Bluebell Wood hospice reach adulthood, and may need further support.

The strategy sits alongside the plans for Long Term Conditions, for Older People, for Dementia and for Care Homes and supports the Sheffield CCG Integrated Commissioning Plan/Better Care Fund, the Sheffield CCG Commissioning Intentions, the Sheffield Health and Wellbeing Strategy and the public health strategy Achieving Balanced Health.

2.1 Defining End of Life

End of Life can be difficult to define. Either

The WHO Definition of Palliative Care (2002) states

' Palliative Care is an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
Palliative Care:
 Provides relief from pain and other distressing symptoms
 Affirms life and regards dying as a normal process
 Intends neither to hasten nor to unduly postpone death
 Integrates the social, psychological and spiritual aspects of care as needed and desired by patients and families
 Offers a support system to;
--Enable patients to access and adhere to optimal clinical care;
--Address social and legal problems and, in particular, to reduce the impact of poverty on patients and their family members, including children;

[6] End of life care strategy Fourth Annual Report Department of Health October 2012
[7] The NHS in England: Operating Framework for 2007/2008

--Help patients to live as actively as possible until death;
--Help the family to cope during the patient's illnesses and in their bereavement;
 Uses a team approach to comprehensively address the needs of patients and their families, including bereavement counselling, where indicated
 Will enhance the quality of life of patients and their families; and will also positively influence the course of illness
 Is applicable early in the course of illness in conjunction with disease modifying therapies implemented to prolong life, such as chemotherapy and radiation therapy for cancer patients and antiretroviral therapy for HIV/AIDS patients; and includes those investigations needed to better understand and treat distressing clinical complications.

Or

The working definition based on the Department of Health Working Paper on End of Life Care [2007][8]. This states that end of life care should encompass:

- Adults with advanced, progressive, incurable illness (e.g. advanced cancer, heart failure, Chronic Obstructive Pulmonary Disease (COPD), Stroke, chronic neurological conditions and dementia)
- Care given in all settings (e.g. home, acute hospital, ambulance, residential/care home, nursing home, hospice, community hospital, prison or other institution)
- Care given in the last year(s) of life
- Patients, carers and family members (including bereavement care)

Exactly when end of life care begins will vary for each individual, but typically people become frailer, less mobile, and their symptoms and treatment needs may increase. Whilst each patient and family are individuals and it is therefore difficult to put timescales on this, for the purpose of this strategy, end of life care is considered to begin 6-12 months before death and ending for family and carers 6-12 months after death during the bereavement period.

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

3. POLICY CONTEXT

Involving people and their carers in decisions about their end of life care and improving access to high quality care closer to home at end of life are both key issues for policy. The White Paper: 'Our health, Our care, Our say' (2006)[9] and 'Delivering Care Closer to Home: Meeting the Challenge' (2008)[10] both set the direction to make care more personalised, responsive and closer to patients' homes. This has been reinforced in subsequent policy documents, together with the need for choice. The White Paper Liberating the NHS (2010)[11] stated "In end-of-life care, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need."

In the Government's mandate to the NHS Commissioning Board in 2013 it stated that one of the objectives is to

'pursue the long-term aim of the NHS being recognised globally as having the highest standards of caring, particularly for older people and at the end of people's lives'

Most recently the Leadership Alliance for the Care of Dying People published 'One Chance to get it Right'; focussing on care during the final days and hours of life

3.1 National End of Life Strategy

The NHS End of Life Care Strategy (July 2008) identified the following as key:

- Taking a whole system approach
- The need for strategic commissioning, bringing senior representatives from commissioning and service provision together to plan services
- Workforce development to support identification of people approaching their end of life and facilitate care planning
- Coordination of care and the need for a central co-ordinating function to ensure people get the services they require from all the different providers
- The need for rapid response services on a 24/7 basis in the community to avoid unnecessary hospital admission.

In reviewing local areas, the National End of Life Care Strategy requests commissioners to consider coordination for individuals, transport, provision of home care services (24/7), specialist palliative care and advice for non cancer patients in the community, including care homes and improved education and training.

Since publication of the strategy annual reports have been produced, and the latest, in October 2012, highlights the work which has taken place regarding Death in Usual place of residence (as a performance indicator in the Quality, Innovation, Productivity

[9] The White Paper 'Our Health, Our Care, Our Say' Department of Health (2006)
[10] Delivering Care Closer to Home: Meeting the Challenge, Department of Health (2008)
[11] The White Paper Liberating the NHS Department of Health (2010

and Prevention programme. It reinforces the need for improved public awareness and supports the Dying Matters campaign, and continues to encourage GPs to identify the patients on their lists who are in their last year of life.

3.2 **One Chance to get it Right**

In Sheffield a local pathway was developed based on the national Liverpool Care Pathway but nationally, following growing concern, Dame Julia Neuberger was commissioned to review national policy and in July 2013 the report More Care, Less Pathway was published. It recognised the value of the Liverpool Care Pathway, but recommended that it should be phased out in 6 to 12 months, and replaced with an end of life care plan.

In June 2014 the Leadership Alliance for the Care of Dying People published the response to these recommendations – One Chance to get it Right.

The new document sets out the approach which should be used in future in caring for dying people by health and care organisations and staff caring for dying people in England. The approach should be applied irrespective of the place in which someone is dying and focuses on achieving five Priorities for care when it is thought that a person may die within the next few days or hours.

1. This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.

3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

The document also states that care should be

- Compassionate;
- Based on and tailored to the needs, wishes and preferences of the dying person, and as appropriate, their family and those identified as important to them;
- Includes regular and effective communication between the dying person and their family and health and care staff and between health and care staff themselves;

- Involves assessment of the person's condition whenever that condition changes and timely and appropriate responses to those changes;

- Is led by a senior responsible doctor and a lead responsible nurse, who can access support from specialist palliative care services when needed; and

- Is delivered by doctors, nurses, carers and others who have high professional standards and the skills, knowledge and experience needed to care for dying people and their families properly.

3.3 Reducing Inequalities

The recent report Deprivation and death: Variation in place and cause of death[12] demonstrates that socioeconomic deprivation is a factor not only in age and cause of death, but also place of death. Nationally, 61% of people living in the most deprived quintile die in hospital, compared to rates between 54-58% for people living in other quintiles, and this is true for each underlying cause of death. Conversely, people in the lowest quintile were least likely to die in a care or nursing home at 11% compared to other quintiles that vary from 16-20%. The proportion of deaths in hospices is also greatest for the least deprived.

People in the most deprived quintile die younger, with twice as many deaths of people under 65 in the most deprived compared to the least deprived.

The cause of death also varies with deprivation, with more people dying both from smoking related cancers of the lung, oesophagus, head and neck, bladder cervix and liver and chronic respiratory disease in people living in the most deprived quintile. There are fewer deaths from malignant melanoma, breast and prostate cancer

This data is significant in that Sheffield has higher rates of deprivation than the England average, with 34% of its population in the most deprived quintile, and 15.5% of its population in the least deprived quintile.

There is also growing national evidence that people from Black, Asian and Minority Ethnic groups have lower access to palliative and end of life care services[13]. This is very relevant to Sheffield since according to the 2011 census the proportion of people from black and minority groups here is around 14.1%

The Care Quality Commission is currently undertaking a thematic project to understand the barriers which prevent people with the poorest experience of care from receiving good quality, joined up care at the end of life, whilst also identifying good practice.

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[12] Deprivation and death: Variation in place and cause of death , National End of Life Care intelligence network (2012)

[13] Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK. Natalia Calanzani, Dr Jonathon Koffman, Irene J Higginson Kings College London, , Cicely Saunders International (June 2013)

3.4 Palliative Care Funding Review

The White Paper *Liberating the NHS* included the following text -
"The previous administration made progress in developing payment by results in Acute trusts. The mandatory scope has changed little since 2005/06, and has not incentivised results throughout the system. The Department will review payment systems to support end-of-life care, including exploring options for per-patient funding."

