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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 22 July 2015 at 10.30 am

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

The Press and Public are Welcome to Attend

Membership

Councillor Cate McDonald (Chair), Sue Alston (Deputy Chair), Pauline Andrews, Jenny Armstrong, Katie Condliffe, Mike Drabble, George Lindars-Hammond, Shaffaq Mohammed, Anne Murphy, Peter Price, Jackie Satur, Geoff Smith, Garry Weatherall, Brian Webster 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
22 JULY 2015

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 Meetings (Pages 5 - 16)
To approve the minutes of the meetings of the Committee held on 15th April and 20th May, 2015

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

7. Update on the Deregistration of Learning Disability Care Homes (Pages 17 - 24)
Report of Kate Anderson, Director of Commissioning, Communities, Sheffield City Council

8. Transforming Care - Update on Winterbourne Actions (Pages 25 - 32)
Report of Pamela Coulson, Commissioning Manager, NHS Sheffield Clinical Commissioning Group

9. Work Programme 2015/16 (Pages 33 - 40)
Report of the Policy and Improvement Officer

10. Child and Adolescent Mental Health Service (CAMHS) Update (Pages 41 - 56)
Report of the Policy and Improvement Officer (For information only)

11. Urgent Care Review (Pages 57 - 84)
Report of the Policy and Improvement Officer (For information only)

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

Wednesday, 23rd September, 2015, at 10.30 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, 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 15 April 2015

PRESENT: Councillors Mick Rooney (Chair), Sue Alston (Deputy Chair), Jenny Armstrong, Olivia Blake, John Campbell, Katie Condliffe, Anne Murphy, Denise Reaney, Jackie Satur, Philip Wood and Sarah Jane Smalley (Substitute Member)

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe and Alice Riddell

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Jillian Creasy, with Councillor Sarah Jane Smalley attending as her substitute.

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 In relation to Agenda Item 8 (Quality Accounts – Sheffield Teaching Hospitals NHS Foundation Trust), Councillors Sue Alston and John Campbell each declared a Disclosable Pecuniary Interest as they were employees of the Sheffield Teaching Hospitals NHS Foundation Trust, but felt that their interest was not prejudicial in view of the nature of the report and chose to remain in the meeting during consideration of the item.

3.2 In relation to Agenda Item 10 (Sheffield Health and Social Care NHS Foundation Trust 2014-15 – Quality Report), the Chair, Councillor Mick Rooney, declared a Disclosable Pecuniary Interest 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 report 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 25th February 2015, were approved as a correct record and the contents of the attached Actions Update were noted.

4.2 Further to the consideration of the above minutes and Actions Update, it was noted that:-

(a) a written response had been provided to the questioner, who had asked a series of questions at the Committee's last meeting, relating to the Council's implementation of the Living Wage for Care Workers and the Unison Ethical Care Charter, and this would be circulated to the Committee;

(b) the Policy and Improvement Officer would check as to whether Members could access staff complaints regarding Adult Social Care and inform Members of her findings;

(c) the Homecare Commissioners would be invited to present a report to the Committee in the next Municipal Year on Adult Social Care Performance;

(d) Domestic Abuse would be included in the Committee's Work Programme as an item for possible consideration at a future meeting;

(e) the Recovery Plan in relation to Adult Safeguarding had been circulated to Members; and

(f) the report of the Child and Adolescent Mental Health Service Working Group was to be presented to the Sheffield Health and Wellbeing Board, as part of the evidence base for proposing changes to the way services were provided in Sheffield.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 There were no public questions asked or petitions submitted from members of the public.

6. QUALITY ACCOUNTS - YORKSHIRE AMBULANCE SERVICE

6.1 Steve Rendi, Head of Emergency Operations (South Yorkshire), Yorkshire Ambulance Service (YAS), and Gareth Flanders, Head of Quality, YAS, gave a joint presentation which updated the Committee on the work of YAS. The presentation focused on the Service's coverage, services provided, the national/regional context, A&E performance in Sheffield and quality. It also set out the priorities for improvement contained in the Quality Account 2013/14 and the priorities for improvement for 2015/16.

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

- One person in each ambulance team was a qualified paramedic and the service target was for 50% from the service being so qualified. It should be noted that approximately 30% of 999 calls were capable of being treated on site.

- A Workforce Plan had been developed whereby paramedics would work with

a more junior colleague, with the aim of upskilling some of the junior operatives.

- A patient story video had been used for training purposes, together with learning from complaints and incidents.

- Staff would stay with a patient for sufficient time to assess the effects of any pain relief which had been administered. This would depend on individual patient needs and patients would not be moved unless given appropriate pain relief.