This work is now in progress and Sheffield is one of the pilot sites, where data is collected to inform a national understanding of palliative care use and associated costs. The national aim is to develop a classification system categorising palliative care patients according to need, and then to attach resource use and costs to each level of need, so supporting tariff development. Sheffield has also extended its remit to cover the range of social care contributing to palliative care provision.

The data collection period has now concluded and Sheffield will continue to participate in the analysis and consideration of the results.

4. LOCAL VISION FOR END OF LIFE CARE

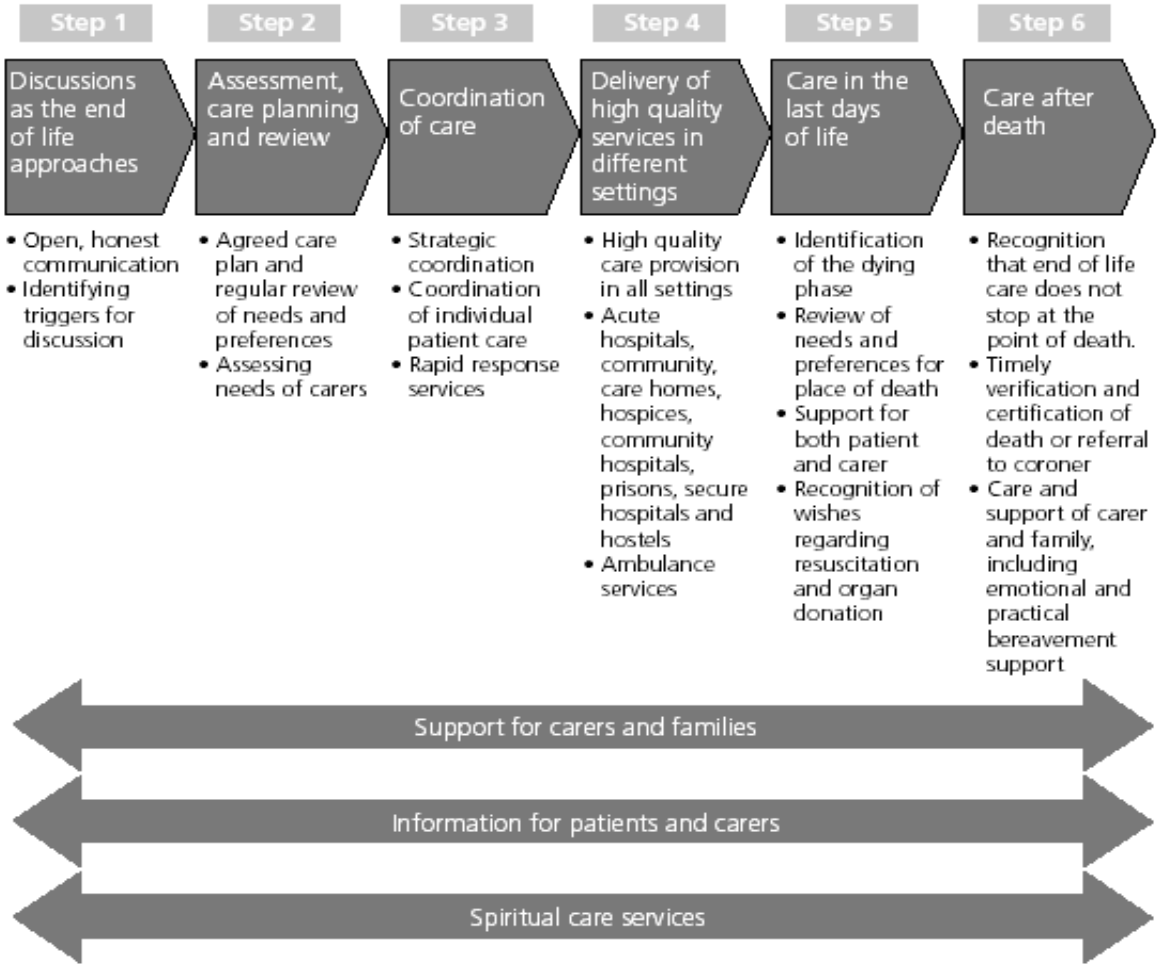
Our vision is integrated end of life care for all patients with advanced disease, irrespective of their diagnosis, who are thought to be approaching the end of their life. We have made considerable progress in broadening the traditional focus on cancer to include non-cancer diagnosis, and this will continue, particularly in areas such as Heart failure, renal impairment, dementia, COPD and long term neurological conditions. .

We aim to commission end of life care consisting of high quality, integrated services, embedding best practice and supporting patients and carers in ways which meet their individual needs, including physical, psychological, spiritual, cultural and social needs during end of life care and in bereavement. This will enable a higher proportion of people, to receive care and die in the place of their choice. We recognize that a preference for place of death may change as the patient's condition changes, and that flexibility and the capacity to adapt to changing views is an important part of the service.

Ultimately we aim to commission end of life care to reduce health inequalities and enable equitable access for people from black, Asian and minority ethnic communities, hard to reach groups e.g. the homeless, as well as those living with a learning disability, neurological condition or severe mental health problem.

The diagram below from the Department of Health further identifies the key steps of an end of life care pathway that we aspire to commission. The best practice tools and resources were developed to facilitate a number of the steps identified below.

Figure 1 End of Life Care Pathway: EOLC Strategy DH 2008[1]



Achievement of this vision is depending on a number of factors, not all of which are within our control. The vision for end of life care is that it is embraced by a society that has increased awareness and a more open attitude to discuss individual preferences for end of life care. The vision for the first step is of empowered generalist and specialist staff facilitating open and honest communication with patients, recognising and acting when a patient is deteriorating and identifying those approaching the end of their life. The next step is appropriately timed conversations about end of life care, progressing smoothly to step 2 and recording individual patients' preferences through care planning.

5. CURRENT STATUS

A key quality marker for end of life care is the place of death, with a major drive to increase the number of people dying at home, or in a care home, as their usual place of residence. For cancer patients, the research from professionals, carers and patients show a preference of 50-70% for a home death. However, for people with non-malignant conditions, just under half have so far reported a preference for home death, and preferences may change over time.[14]

[14] Murtagh, F.E.M., Bausewein, C., Petkova, H., Sleeman, K.E., Dodd, R.H., Gysels, M., Johnston, B., Murray, S., Banerjee, S., Shipman, C., Hansford, P., Wakefield, D., Gomes, B. and Higginson, I.J. (2012) „Understanding place of death for patients with non-malignant conditions: A systematic literature review",

The factors influencing whether someone dies at home or not vary from demographic - higher socio economic status, not being in older age groups, ethnic background, gender, not being married or living alone, - the condition of the patient – cancer diagnosis, absence of complex conditions, symptoms that can be managed in a home setting, to service provision, the presence of a carer and availability of local services.[15]

Sheffield has a registered population of around 580,000 and it is estimated that approximately 1% die annually. This equates to approximately 5800 deaths each year with the commonest causes of death categorised as cardiovascular disease (including strokes), cancers and respiratory disease.

Data from the National End of Life Care profile for Sheffield, based on ONS data, shows the following breakdown for place of death in Sheffield and England averages for the years 2010 - 2012

Place of death	Sheffield	England average
Percentage of deaths in hospital	53.84 %	50.71%
Percentage of deaths in own home	19.76%	21.54%
Percentage of deaths in hospice	4.45%	5.59%
Percentage of deaths in care home	19.45%	19.59%
Percentage of deaths other places	2.04%	2.12%

It should be noted that the figure for deaths in hospital includes those in the Macmillan unit on the Northern General site, which is a 20 bedded specialist palliative care unit. Therefore, in addition to those people dying in the hospice, a significant additional number die within a specialist palliative care service.

Overall, according to a national research over 65% of the population wanted to die at home[16]. Clearly, locally we are at some distance away, from that in reality and the percentage of people dying in their usual place of residence is lower for Sheffield than the England average. Whilst the Sheffield figures have improved since 2011, there has also been an improvement in national figures. We know that those who currently die at home are more likely to have a cancer diagnosis. This is reflected in national data, according to which only 12% of deaths from neurological causes occur at home, and almost all deaths from dementia happen in either a care home 55%) or hospital (39%) [17]

London: National Institute for Health Research, Service Delivery & Organisation

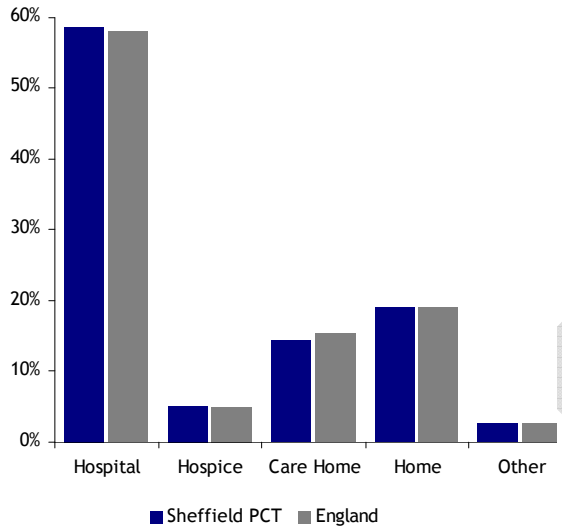
[15] Dying well at home: the case for integrated working Social Care Institute for excellence (May 2013)

[16] Home or Hospital? Choices at the end of life (Sept 04) Barbara Gomes, *Research Associate* and Irene J Higginson, *Scientific Director*

[17] Murtagh, F.E.M., Bausewein, C., Petkova, H., Sleeman, K.E., Dodd, R.H., Gysels, M., Johnston, B., Murray, S., Banerjee, S., Shipman, C., Hansford, P., Wakefield, D., Gomes, B. and Higginson, I.J. (2012) „Understanding place of death for patients with non-malignant conditions: A systematic literature review", London: National Institute for Health Research, Service Delivery & Organisation

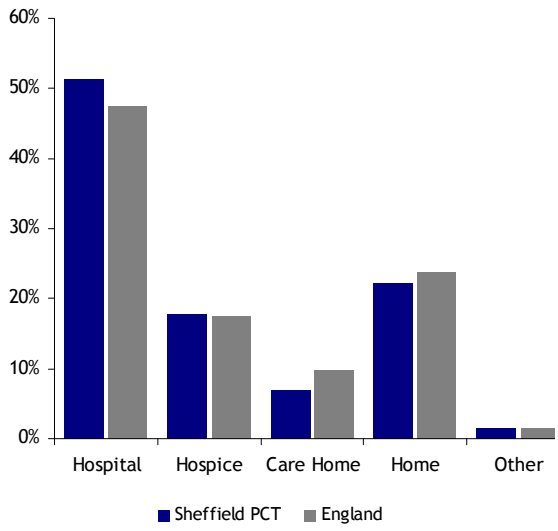
Place of Death for All Patients Compared to Cancer Patients Sheffield 2006 – this data is being updated with more recent figures.

Place of death for all patients in Sheffield PCT 2006



Data from 2006 Mortality Statistics

Place of death for cancer patients in Sheffield PCT 2006



Data from 2006 Mortality Statistics

To further understand the current status Sheffield contributed to a number of local research studies, full details of which can be found in the appendix. One study found that there is variable recognition in identifying people who may be approaching their end of life and initial discussions about people's preferences for end of life care[14]. A number of other local studies highlighted the lack of education, training and support for health and social care staff to manage end of life care issues[11].

One key study undertaken by The Balance of Care Group focused on auditing the notes of a number of individuals who died in hospital in October 2007 and where possible identifying alternatives. The study used the Gold Standards Framework categories and identified that frailty [42%] was more common as an underlying reason for dying than cancer [30%] or chronic disease [20%] with 8% assessed as dying unexpectedly. It also identified that up to 25% of those dying during this period might have had dementia.

In the Study it was identified that 40% of the patients who died in hospital during the audited period did not have medical need that required them to be cared for in an acute setting. The key categories where alternatives were identified were the frail elderly and those with a cancer diagnosis, where palliative care had not been effectively mobilised in time. For those frail elderly patients it was suggested that suitable alternative could be nurse led non-acute beds or support at home.

Current Services

NHS Sheffield currently commissions a range of end of life care services both generalist and specialist palliative care.

6.1 Specialist Palliative Care Services

The following table summarises the Specialist Palliative Care Services currently commissioned

Provider	Current Service Commissioned
St Luke's Hospice *Not all the services listed are formally commissioned as St Luke's is only partially funded by the CCG*	• In-patient unit – 20 beds for cancer and non-cancer patients • Therapies and Rehabilitation Centre 20 places per day four days a week • Outpatient clinics one day per week • Community Specialist Palliative Care Nursing Team, with medical support • Rapid Response Service 7 days a week • AHP, Spiritual Care and Wellbeing support available for all care settings • Bereavement Service • Specialist Palliative Care support for nursing and residential homes, and GP Practices • Volunteer service both in hospice and in the community Dedicated Service User Coordinator
STHFT-Sheffield Teaching Hospital Foundation Trust Palliative Care Service STHFT Weston Park	• Palliative care team –2 Hospital Support Teams covering the sites of Northern General Hospital, Royal Hallamshire Hospital, Weston Park Hospital • In-patient unit-18 beds for cancer and non-cancer patients • Out patients • 24/7 on call advice by consultants and specialist registrar • 7 day a week palliative care CNS • Specialist cancer hospital • Outpatients
STHFT Community Service Marie Curie	Intensive Home Nursing Service & Variable Intensity Palliative Care Scheme
Continuing Health Care from range of providers	Available via fast Track for Palliative Care Patients – support in the home available for eligible patients. The CCG commissions care for people in their own residence or a nursing home, in line with its policy on

	'Commissioning Care'
Cavendish Centre This is an independent charity and the CCG makes a contribution towards the costs.	Multi-disciplinary service offering supportive care, assessment and counselling and a range of complementary therapies to people with cancer.
Sheffield Macmillan Lymphoedema Service	Management of Oedema including in advancing malignancy

There is an externally funded trial of the implementation of the Amber bundle in particular wards in Sheffield Teaching Hospitals.

In addition a number of local and national charities provide support for patients and families including Cruse bereavement support.

One example of high quality services is the Variable Intensity Palliative Care Scheme, which is part of the Intensive Home Nursing Service provided by the Sheffield Teaching Hospitals Foundation Trust and Marie Curie. This scheme was recognised by the National Audit Office due to its flexible provision of nursing care and support to enable individuals to receive palliative care at home. It provides an individualised one to one service with a number of care options to meet individual's needs.

In addition St Luke's Community Specialist Palliative Care Service delivers specialist care in the community, and provides advice and support to health care professionals across primary care.

6.2 Generalist Palliative Care Services

For many people, the majority of their care during the last year of life comes from generalist services such as GP practices, care homes, district nurses, hospital wards and outpatient departments and domiciliary carers.

It is therefore important to work with the commissioners and providers of these services to ensure that end of life care is understood, and that staff have the appropriate skills and knowledge.

General Practice

A GP facilitation team consisting of two consultants and two GPs were recruited to work with GP practices to improve their End of life Care. The CCG continues to update general practice on new developments, and to provide update training.