- Figures showing the trend in Red call demand (for the sickest patients) could be provided in the Quality Account.

- There were presently 25 paramedic vacancies across South Yorkshire. Recruitment was a national problem, with more paramedics being recruited from abroad.

- The National Staff Survey results were contained in an action plan which was included in the Quality Account.

- The introduction of a new Band 4 role would have no immediate impact on the numbers of paramedics. It was part of a career pathway to becoming a qualified paramedic and there was a rolling programme to upskill 70% of Band 3 operatives to Band 4.

- Applications for paramedic vacancies would be welcomed from those working for other NHS providers and consideration would be given to the Committee's suggestion of adopting a more pro-active approach to this.

- The YAS provided clinical staff for the Yorkshire Air Ambulance with four staff from South Yorkshire having completed the training to act in this capacity.

- Each paramedic had a report form to complete in relation to each call, which included information on the pain score. Staff were continually being educated to ensure completion of these forms, from which action plans were developed. The reporting of pain scores had improved and consideration was now being given to the use of electronic recording. Tough electronic boards were presently being used in West Yorkshire and these were to be introduced in South Yorkshire in September 2015.

- In relation to End of Life patients, partnership work was taking place which was looking at the right place-right time theme. Obviously, ambulance staff would not know the individual patient and an assessment would be made at the time of the appropriate pathway. The introduction of a clinical hub in the 999 call centre and the use of the tough book would contribute to improving this process.

- The Quality Account would include details of strategies to reduce patient falls.

- Patient feedback was based on six questions which covered the patient experience from initial call to the attending ambulance crew. The friends and family statement was also included, together with a comments text box. This information was used for training purposes and would be included by means of a chart in the Quality Account.

- In relation to the priorities, a CQUIN (Commissioning for Quality and Innovation) 3 report had been submitted and these had all been achieved, apart from the national response times. This was currently under discussion with the Trust Commissioners. The priorities would be RAG rated in the Quality Account.

- Work was being undertaken with staff to ensure a better balance between work and break time and it was managers' role to support this. These were very challenging times, with demand being very high at the moment, and it was important to ensure that staff had adequate rest and took leave.

- The YAS worked with acute partners in relation to pressures on A&E services on a local and regional level.

- A geographical breakdown of where timing targets were not being achieved would be circulated to Members, as would further information on survival to discharge.

- The movement to electronic recording would assist with patients receiving appropriate treatment.

- Bad, as well as good, patient experiences were included in the patient stories.

- Staff were aware of the need for recognition of both verbal and non-verbal communication, so that they could check for pain with patients where there were language issues.

- The 11.5% increase in Red call demand had been reported to the Clinical Commissioning Group.

6.3 RESOLVED: That the Committee:-

(a) thanks Steve Rendi and Gareth Flanders for their contribution to the meeting;

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

(c) requests that the Yorkshire Ambulance Service Quality Account 2014/15 be drafted so as to take account of the audience to which it was to be presented, with particular reference to the inclusion of:-

(i) proof, trends and context to make it more meaningful;

(ii) an explanation of how indicators were determined;

(iii) actions being taken where targets were not being met; and

(iv) further information about the impact of continued underperformance on the eight minute target; and

(d) notes that the Committee's response to the presentation, based on the Committee's discussions, would be drafted by the Policy and Improvement Officer.

7. QUALITY ACCOUNTS - SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

7.1 The Committee received a report of the Medical Director, Sheffield Teaching Hospitals NHS Foundation Trust, which presented a draft of the Trust's Annual Quality Report 2014/15. The report was presented by Sandi Carman, Head of Patient and Healthcare Governance, Sheffield Teaching Hospitals NHS Foundation Trust, who explained that the draft Quality Report took account of the Committee's comments made at its previous meeting. Also in attendance for this item was Michael Harper, Chief Operating Officer, Sheffield Teaching Hospitals NHS Foundation Trust.

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

- The discharge of patients took place each day but Saturday and Sunday had the lowest number of discharges. Staff availability was being looked at in an attempt to address this imbalance.

- Consideration was being given to the best way of adapting the friends and family test to cover a number of situations.

- Work was being undertaken with the Commissioners with regard to the incidence of pressure ulcers, but it should be noted that some care was delivered in the community and this could include a multitude of providers.

- Discharge information was available online to supplement the leaflets which patients were already given. This was not, however, promoted widely, but consideration could be given as to how this could be flagged up on the Trust's website.

- All of the 2014/15 quality objectives had been carried forward to 2015/16, with three objectives being added as required.

- Patients were engaged in the process of the introduction of tent boards, which gave the name of the consultant and nurse responsible for the patient's care.

- The Trust's Governors reviewed the Complaints Service and on occasions met with individual complainants. Patients were also represented by having a Healthwatch representative on the Patient Committee.

- All literature was badged and all staff wore badges, so that people were aware that community services were part of the Trust. This contributed to helping people get in touch with the right service if they had any cause for complaint.

- Members' comments regarding the adaptation of tent boards for those who were not ambulant and ways in which the public could be made more aware of the Quality Report would be given due consideration.

- Statistics on patients' length of stay were included in returns to the Clinical Commissioning Group (CCG) and consideration would be given as to how delayed discharge could be included.

- The Trust undertook work with Sheffield Hallam University on dementia care training, with a wide range of training being available for staff and support workers. Details of mandatory training for staff on dementia care would be provided to Councillor Jenny Armstrong.

- The experiences of End of Life Care patients were monitored through the patient's family and the End of Life Care Group and were subsequently reviewed.

- Nursing staff and medical cover operated over a 24 hour period but there was a difference at weekends, particularly in relation to Accident and Emergency services and in relation to the presence of decision makers, although it should be noted that robust support was available to the junior doctors present, at all times.

- It was aimed to ensure that 'Do Not Resuscitate' notes were used discretely, as a matter of good practice.

- In relation to the low morale of nursing staff, it should be noted that their salaries were tied to a national pay scale and the importance of supporting staff was emphasised, with particular reference to monitoring sickness patterns, particularly where stress was a feature. A staff engagement survey also assisted in identifying any particular issues.

- It was expected that the guidance on the timing of the presentation of quality accounts was to be revisited next year, so that all data was available for inclusion. It was accepted that the present timescale was challenging and the Trust would welcome the Committee's offer to raise this with the Department of Health.

- Factors leading to cancelled operations were a lack of beds, equipment and

staff. This was currently being looked at and an action plan had been produced which could be shared with the Committee.

- The safety priority for 2015/16 had been included as part of a national safety campaign and additional funding had been received in this connection. There was therefore a national imperative for this priority and no specific cause for concern locally.

7.3 RESOLVED: That the Committee:-

(a) thanks Sandi Carman and Michael Harper for their contribution to the meeting;

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

(c) notes that the Committee's response to the report, based on the Committee's discussions, would be drafted by the Policy and Improvement Officer; and

(d) requests that an item on Cancelled Operations be included in the Committee's Work Programme.

8. QUALITY ACCOUNTS - SHEFFIELD CHILDREN'S HOSPITAL NHS FOUNDATION TRUST

8.1 The Committee received a report of the Director of Nursing and Clinical Operations, Sheffield Children's Hospital NHS Foundation Trust, which presented a draft of the Trust's Quality Report 2015. The report was introduced by John Reid, Director of Nursing and Clinical Operations, Sheffield Children's Hospital NHS Foundation Trust, who made particular reference to the installation of a new computer system, the Care Quality Commission visit in 2014 and the building work which was taking place at the Children's Hospital.

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

- In relation to the implementation of the recommendations from the Mid Staffordshire Public Inquiry, meetings were held with ward managers every six months and a tool had been developed to assess the number of interventions per child, so that the number of nurses required could be predicted. In addition, a quality dashboard had been placed on the Trust's website.

- A nutritional strategy was being developed, but this was difficult with children, mainly because of their short stays in hospital. They were given a visual choice and new trolleys had been introduced since the Task and Finish Group had investigated this issue. In addition, breastfeeding facilities had been provided.

- There were some IT issues involved in the electronic discharge process, with the Trust wishing to send this information by email to GPs, whilst they wished to have it put straight into their databases.

- It should be noted that families' satisfaction with the Children's Hospital had not suffered as a result of the building works, which was to be commended given the scale of the works.

- The presented Quality Report was a summary document, with hyperlinks being included to enable access to more detail.

- Current issues related to violence and aggression, which it was thought arose due to the Children's Hospital having a significant Mental Health Unit, and children's medication, which took many different forms, thus increasing the potential for error. With regard to the latter, a prescribing software application was awaiting approval.

8.3 RESOLVED: That the Committee:-

(a) thanks John Reid for his contribution to the meeting;

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

(c) notes that the Committee's response to the report, based on the Committee's discussions, would be drafted by the Policy and Improvement Officer; and

(d) requests that the Trust's report on Child and Adolescent Mental Health Services, which was to be presented to the Sheffield Clinical Commissioning Group in May 2015, be circulated to the Committee, and it was hoped that this would generate a collective response across providers and commissioners to improve current services.

9. SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST 2014-15 - QUALITY REPORT

9.1 The Committee received a report of the Director of Planning, Performance and Governance, Sheffield Health and Social Care NHS Foundation Trust, which presented a draft of the Trust's Quality Account 2014/15. The report was presented by Jason Rowlands, Director of Planning, Performance and Governance, Sheffield Health and Social Care NHS Foundation Trust. Also present for this item was Tania Baxter, Head of Integrated Governance, Sheffield Health and Social Care NHS Foundation Trust.

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

- Questions relating to the Intensive Treatment Service, the access to outside space at the Dovedale ward, the use of the outside space at Woodland View,

health and safety training and the carrying forward of the quality objectives from 2014/15 as part of a two year plan, would be addressed in the Trust's next report to the Committee.

- In relation to the Intensive Treatment Service, it was important to get the balance right between individual needs and group activities, with the service being developed in conjunction with the Occupational Health team.

- Work had been undertaken at the Dovedale ward to improve access to the outside space there.

- The Trust was looking to make improvements at Woodland View.

- In relation to the Mental Health Survey 2014, the performance of the planning of care centred on issues around the provision of a copy of the patient's care plan. A significant improvement programme, which focused on ensuring that recovery goals were reached, had been put in place, and the final draft of the Quality Account would provide more information on this.

- The side effects of medication were looked at in terms of recovery goals, recognising that treatment could have an adverse effect on physical health and getting better at communicating with other support organisations.

- In relation to the Memory Service, the Trust's performance with regard to getting seen was one of the best in the country. The improvement plans agreed with the Commissioners were being revisited and the outcome would be reported back to the Committee.

9.3 RESOLVED: That the Committee:-

(a) thanks Jason Rowlands and Tania Baxter for their contribution to the meeting;

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

(c) requests that:-

(i) a further report on the outcome of the Care Quality Commission inspection which took place during October/November 2014, be presented to the Committee at an appropriate time; and

(ii) a report on the Memory Service be presented to the Committee at a future date, to explain actions being taken to improve waiting times; and

(d) notes that the Committee's response to the report, based on the Committee's discussions, would be drafted by the Policy and Improvement Officer.

10. WORK PROGRAMME

10.1 The Committee noted the Draft Work Programme 2014/15.

11. DATE OF NEXT MEETING

11.1 It was noted that the next meeting of the Committee would be held on a date to be arranged.

S H E F F I E L D C I T Y C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 20 May 2015

PRESENT: Councillors Sue Alston, Pauline Andrews, Jenny Armstrong, Katie Condliffe, George Lindars-Hammond, Cate McDonald, Anne Murphy, Peter Price, Jackie Satur, Geoff Smith, Garry Weatherall, Brian Webster and Joyce Wright

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Shaffaq Mohammed.

2. APPOINTMENT OF CHAIR AND DEPUTY CHAIR

RESOLVED: That Councillor Cate McDonald be appointed Chair of the Committee and Councillor Sue Alston be appointed Deputy Chair.

3. DATES AND TIMES OF MEETINGS

3.1 RESOLVED: That meetings of the Committee be held on a bi-monthly basis, on dates and times to be determined by the Chair.

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Update on the De-registration of LD Care Homes

22nd July 2015

Communities Commissioning

Overview

- 9 Residential Care Homes to be de-registered to Supported Living Services
- 5 Registered to CQC by Housing Associations with care and support delivered by SHSC
  - Handsworth
  - Cottam Road
  - East Bank Road
  - Wensley Street
  - Beighton Road
- 4 provided by Dimensions
  - Burncross
  - Frazer Drive
  - Station Road
  - Gleadless Road/Common

Progress to date

- **Handworth** de-registered on the 1st April 2015
- Care and Support now delivered by Lifeways

- **Cottam Road** de-registered on the 1st June 2015
- Care and Support now delivered by Community Integrated Care (CIC)

- **East Bank Road** de-registered on the 6th July 2015
- Care and Support now delivered by Dimensions

- TUPE (Transfer of Undertakings (Protection of Employment)) from SHSC has applied in all of the de-registrations

Progress to date cont..

- **Wensley Street** is currently going through the Deciding Together process following Assessments and Support Plans
- **Beighton Road** is in the process of having Assessments and Support Plans completed
- Planning is taking place on the timeline for the Dimensions services which will also go through the Deciding Together process

Progress to date cont..