Sheffield Teaching Hospitals Foundation Trust

The majority of the people who die in Sheffield Teaching hospitals do so on general wards, rather than in the Macmillan unit. The Trust has a specialist nurse working the trust on EOLC education, and also working with staff on targeted wards to implement the Amber bundle.

Care Homes- covering both nursing and residential homes

Since 19.5% of the population die in Care Homes, and there are 5173 care home beds in Sheffield, it is important to focus on this area to ensure that high standards are maintained. There is a GP Locally Commissioned Service in place, covering nearly all the care homes, whereby a GP practice takes on the responsibility for providing general medical services for all the patients of the home. A key element is end of life care, and this is included within the quality standards and accompanying training.

St Luke's community team of specialist nurses also work with care homes to provide advice and guidance on palliative care for care home staff, and there is also a nurse focused on providing training.

Skills for Care facilitate an End of Life Care network for care home staff.

6.3 Service & Quality Gaps

There are a number of service gaps identified across the end of life care including key services that do not currently provide 24-hour access and the availability of equipment, alongside social and health care support. In addition there is a lack of bereavement and carer support services, outside of those available at the specialist palliative care services, and respite services are limited. The specialist services commissioned are very committed and strive to improve quality, although there is greater variation in skills and confidence identified in generalist services.

There are also inequalities in access to end of life care, information & support for non cancer patients, people with neurological conditions, dementia, severe mental health problems, a learning disabilities, BME groups and hard to reach groups e.g. the homeless[2/11].

7. REALISING OUR VISION

To deliver our local vision for end of life care, Sheffield CCG will work in partnership with Sheffield City Council as a commissioner, and with our local providers to reach agreed priority standards.

7.1 Seeking views of user/carers

The views of users and carers gathered through stakeholder engagement in the baseline review contributed significantly to the understanding of need and the development of this Strategy. Through the national Voices work, the National

Strategy also set out national plans to seek the views of carers, including surveying bereaved relatives. Locally there is a need for further development of mechanisms to enable the views of patients and carers to continue to influence commissioning for end of life care.

7.2 Assessing Needs

Whilst the previous baseline review helped to understand some of the local need, further work is required to understand the impact of Sheffield's changing population on further need. The baseline review enabled Sheffield to understand the local need, and the likely future impact. There is also scope in the future to build on the developing Joint Strategic Needs Assessment.

7.3 Strategic Priorities

The baseline review put forward a number of recommendations and assimilating these with the key findings from local research studies, the themes in the National End of Life Care Strategy and recent policy and research documents, has enabled Sheffield to identify local priority areas.

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End of Life Care	Local Priority Areas
Identification and care planning	**Palliative Care Registers** In order for clinicians across providers, especially generalists, to develop the necessary skills to identify those individuals that are progressing towards their end of life and initiate early discussions there is a need for increased knowledge and skills in end of life care and communication skills. A range of training has been provided, including support teams going into general practice, and overall, Sheffield has a higher proportion of people on palliative care registers than the national average. The range does, however vary across the city, and training will be maintained. **Communication System** Sheffield has a communication system whereby clinicians at STH, when a person is identified as at end of life, are enabled to communicate this, together with suggested focus of care, to general practice. This is being expanded across different directorates within STH, with a view to gaining whole hospital coverage. **Dying Matters** At the same time as training professionals, there is a need to encourage the general population to plan for their own deaths, and the CCG supports the national Dying Matters Campaign every year, as well as using available opportunities to promote the message

	through representation at public meetings, website information, and partnership work with other agencies. **Care Plans** Most general practices are using the Sheffield end of life template for clinical records, but there is a need for continual improvement in the quality of the end of life plans with full patient and carer engagement. The CCG is committed to supporting greater use of care planning, and including those people on the palliative care register within its target group. **DNACPR** The development of an agreed DNACPR form across Yorkshire and Humber has been a major step forward, but there is a need continually to update training for all relevant staff on use of the form, and to keep up to date with best practice.
Models of Care	Since our key aim is to increase the choice for people about where they wish to be cared for and where they wish to die, we are looking at how we can improve community support to enable this to happen. Across the country there have been developments of differing models of care, such as hospice at home, and community based teams. It will be important to learn the lessons from this work, and their impact on the quality of care and support for people dying in their preferred place. Locally, St Luke's hospice is now delivering a Rapid Response service (following a successful pilot), and is piloting other home support services such as nutrition, laundry and volunteering, and we hope to learn from these experiences and their implications for future commissioning. Co-ordination of care at home A key identified need is for greater co-working between the City Council commissioned domiciliary care services and the other services supporting people at home including primary care, district nursing and specialist palliative care. We are currently developing a pilot in the north of the city to improve co-ordination and increase community support with the aim of reducing hospital admissions during the last year of life and increasing the number of people who die in their own home if that is their wish. The findings from the pilot will inform future commissioning.
Communication and co-ordination	**Electronic Palliative Care Co-ordination System** There is national requirement for CCG's to work on developing an EPaCCS and whilst we have made progress in our communication

	system, this is an area with the potential to make considerable improvements in care by ensuring greater communication and co-ordination across agencies and professions. We are currently working on a practical way forward, ideally with colleagues across South Yorkshire. Integrated Commissioning Sheffield's work on the Better Care fund and integrated commissioning provides potential opportunities for improved quality in EOLC through more integrated working between health and social care agencies.
Quality of care in the last days and hours of life	One Chance to get it Right gives guidance on the quality standards with a clear focus on the discussions to be held with the patient and family. It is important that we have high quality consistent guidance and documentation across Sheffield, and that all staff engaged in end of life care, both specialist and generalist have an understanding of what is needed.
Education and training	The key to good quality end of life care is staff who are trained, supported and committed. This applies not only to specialist staff, but to all staff who work with patients in a palliative phase. We are committed to continuing and expanding this training to include both NHS staff in primary care, community services, mental health care and generalist medical care, together with domiciliary care staff, care home staff, and staff providing Continuing Health Care. This will build on the good work already taking place such as the use of Sage and Thyme and the senior clinical development programme at STH, advanced communications skills courses and the new one day courses for frontline staff developed by Sheffield City Council.
Equality of access	Since there is evidence that people from Black, Asian and Minority Ethnic communities, people with mental health problems, people with learning difficulties and from more deprived communities have lower access to EOLC services: we will seek to learn from the CQC review and good practice elsewhere, how we can ensure that Sheffield provides fair and equitable access. We will undertake a review of take up of palliative care services from more deprived communities, including people with learning difficulties and severe mental health problems, to enable us to target where we need to focus our efforts. We will also complete an electronic resource for primary care to enable them to understand the religious and cultural needs of people from Black, Asian and Minority Ethnic communities.

Service User and Carer engagement	Palliative care is not the easiest field in which to gain effective service user and carer engagement, since patients may not wish, or may not be well enough to participate, and carers may be very involved in care or grieving. However, there are areas where this has been done well, and we will work with our provider organisations to develop ways of gaining patient and carer views as an integral part of the way we work.

8. DELIVERY

In order to deliver this Strategy and realise the benefits for users and carers a more detailed implementation plan has been developed by the End of Life Care Planning and Commissioning Group.