- 1 of the services has had a number of issues since the date of transfer
- Some issues are linked to the residential service although some are due to the new providers approach
- Manager has left the service and a new manager appointed
- Contracts are visiting on a fortnightly basis and an action plan for improvements is in place
- The other 2 services have transferred without significant issues and the staff teams have engaged well with the transfer
- Lessons learnt have been shared between the 3 providers to aid resolution at the earliest point

Lessons Learnt

- The Deciding Together has been amended to allow a longer session with providers and relatives/individuals and this worked much better for Cottam Road and East Bank Road
- Activity sessions for the individuals were completed for Cottam Road but not East Bank at the request of the relatives
- Extra session held for East Bank Road due to hung decision
- Positive feedback has been received on the process from all involved
- Greater emphasis on the relationship between incoming/outgoing provider following the 1st transfer – less emphasis on SCC acting as the 'broker'– smoother process and better transition
- Plans in place to further develop the services with transformation to Supported Living

Changes to services

Improved Independence

- Gardening Group set up
- Involvement in cooking and cleaning
- Using public transport
- Developing weekly activity planners

Social Inclusion

- Attending Under the Stars nightclub
- Visiting local pubs for drinks/ food
- Attending swimming weekly, and will be starting to go twice weekly
- Attending “snoozelum sessions”
- Going to the greyhound races
- Attending BBQ’s/ garden party’s at other services
- Playing cricket

Changes to services cont…

Personalised Staffing

- Individuals involved in the recruitment of staff
- Relatives Forum set up to contribute to recruitment of staff
- Individuals choosing own key-workers
- Individual taken role of Health and Safety Champion
- Gardening Group set up
- Involvement in cooking and cleaning
- Playing football/horse riding/attending the gym
- Using public transport
- Developing weekly activity planners

Report to Healthier Communities and Adult Social Care Scrutiny Committee 22nd July 2015

Report of: Head of Commissioning

Subject: **Transforming Care – update on Winterbourne Actions**

Author of Report: Pamela Coulson, Commissioning Manager NHS Sheffield CCG

Summary:
Winterbourne View Concordat is now incorporated into the national "Transforming Care" agenda.

Whilst the initial programme requirements of the original Concordat are completed, in relation to the return of the identified cohort of people for local repatriation, and data collection for this time period, there will be a requirement for continued city wide collaboration to safeguard this population. This will be done by ensuring that the right services are available at "the right time in the right place," as defined by Sir Stephen Bubb, in his report "Transforming Care, the national response."".

The programme requires continued collaborative commissioning and provision of services across Children and Adults Directorates, given the newer obligations outlined in Transforming Care. New groups have been constituted within the city to progress this work, with identified leads across health and social care.

Sheffield's LD Commissioning Strategy reflects the requirements of "Transforming Care" and detailed implementation plans are being developed. This includes progressing improved access to general needs housing, building business cases for new build one bedroom apartments, and deregistration of a number of registered residential care homes to supported living arrangements.

The Better Care Fund and Integrated Commissioning agenda, particularly the Long Term High Cost work stream and the emerging Whole of Life Learning disability strategy provides an opportunity for greater coordination and collaboration to meeting the needs of the learning disabled population.

The work will require extended joint working with NHS England and other regional Clinical Commissioning Group and Local Authority commissioners relating to the implications of the responsible Commissioner guidance.

Transforming Care requires continued high level leadership by Executive Directors, and scrutiny of the Safeguarding Boards to ensure our focus remains on meeting the needs of this vulnerable group of people.

There is more work to be done to ensure that joint processes across Health and Social Care commissioning and provision work effectively to safeguard against people being cared for in inappropriate settings which do not meet their needs. This includes streamlining processes for preventing mental health and learning disability hospital admissions, supporting hospital discharges, and ensuring reviews are done in a timely and effective manner, to safeguard people with complex needs. We need to maintain a vigilance and joint recognition that hospitals are not homes.

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:

- **Note the new national programme to continue this work, "Transforming Care"**
- **Note Sheffield's response to meeting the recommendations within this new programme**

Background Papers:
WinterbourneView – Time for Change (2014)
Transforming Care for People with Learning Disabilities
Sheffield's Learning Disability Commissioning Strategy

Category of Report: OPEN

1. Introduction/Context

1.1 In May 2011, a BBC Panorama programme exposed staff abuse of patients with learning disabilities at Winterbourne View, a private mental health hospital. The government responded with a commitment to

transform services for all people with learning disabilities or autism who had challenging behaviour or a mental health condition.