In 2014-15, in addition to maintaining the current level of services for end of life care, the Commissioning Group will:-

- Plan and specify a pilot for a new model of home care in one locality
- Plan for further development of the EPaCCS
- Support the contribution from Sheffield for the Palliative care Funding Review
- Support work to improve End of Life Care in care homes
- Implement training funded by MPET for hospital and primary care staff
- Support development of EOLC in primary care including the Care Homes Locally Commissioned Service and the Care Planning local scheme
- Complete the programme of facilitation visits for GP practices
- Respond in a timely and co-ordinated way to One Chance to get it Right including an effective implementation of Palliative Care Plans in the last stage of life
- Support improvements in hospital EOLC including implementation of Amber
- Deliver a Sheffield contribution to Dying Matters week
- Support the procurement of Continuing Health Care services, and work with the new providers to ensure they are integrated into the End of Life care service across Sheffield
- Revise and update the service specifications for End of life Care with our main providers
- Explore the potential for inclusion of End of life Care within the Better Care Fund and Integrated Commissioning.

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9. REVIEW AND ACCOUNTABILITY

Progress against the implementation plan is monitored regularly by the End of Life Care Planning and Commissioning Group; which is chaired by the CCG Clinical Lead for End of Life Care who is a GP, and includes representation from:

Clinical Commissioning Group

Sheffield Teaching Hospitals Macmillan Unit
Sheffield Teaching Hospitals Community Services
St Luke's Hospice clinical and managerial representation
Sheffield City Council
Macmillan
Marie Curie

The GP out of Hours Service and ambulance service also attend for relevant agenda issues.

The Planning and Commissioning Group is part of the Long Term Conditions, Cancer, Older People and End of Life Portfolio within the CCG.

There are strong links with Sheffield City Council, particularly around work with Care Homes and domiciliary care.

APPENDIX 1

Further Detail of Local Research Studies

- **A Review of the Provision of End of Life Care services in Sheffield: National Audit Office Whole System Review [draft] July 2008**
  This forms part of a National Audit Office (NAO) End of Life Care National Review which sought to understand the strengths and challenges of end of life care in Sheffield. The NAO Review Team interviewed over 40 members of staff involved in the commissioning and delivery of services as well as current patients and carers.

- **Identifying Alternatives to Hospital for People at the End of Life – Draft Report of Findings. The Balance of Care Group in association with the NAO. July 2008**
  This retrospective study reviewed all people who died in Sheffield in October 2007. The main focus of this study was on people dying in hospital and looking at the potential for more appropriate alternatives to be in place. This study therefore examined how many hospital deaths might have been avoidable had alternatives been available and given due consideration. Key findings include:

- **Improving Supportive and Palliative Care for Adults with Cancer in Primary Care: a National Survey of General Practices. University of Sheffield. May 2008**
  This study set out to establish the extent to which UK Primary Care had adopted recommended practices in relation to supportive and palliative care of adults with cancer and to relate this to participation in previous initiatives. All Sheffield GP Practices were included in this study and results showed: General Practice in Sheffield engages significantly less with end of life care policy initiatives, such as the Gold Standards Framework [19%], than is the case elsewhere in England [61.1%]

- **The Standards We Expect – Choices for End of Life care. Joseph Rowntree Foundation. February 2008**
  This study aimed to collect the views of people living in nursing and residential homes, relatives and carers of people living in homes (or those whose loved ones had recently died) and practitioners and managers working in homes. The study explored the choices in end of life care in a care home. It also wanted to find out what participants thought were the barriers to support being person centred at the end of life and how these might be overcome.

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Report to Healthier Communities & Adult Social Care Scrutiny Committee

15th October 2014

Report of: Tim Furness, Director of Business Planning and Partnerships, Sheffield CCG and Joe Fowler, Director of Commissioning, Communities Commissioning SCC

Subject: Sheffield Dementia Strategy / Joint Commissioning Plan

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Author of Report: Sarah Burt, Senior Commissioning Manager, Sheffield CCG / Sharon Marriott, Commissioning Officer, SCC

Summary:

The enclosed information is being presented at the request of the Scrutiny Committee following a discussion of the Sheffield Dementia Strategy on 20th November 2013. The report discusses the dementia strategy and Sheffield Commissioning Plan within the context of a joint health and social care commissioning approach.

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

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	

Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	√
Other	

The Scrutiny Committee is being asked to:

Please note for information

_____

Category of Report: OPEN

Report of the Director of Business Planning and Partnerships, Sheffield CCG / Director of Commissioning, Communities Commissioning SCC

Sheffield Dementia Strategy and Commissioning Plan within the context of a Joint Commissioning Approach

1. Introduction/ Context

The following report is being presented at the request of the Scrutiny Committee following its meeting on 20th November 2013.

The Committee requested an update on progress of priorities identified in the 2013/14 dementia commissioning plan, focussing specifically on:

- the action plan
- financial details
- public engagement undertaken
- a detailed explanation of the integration of the service.

2. Action Plan

Since we developed our action plan in 2013/14 we have made good progress towards some of our key priorities. However a review of the plan identified that there had been significant change in some areas with means we need to refresh our actions going forward. Sheffield benchmarks well against key outcomes indicators. There continues to be areas that require further work in order to improve services for the people of Sheffield and the 14/15 work plan aims to ensure that progress continues. A copy of the revised action plan is attached at **Appendix A.**

Summary of Main Achievements in 13/14

A summary of the achievements and progress against the key priorities set out in the joint dementia work plan 13/14 are set out below.

- Savings achieved through reconfiguration of specialist dementia support and bed based services at Hurlfield - including closure of 2 resource centres, improvement of centre facilities and additional bed space at Hurlfield.

- Secured investment from Department of Health for a number of Pilot projects aimed at increasing wellbeing / reducing crisis. The outcomes of the evaluation will contribute to future service design. One pilot has already resulted in the development of a new dedicated Dementia Carer Website

- Continued improvement in the dementia diagnosis rate (68.4% based on 13/14 data)

- Development of the Sheffield Dementia Action Alliance

- Care in Hospital – The STH Dementia Care Group continues to lead on the Dementia Friendly Hospitals initiative. Significant changes have been made to improve the experience of people with dementia and their carers during a hospital admission.

- Further work within primary care to reduce the use of antipsychotic medication.

Key Changes

A summary of the key changes are summarised below some of which are being taken forward as proposals in the new 2 year plan.

- **Dementia Information, Advice and Support Service** – The plan described our proposals to replace the current commissioned services with an enhanced model. Following review of the plan it was agreed to postpone the procurement of a new service until the impact of the New Care Act in relation to a wider approach to Advice and Information Services was better understood.

- **Adopt a Care Home Pilot -** a pilot to raise awareness amongst young people about dementia linking schools to care homes and local communities. A care home has been identified and will link with Prince Edward Primary School for this initial pilot. A dementia awareness programme is planned to start at the school in early September 2014, and the Registered Managers from the care homes will assess how the programme develops.

- **Dementia Strategy -** The central objectives identified as part of the local dementia strategy remain the same, and as such, the same priorities will remain in place. This action plan covers the period up to the end of the current strategy; with the possibility that some actions may extend beyond this period.

- **Big Lottery -** Sheffield's bid to the Big Lottery fund was successful in securing £6 million of funding to tackle social isolation and loneliness in older people. This will take account of the specific needs of people with dementia and their carers.

- **Memory Service Redesign –** Work started in 13/14 to redesign the Sheffield Health and Social Care Trust (SHSCT) This work has continued in 14/15. To date, it has enabled the development of a single hub for assessment and diagnosis and will shift follow up into the community. The resulting change in service aims to; significantly reduce the waiting times for diagnosis, deliver follow up closer to home and improve the skills and confidence of primary care practitioners with regard to dementia.

3. Financial Details

There is significant investment in independent sector care homes, home care services and specialist treatment for people with dementia. In addition the CCG and SCC also fund a range of other services, including day support, bed based respite care and services to support carers of people with dementia.

The main focus of the new revised action plan will be the development of new jointly commissioned services that provide timely information, advice and support services and a more innovative approach for community based day opportunities, in line with what people with dementia tell us helps them retain their independence and provides opportunities for their informal carers to have a break. This investment is currently around £2.8million.