1.2 In December 2012 The Department of Health published "Transforming Care: A National Response" and the accompanying "DH Winterbourne View – Concordat: Programme of Action" (the concordat). The concordat set out 63 Transforming Care commitments with the central commitment being by 1st June 2014, if anyone with a learning disability and challenging behaviour whose care would be appropriately delivered in the community, then they should be moved out of hospital.

1.3 As of July 2013 Sheffield had a total of 18 adults funded in out of city placements:

- Of those 18 placements 12 were place by NHS Specialist Commissioners;
- The remaining 6 were identified as having the potential to be repatriated to Sheffield;
- All 6 have now returned, with 5 of the 6 being returned within the target timescale;
- It took until March 2015 for the final person to return, due to the complexity of their support needs.

The Government did not met its central goal of moving people with learning disabilities and challenging behaviour out of hospital by 1 June 2014, because it underestimated the complexity and level of challenge in meeting the commitments in its action plan. The Government commissioned Sir Stephen Bubb to consider how a mandatory national framework – The Transforming Care Programme – could be implemented nationally, delivered locally, to achieve the growth of community provision to move people out of inappropriate institutional care.

2 The Transforming Care Programme and what this means for the people of Sheffield

2.1 The original concordat actions the Winterbourne View Concordat has now been extended into the Transforming Care Programme locally.

2.2 "Transforming Care for People with Learning Disabilities – Next Steps" (January 2015), written in response to Sir Stephen Bubb's report "Winterbourne View – Time for Change" (2014) sets out the actions to progress transformation. Below are the main priorities and what we are doing for the people of Sheffield

1. Empowering people and their families by giving them the means to challenge their admission or continued placement in inpatient care through an admission gateway process and Care and Treatment Reviews, to reduce the number of admissions and speed up discharges.

A Care and Treatment Review brings in two advisors, one clinical and one expert by experience plus a representative of the responsible CCG with the aim to act as a “critical friend” by supporting the individual and their family to have a voice and to support the team working with them to identify the blocks which are preventing a discharge.

In Sheffield we are rolling out a programme of Care and Treatment Reviews staring with people currently placed out of City.

1 person has been identified as being ready for transfer in to a more appropriate setting. The Community Enhancing Recovery Team is working with NHSE Specialist Commissioners to develop a transfer pathway.

We are discussing recruitment of two social workers to work back into the Out of City Team to enable this to fully function.

We are aiming by September to have Care and Treatment Reviews imbedded “as business as usual” and will begin of people in inpatient setting within Sheffield.

A Care and Treatment Review process will also take place prior to an admission to ascertain whether there is an alternative to an inpatient stay. When there is an emergency admission a review will take place within two weeks.

2. Getting the right care in the right place by working with local authorities and other providers to ensure that high quality community-based alternatives to hospital are available, meaning more people can get the support they need close to home.

Sheffield has a new Learning Disability Commissioning Strategy which has been developed in line with local and national policies, with a focus on providing high quality care that promotes independence, social inclusion, choice and provides best value. The strategy reflects the requirements arising from the Winterbourne scandal – stronger local community based services based on co-production, community building, a capability based approach, integrated services and personalisation.

Following the approval of the commissioning strategy, the City Council and partners have agreed to develop a strategy based on whole life, asset based approach to ensure social and economic inclusion within the City for people with learning disabilities.

We have a joint (CCG and SCC) working group developing plans for accommodation in the city – the main thrust of this is to ensure that people have good access into mainstream housing options. In addition, we are developing business cases for a number of new build one bedroom flats to ensure that the range of choice for people will meet demand, now and in the future. NHS Sheffield CCG successfully bid for regional capital to support the SCC accommodation strategy, and have recently applied for further regional funding from NHS England.

Sheffield CCG and Sheffield City Council are working in partnership to review short breaks and respite provision in both Adult Services and Children and Young People's services. There is potential for the provision of health and social care short breaks to be jointly commissioned and to be a continuous service from childhood to adulthood. This aims to reduce carer/family breakdown, which in turn can lead to out of city placements.

3. Driving up the quality of care by tightening the regulation and inspection of providers, including closing poor quality settings and preventing inappropriate new settings from opening.

We have already put in place quality assurance arrangements for those people living in private rented accommodation which will be put in place across the full range of supply to ensure that people are living in appropriate and good quality accommodation.

The City Council established a Framework Agreement preferred list of providers last autumn which sets out standards and quality requirements for all supported living services. We are also planning to establish a Framework Agreement for meaningful day time activities promoting innovation, diversity and quality which will be available for Council arranged services and for people who are in receipt of direct payments.

The CCG and SCC work closely together to ensure that the monitoring and quality assurance of all provision is both robust and effective. We are currently reviewing these arrangements with a view to ensuring that people who use services and their family carers are fully engaged and that their views and experiences are key to our feedback to providers. We have also increased resources available to work with providers to improve quality.

All CQC reports are scrutinised by the monitoring team and follow up action instigated when required.

4. Strengthening accountability for improving outcomes by reforming contracts, including giving commissioners the ability to fine providers who fail to meet care standards or an individual's personal objectives.

Within the Council we are currently reviewing our contract management arrangements and a workshop has been set up in August with all our providers.

5. Increasing workforce capability by working with patient and carer groups to address gaps in skills, best practice and staff awareness of learning disabilities and mental health problems.

We are exploring options in how we can engage service users and carers in developing best practice. The Learning Disability Partnership Board is developing a Service Improvement sub-group of service users and carers.

Sheffield CCG is holding a Learning Disability Protected Learning Event for 300 GPs and practice nurses in September 2015.

A Supported Living Forum has been developed to raise awareness and drive up good practice.

6. Improving the amount of data and information collected and shared by public agencies to ensure that a person's outcomes and destinations are monitored, and that local public services can be held to account for their progress.

Sheffield CCG is working with Local Authority and Sheffield Health and Social Care Trust to develop a register of people who are 'at risk of admission' and will closely maintain and monitor this with all agencies (Health, Social Care and Education).

Sheffield CCG submits data to the Assuring Transformation "Clinical Audit Platform" which is the new reporting mechanism. This is being managed by the national Health and Social Care Information Centre, This has been introduced to collect data on all adults with a learning disability or with an autistic spectrum condition who are in a mental health hospital bed whether in city or out of city.

In addition to this the CCG has to report fortnightly to NHS England on patients who were in hospital and out of city as of 1st April 2014 to enable them to track discharges and delayed discharges.

3. Nationally this work will be spearheaded by the Transforming Care Delivery Board which is made up of senior representatives from each organisation responsible for delivery.

3.1 In response to "Assuring Transformation – A Time for change – The next steps", the former "Winterbourne Steering Group", with leadership from Kevin Clifford, Chief Nurse, NHS Sheffield Clinical Commissioning Group, and Moira Wilson Interim Director of Adult Services, has reformed after a break of some months. Kevin Clifford is meeting with Phil Holmes to discuss the continutation of this group.

This group is working on a new "Transforming Care Action Plan", to give a renewed focus to the development of a joint citywide strategy relating to the care of people with complex needs arising out of autism, behaviour that challenges services to support and mental health conditions. The action plan development is being led by Barbara Carlisle as Head of Commissioning at Sheffield City Council. Pamela Coulson, Commissioning Manager leads on this work for NHS Sheffield CCG.

3.2 To ensure delivery of the operational elements of the Transforming Care Action Plan the former Complex Needs Implementation Group is to be reformed as the Transforming Care Operational Group. This will be chaired by Heather Burns as the Head of Commissioning for the Mental Health Portfolio in Sheffield CCG It will support the delivery of Care and Treatment Reviews in Sheffield

and monitor and review the data on the Assuring Transformation Clinical audit platform.

The Steering Group will have oversight and scrutiny of the action plan and its delivery.

4. Recommendation

- Note the new national programme to continue this work, “Transforming Care”
- Note Sheffield’s response to meeting the recommendations within this new programme

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
22nd July 2015

Report of:	Policy & Improvement Officer
Subject:	Work Programme 2015/16
Author of Report:	Emily Standbrook-Shaw, Policy & Improvement Officer emily.standbrook-shaw@sheffield.gov.uk 0114 27 35065

A proposed work programme is attached at appendix 1for the Committee's consideration and discussion

1) Agenda Items

The proposed work programme aims to focus on a small number of issues, in depth. This means that the Committee will need to prioritise which issues will be included on formal meeting agendas. In doing this, the Committee may wish to reflect on the prioritisation principles attached at appendix 2 to ensure that scrutiny activity is focussed where it can add most value.

Where an issue is not appropriate for inclusion on a meeting agenda, but there is significant interest from members, the Committee can request written briefings or presentations outside of formal scrutiny meeting time.

2) Homecare Task Group

The work programme includes a proposal to convene a task and finish group looking at Homecare in Sheffield. The group will finalise the scope of the review at its first meeting, but will take a whole systems approach and is likely to focus on the role of the modern service, how the quality of homecare is assured, considering whether all parts of the system are joined up; training and skills of the social care workforce; how the way we commission and contract homecare can impact on quality and how well services meet individual needs, particularly cultural appropriateness. This scrutiny work will run alongside and feed into a wider review into homecare being carried out by the service.