4. Public Engagement undertaken

A major consultation and involvement exercise was undertaken in 2012 by SCC and the Sheffield Health and Social Care Trust about the proposals for change to services that support people with dementia. The outcome of these proposals informed the agreed plan for change. Since this time been some reconfiguration of bed based emergency care and respite bed services however, day support, other support and information services have largely remained the same and are more variable in terms of the outcomes and benefits they deliver and the current provision varies in terms of access and care pathways. There is still a need to recommission a new model of more specialist day support/day opportunities and the information, support and advice service if we are to meet the changing needs and demographic profile of the city.

We will be developing a new specification for information, advice and other support services which will include plans for a more innovative approach to community day support/day opportunities services. The new specification will be developed in line with the outcomes people with dementia and their carers told us would support them to remain independent.

5. A Detailed Explanation of the Integration of the Service.

Commissioning high quality Dementia services for the city remains a key priority for the CCG and SCC and the revised action plan makes proposals to progress with the joint approach to new commissioning arrangement to ensure coherence for people with dementia and their carers. There are mechanisms in place to ensure that throughout the integrated commissioning programme between the Local Authority and the CCG the needs of people with dementia and their carers are considered.

6. Recommendation

The committee is asked to note the details of this update and endorse the proposals in the revised action plans attached at **Appendix A**

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Commissioning Landscape Level	Key Outcomes	Commissioning Intentions	Key Actions	Investment per level	Lead
Support for everyone	**People live well and feel supported in dementia friendly communities**	**Raise awareness to ensure communities understand the impact of dementia.** **Build a strong market that can respond effectively to the needs of people living with dementia to prevent decline.** **Promote and support the work of the market to ensure people living with dementia know what is on offer**	Develop and promote the Sheffield Dementia Action Alliance including increasing membership, & develop a vision / action plan and linking to the regional dementia alliance Promote opportunities for people with dementia to engage with establishing Sheffield as a dementia friendly city. Reduce stigma of dementia as part of dementia awareness campaigns Promotion and marketing of the community interventions to raise awareness of support on offer. Developing dementia friendly community evaluation guidelines Public Health dementia prevention work which includes scoping evidence based activities		} Kath Horner SCC

			that demonstrate dementia prevention activities in Sheffield and developing a dementia prevention plan. Promote workforce development including promotion of dementia friends /champions within health and social care workforce Ensure the Sheffield's Big Lottery Ageing Better programme tackling isolation and loneliness in older people, takes account of the specific needs of people with dementia, their carer's, and those who live alone. Develop the adopt a care home pilot to raise awareness amongst young people about dementia linking schools to care homes and local communities		SYHA - Big Lottery Core Partnership includes SCC & CCG commissioners Andy Wallace SCC
Early Intervention	**People receive the right information and support at an early stage which maximises their opportunities to remain as independent as possible.**	**Improve access to early assessment and diagnosis.** **Ensure there specialist information, advice**	Redesign of memory service to reduce waiting times and develop follow up closer to home Develop a specification for specialist information, advice and	CCG 51K plus cost negotiation for 14/15 via	Sarah Burt CCG Jade Bann/Sharon

	Carers of people with dementia live well and feel supported to continue caring and learn new skills to manage caring **Deterioration is delayed or reversed** **Independence and wellbeing is improved**	**and support available to access.**	support and tendering for this Influence the integration agenda to incorporate support for dementia in keeping people well in the community	cluster based payment from 15/16 SCC 34K	Marriott SCC Sarah Burt CCG /Joe Fowler SCC
Early Intervention & Specialist Care & Support **(includes support for people with and without personal budgets)**	**Carers of people with dementia have opportunities to have regular breaks and the risk of crises is reduced.** **Independence and wellbeing is improved** **Deterioration is delayed or reversed** **Care is provided closer to home**	**Increase the range of carer respite choices available, including access to pre-bookable respite beds.** **Ensure there is access to a range of day time interventions including specialist day care that maintains healthy, active and socially engaged lifestyles.** **Ensure that journey times are kept to a minimum, e.g. availability and access**	Review respite beds/day opportunities to determine appropriateness and value for money Develop a new specification for a wide range of flexible day/respite and social activities in local communities and tendering for this.	SCC £2.8 CCG 200K	Jade Bann/Sharon Marriott/ Commercial services SCC/Sarah Burt CCG

		to facilities and services in local communities. **Represents good value for money**			
Specialist & Intensive Care & Support **(includes people with personal budgets)**	**Staff and professionals feel supported and have the right skills and knowledge to care for people with dementia.** **People's experience of care is improved.**	**Improve the quality of care in various settings. I.e. home support, care & nursing homes.** **Ensure all staff working for people with dementia and their carer's have a good understanding what good looks like, and are able to deliver services with dignity and respect.**	Reviewing the quality standards for home support and care homes and setting a framework for this Ensure care homes are choosing priorities to support wellbeing of people with dementia Working to improve the experience of people with dementia and their carers which covers • Environment • Workforce development plan • CQUIN • Pathway • Liaison Work with LCS GPs and care		Andy Wallace/ Louise Pigott SCC Kath Horner SCC Sarah Burt CCG Sarah Burt/Jackie gladden/Pat Whittaker CCG

			homes to ensure robust end of life care plans for people with dementia to ensure that they are able to die in their preferred place of death		
Total Investment				**SCC £2.8m CCG £250K plus additional via cluster based payment in 15/16**	

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
15th October 2014

Report of: NHS England

Subject: Minor Oral Surgery

Summary:

NHS England are planning to change the way minor oral surgical services are provided in Sheffield. The deadline for commenting on these proposals is the 6th November.

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

Reviewing of existing policy	
Informing the development of new policy	**x**
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:
Consider and comment on the proposals

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Briefing Note to Stakeholders

6th October 2014

Oak House
Moorhead Way
Bramley
Rotherham
South Yorkshire
S66 1YY

Procurement of Services
to provide Minor Oral Surgery Procedures in the Community

NHS England is responsible for commissioning primary and secondary care dental services for the population in South Yorkshire and Bassetlaw.

A number of the dental procedures that are currently carried out in hospitals are able to be delivered by specialists who are based in general dental practices within the community. These procedures, which include treatments such as wisdom tooth extraction and removal of retained roots, are generally referred to as minor oral surgery procedures.

In some Local Authority areas of South Yorkshire and Bassetlaw patients are already referred to a specialist in a community based practice for their minor oral surgery procedure. These services have been established and operating successfully for a number of years. However in the Sheffield and Rotherham areas the only referral option for patients at the moment is to the local hospital. We propose to change this situation by commissioning suitable Providers to deliver minor oral surgery procedures in these areas.

The cost of these new services will be met by reducing the amount of resources for minor oral surgery activity carried out in the local hospital. However there will be no overall reduction in the amount of activity commissioned and in some areas the amount of activity is expected to increase slightly to better reflect need.

The benefits of this change are;

- Patients offered a choice of Provider for their minor oral surgery procedure
- Improved local access for patients by having community based provision
- More cost effective use of NHS resources

In addition to the commissioning of new community based contracts in Sheffield and Rotherham, the procurement process will also include re-tendering of existing provision of community based services in Barnsley and Bassetlaw where existing contracts will end next March 2015.

Cont……

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There are 5 separate contracts that will be offered and these are as follows;

Local Authority Area	**Service Description**	**Additional Information**
Sheffield	2 contracts each with the capacity to treat 600 patients per year	1 contract to be delivered from premises within an electoral ward to the east of the centre 1 contract to be delivered from premises within an electoral ward to the west of the centre
Rotherham	1 contract with the capacity to treat 600 patients per year	
Barnsley	1 contract with the capacity to treat 850 patients per year	Existing contract ends on 31st Mar 15
Bassetlaw	1 contract with the capacity to treat 250 patients per year	Existing contract ends on 31st Mar 15

It is intended that the new services will commence from 1st April 2015.

Service users have been invited to submit views through a poster displayed in General Dental and General Medical practices across the relevant localities.

Distribution

(For the localities of Sheffield, Rotherham, Barnsley, Bassetlaw)

Overview and Scrutiny Committees
Health and Wellbeing Boards
Healthwatch
Clinical Commissioning Groups
Members of Parliament

Oak House
Moorhead Way
Bramley
Rotherham
South Yorkshire
SGG 1YY
email paulstones@nhs.net
01138 253445

Overview and Scrutiny Committees

Barnsley
Bassetlaw
Rotherham
Sheffield

6th October 2014

Dear Colleague

Procurement of Minor Oral Surgery Services – South Yorkshire and Bassetlaw

Please find enclosed a briefing note which describes NHS England's intention to procure and commission minor oral surgery services from community based providers in South Yorkshire and Bassetlaw.

I trust that the briefing note provides all the information you need to consider any response or comments you may wish to submit with regard to this proposal.

If you do require any further information please do not hesitate to contact Paul Stones at the address above.

Any comments that you may wish to submit regarding this proposal should also be sent to the address shown above by 6th November 2014.

Yours sincerely

pp Richard Armstrong
Interim Head of Commissioning

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Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Draft Work Programme 2014-15

Chair: Cllr Mick Rooney **Vice Chair**: Cllr Sue Alston
Meeting day/ time: Wednesday, 10am-1pm
Please note: the Work Programme is a live document and so is subject to change.

Topic	Reasons for selecting topic	Contact	Date	Expected Outcomes
15th October 2014				
End of Life Care Strategy	Minutes from 15th January. The Committee requests that "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"	Jackie Gladden, Senior Commissioning Manager, Long-Term Conditions and End of Life Care / St Luke's Hospice	Oct-14	
Dementia Strategy & Integrated Working	Minutes from 20th November 2014: the committee requests, "the Director of Business, Planning and Partnerships, Sheffield CCG, to submit a report to a future meeting of the Committee, containing details of the	Sarah Burt Senior Commissioning Manager (CCG) SCC Executive Director, Communities	Oct-14	

	progress made in terms of the Sheffield Dementia Strategy and Commissioning Plan, with an emphasis on the Action Plan, financial details and work undertaken in terms of public engagement, together with details of an explanation as to how the service was integrated, and (B) the Executive Director, Communities, to attend the same meeting to explain how the Council and Health were responding to the requirement for integrated service provision			
17th December 2014				
Learning Disability Service Petition – Update	Petition presented on 23rd July 2014 – minutes request an update on the consultation process be presented to a future meeting within 6 months	Moira Wilson, Interim Director of Care and Support	Dec 14	

25th February 2015				
Health Inequalities Action Plan	Request from 23 July meeting. Committee to be involved at early stage in any refresh of HIAP esp in regard to (i) working closely with local communities;(ii) issues regarding communities supporting each other; (iii) flexibility in care plan arrangements in the context of developing the Council's strategic plans	Jeremy Wight, Director of Public Health.	Feb 2015	Committee to consider progress on action plan and make comments in advance of Health and Wellbeing Board's consideration of the action plan in March.
Care Act 2014	Progress update on implementation of the Act, including financial implications.	Luke Morton, Programme Manager.	Feb 2015	Gain understanding of Act and Sheffield City Council's response
Sheffield Health and Social Care Trust – Annual Quality Account.	The Committee is required to comment on the Quality Accounts of providers of health services in the City	Jason Rowlands, Director of Planning and Performance, Sheffield Health and Social Care NHS Trust	Feb 2015	Committee comments will be published as part of final Quality Account.
15th April 2015				
Sheffield Children's Hospital, Annual Quality Account	The Committee is required to comment on the Quality Accounts of providers of health services in the City	John Reid, Director of Nursing and Clinical Operations, Sheffield Children's Hospital.	April 2015	Committee comments will be published as part of final Quality Account.

Right First Time Programme.	Minutes from 17th September 2014: the committee requests a progress report on the Right First Time Programme. including details of patient feedback, and the communication and informatics workstreams.	Kevan Taylor Sheffield Health & Social Care Foundation Trust	Apr-14	
Date TBC				
GP Practices	Minutes from 17th July 2013 the Scrutiny Committee identifies (i) the need for discussions "(A) with the National Commissioning Board's Local Area Board regarding GP practices in the City, including the numbers, location and skill mix."	tbc	tbc	
A Guide to Health Scrutiny in Sheffield	Presenting the final draft health protocol for approval by the Scrutiny Committee.	Cllr Mick Rooney, Chair	tbc	

Transitions within the CAMHS service	There was a recommendation in the CAMHS Working Group Report to include this topic on the work programme for 2014-15.	Anthony Hughes (CYPF), Tim Furness (CCG), Steve Jones (SCH)	tbc	
Joint Commissioning strategy	A report providing an overview of the Joint Commissioning Strategy, to include an overview of the services, timescales etc.	Laraine Manley, Executive Director Communities	tbc	
SHSCFT - how patients with specific needs are supported when they are admitted to adult acute care at the Teaching Hospitals	The governors have asked if Scrutiny could look into how patients with specific needs are supported when they are admitted to adult acute care at the Teaching Hospitals. They have identified people with dementia, significant mental health issues, learning disabilities, deafness and blindness. They are particularly interested in how a person's level of need is firstly identified and then how the Trust assures itself that this need has been met	Sam Stoddart Membership Manager	tbc	
Briefing Papers				

Sheffield Adult Safeguarding Partnership - Annual Report 2012/13	Minutes from15th January 2014, the Committee requests that the Sheffield Adult Safeguarding Partnership (iii) provide a progress report to the Committee on a quarterly basis.	Simon Richards, Head of Quality & Safeguarding & Sue Fiennes, Independent Chair	(April 2014) July, Oct 2014, Feb 2015	
Update Report on developing a Social Model of Health/ Health Communities Review	Minutes from 19th March 2014, That the Committee:- 8.4 (c) "requests that a written update report on progress with the Social Model of Public Health/Healthy Communities Review be included on the agenda for each future meeting of the Committee"	Chris Shaw, Director of Health Improvement	(April 2014) July, Oct, Dec 2014, Feb & April 2015	
Task & Finish Work				
CAMHS Working Group	Report finalised and response received. Awaiting progress update	Emily Standbrook-Shaw, Policy and Improvement Officer		

Nutrition & Hydration Working Group	Report finalised, awaiting response from Trusts	Emily Standbrook-Shaw, Policy and Improvement Officer	Oct 14	
Joint Health Overview and Scrutiny Committee – Cardiac Services	Work ongoing, awaiting JHOSC meeting date, likely to be late Sept, early Oct.	Led by Leeds City Council		

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
15th October 2014

Briefing Paper of: Sheffield Adult Safeguarding Partnership

Subject: Business Plan Update

Author of Report: Simon Richards, Head of Quality and Safeguarding

Summary:
As requested, a quarterly update on the Adult Safeguarding Business Plan is submitted to the Committee.

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

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

The Scrutiny Committee is being asked to:
Consider the update and request further information if required.

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SASP 2014-15 Business Plan: Update Oct 2014

Introduction

Each year, SASP Executive Board develops and agrees a business plan setting strategic direction and key outcomes, and connecting these to the council's vision and wider objectives, and matters of national strategy. Members are sufficiently senior in their organisations to influence, lead and support the implementation of the Business Plan and its further development.

Vision Statement

People of Sheffield are able to live a life free from avoidable harm, in communities that

- *do not tolerate abuse,*
- *work together to prevent abuse occurring*
- *know what to do when abuse happens'*

Core objectives and outcomes for 2014-15:

1. Implement an effective Performance Framework and use data and information to improve safety and practice quality
2. Improve the Quality of safeguarding practice, ensuring consistent standards across the partnership
3. Respond to improvement drivers (local and national) ensuring learning is embedded in practice, strengthening of risk mitigation and to ensure partnership working is effective
4. Deliver the Equalities Action
5. Promote public awareness of safeguarding being everyone's business

Key	**G/C**	completed
	G	Performing well / No concern - No further action needed
	A	Slightly off track / Minor concern - Active management needed
	R	Significantly Off track / Major concern - Escalation needed

step	What we will do	Update: Oct:14	RAG
1.1	Interrogate data and information presented to interpret apparent inconsistencies and trend	Q1 2014-15 performance data presented to Sept-14 Operational Board: report draws together routine statistical data to develop an over view of trends and interrogate information to evidence what's really happening. Performance around timescales and the backlog of open overdue cases remain a concern : Interim Head of Care and Support has put in place a range of initiatives to improve accountability, pin point blockages and improve data integrity. Financial abuse continues to be the most reported category of concern. Overall there has been no significant change in the characteristics of individuals at risk of abuse, or alleged perpetrator. SASP Task and Finish group meeting 13 Oct to review data in more detail – findings and recommendations will be reported to the Nov-14 Operational Board	G
1.2	Seek additional information to verify and explain when things are starting to go wrong so that we can act promptly to safeguard people	South Yorkshire Police (SYP) presented a draft Information Sharing Agreement to Sep-14 Operational Board: its purpose is to agree a formal information exchange between social care services to assist working together to protect adults at risk, and provide a framework for action. The agreement includes Barnsley, Rotherham, Doncaster and Sheffield social services.	G
1.3	Accepting there is no single system that allows us to easily report and analyse concerns that do not meet the Safeguarding threshold, share local intelligence to describe activity, themes and trends. Use this to help predict emerging areas of risk and opportunity	Independent Chair of Adult Safeguarding presented a recommendation to the Sep-14 Operational Board, seeking support to report ongoing initiatives and campaigns that are taking place across partner organisations, that influence and perhaps go beyond the key priorities of the SASP Business Plan. It was agreed SASP will provide quarterly updates to the Operational Board, commencing Nov-14.	G

1.4	Ensure safeguarding workers have access to appropriate legal and professional advice to support risk management We monitor and report: • Use of Mental Capacity Act, analyse usage and identify areas for concern • Case advice response times, analyse usage and identify areas for concern • DOL These measures will feature as components of the performance, provide assurance that workers know where to access advice, and help identify 'cold' spots	In line with national trend, Sheffield has seen an unprecedented increase in demand on DOLs. Additional resources have been put in place to help meet this demand.	A 
step	What we will do	Update: Sep-14	RAG
2.1	Quality assure Safeguarding process stages - Alerts, Strategy, Investigations via planned audits	A temporary additional Safeguarding Development manager has been appointed and is currently undertaking quality assurance audits into decision making throughout the safeguarding pathway. An over view of themes is being collated, and from this improved training material will be developed. Initial findings include 'inappropriate' alerts are made, but we accept this tolerance as evidence we are meeting the expectation of CQC. Performance around timescales and backlog of open overdue cases remain a concern and promplted the need to hold a Performance Improvement session in Jul-14, led by the Interim Head of Care and Support.	A 
2.2	Continue to link all sources of intelligence to inform Risk management in safeguarding	A review of the relationship between VAP and PRAM panels and their interface is progressing. Prevent strategy presented to Jun-14 Operational Board to improve understanding across SASP, relating to key issues. Associate Designated Nurse Safeguarding Adults is leading work to share public health data mapping, to help reveal hotspots. Concerns about consistency of decision making in terms of whether cases are included or excluded from the	G 

		Safeguarding process have been raised as part of Performance Improvement (PI); actions include review of training cycles to improve skills.	
2.3	How good is safeguarding in care homes and how can it improve	An update report from the Head of Strategic Commissioning and Partnership (Communities) will be presented to the Nov-14 Executive Board.	G 
step	What we will do:	Update: Sept-14	RAG
3.1	Seek and receive assurance that outcomes relevant to Adult Safeguarding are progressed in a timely and effective manner • Winterbourne View • Francis Report • Cheshire/West	A verbal update from Kevin Clifford (NHS Sheffield CCG) about local implications of the Winterbourne View reports were was given to the June-14 Exec Board, to provide assurance about governance arrangements The Supreme Court ruling has significantly reduced the threshold for DOLS and for the first time brought individuals in supported living accommodation into the scope of the legislation and people who are in receipt of 24 hour home care packages. It does not impact on people eligible for or subject to detention under the Mental Health Act. Identify any Best Interest Assessor resource released from NHS Sheffield for an interim period. to respond to the pressures in the short/medium term and to examine how longer term Best Interest resource can be embedded into large managing authorities and within placing agencies – SCC and CHC System agreefor auditing capacity and best interest decisions by workers to avoid challenge by the supervisory body or via the courts.	A 

3.2	Ensure SASP is able to implement Care Act 2014	Communities Business Strategy are leading the implementation project. The monthly Adult Social Care Managers' Meetings, led by Moira Wilson, Interim Director, will ensure regular and consistent communications across adult social care to report the actions and progress made, and ensure managers are kept up to date with changes, how they are expected to implement change .	G
step	What we will do:	Update; Sept-14	RAG
4.1	Encourage, guide and monitor progress of Safe In Sheffield project to reduce disability related harassment and abuse of vulnerable adults	An update report to the steering group is expected in early October: routine monitoring confirms the outcomes of this work are well received.	G
4.2	Improve our understanding of the circumstances and motivations of perpetrators, and embed learning in training front line staff and partners in how to recognise and treat disability-related harassment	Improved training materials have been developed to ensure alleged perpetrators feed into case conferences as part of the investigation process in individual cases. Learning will be embedded in training and embedded in practice.	G
4.3	Review of existing data to produce a map analysis for Safeguarding in Sheffield, and build on analysis to construct a model against which levels of types of Safeguarding activity and outcomes can be effectively assessed	First drafts produced but needs further development to reveal 'hot' and 'cold'spots without compromising confidentiality.	A
4.4	Implement actions from the Equalities Workshop to improve access to services, and engagement with Adult Safeguarding across all communities in Sheffield	The implementation of the Equalities plan will consider how to overcome barriers which may prevent some communities engaging with the safeguarding agenda and address cultural issues: interpreting data confirms Sheffield demographic is changing. Consider impact of Forced Marriage legislation. Seek and use best practice models from other local authorities and learning from Case Reviews and Serious Case reviews to promote public awareness in Sheffield	A
step	What we will do:	Update: Sept-14	
5.1	Run a campaign to improve awareness and confidence as Safeguarding being an effective way to protect	SASP Executive Board has endorsed the decision by SCC to engage with the Making Safeguarding Personal agenda (led	G

	people at risk	by LGA). Representatives from Sheffield attended a workshop in York (29 Sept) to better understand the key principles of shifting safeguarding a process, to a commitment to improving outcomes alongside people, to developing a real understanding of what people wish to achieve. key issues to consider are: • How we engage practitioners in changing their responses to safeguarding • Balancing risk with the views of the person • Mental capacity issues and duress • Ensure advocates are available to people in safeguarding • How we will engage customers and customer groups to empower them to take on this role	
5.2	Target campaigns	Outcomes from Customer Forum meeting held in Aug include the routine reporting back from Operational Board, andthat a standing item 'Customer Board Feedback' is included in the Operational Board agenda. SASP agreed to support a scoping exercise into how young adults at risk of sexual exploitation are supported. This work is being commissioned, but no update is available at this stage.	G