The Committee is asked to agree to establish the task and finish group, and appoint members to it.

3) Quality Accounts

Providers of health services are required to share their annual Quality Accounts with the Scrutiny Committee for comment. The draft work programme proposes establishing a sub-group of Members to carry out work on the Quality Accounts this year. It is proposed that the sub group meets twice: with providers early in the process to identify issues that should be addressed in their reports, and then again next spring to comment on the final draft.

The Committee is asked to nominate members to sit on the Quality Accounts subgroup.

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4) The Scrutiny Committee is being asked to:

- Comment on the proposed work programme
- Identify priorities for inclusion on agendas
- Identify items for briefings outside of formal meeting time
- Agree to establish, and appoint members to, a task and finish group looking at Homecare
- Nominate Committee members for the Quality Accounts Sub Group.

Appendix 1

Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Draft Work Programme 2015-16

Last updated: 14 07 2015
Please note: the draft work programme is a live document and so is subject to change.

Topic	Date	Notes
Major Task and Finish work		
Homecare – assuring quality.	Reporting by March 2016.	Task group to finalise scope but will take a whole systems approach and is likely to focus on the quality of homecare, considering whether all parts of the system are joined up; training and skills of the social care workforce; how the way we commission and contract homecare can impact on quality and how well services meet individual needs, particularly cultural appropriateness.
Sub-Group		
Quality Accounts	Autumn 15 & Spring 16	Sub group of Committee Members to carry out work on Quality Accounts on behalf of the Committee. The group will meet with providers twice; early in the process to identify issues it wants to see addressed in their reports, based on previous Quality Accounts, issues raised through scrutiny work and case work of members, and then again to comment on the final draft of the report.
Single Item Agenda Issues		
Carers' Strategy	Sept 15	Carer's views currently being sought. Over the summer, headline proposals/actions will be developed. Committee could test these in September, prior to final decisions on the strategy being made.

Better Care Fund	Nov 15	To gain a better understanding of what the Better Care Fund means for partners in the city, and how it will be delivered
Active support and recovery (formerly Intermediate Care)	Nov 15	To look at proposals for active support and recovery under the Better Care Fund, and consider what Sheffield could be doing better.
Children's health and food		To look at the current picture in terms of obesity and under-nutrition in children in Sheffield, understand the influencing factors and consider how Sheffield could improve its approach.
Public Health Vision		The cabinet member is planning to review and refresh the vision for public health, adopted when the Council took on responsibility for the service. This would give the Scrutiny committee the opportunity to challenge and comment on the proposed vision.
Improving Access to Psychological Therapies		To consider how Sheffield can maximise the benefits of the IAPT programme.
Elective Care Review (CCG)		
Issues for briefings/information/updates		
Update on the development of a voluntary code of conduct for supported living		
Right First Time Programme		
Dementia Strategy		
End of Life Care – access to services.		
Care Act		
Safeguarding Review		

Appendix 2

Selecting Scrutiny topics

This tool is designed to assist the Scrutiny Committees focus on the topics most appropriate for their scrutiny.

- **Public Interest**
  The concerns of local people should influence the issues chosen for scrutiny;

- **Ability to Change / Impact**
  Priority should be given to issues that the Committee can realistically have an impact on, and that will influence decision makers;

- **Performance**
  Priority should be given to the areas in which the Council, and other organisations (public or private) are not performing well;

- **Extent**
  Priority should be given to issues that are relevant to all or large parts of the city (geographical or communities of interest);

- **Replication / other approaches**
  Work programmes must take account of what else is happening (or has happened) in the areas being considered to avoid duplication or wasted effort. Alternatively, could another body, agency, or approach (e.g. briefing paper) more appropriately deal with the topic

Other influencing factors

- **Cross-party -** There is the potential to reach cross-party agreement on a report and recommendations.

- **Resources**. Members with the Policy & Improvement Officer can complete the work needed in a reasonable time to achieve the required outcome

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Briefing for Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
22nd July 2015

Subject: Child & Adolescent Mental Health Service (CAMHS) update

Contact Officer: Emily Standbrook-Shaw, Policy & Improvement Officer
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0114 27 35065

Overview
Between 2012 and 2014 the Healthier Communities and Adult Social Care Scrutiny Committee set up a working group to look at Child and Adolescent Mental Health Services in response to parents of service users who were unhappy with elements of the service, in particular waiting times. The group put together a report and recommendations.

In March 2015, the Health and Wellbeing Board considered a report on CAMHS. An update on the scrutiny recommendations was included in the report, and both documents are attached for the Committee's information. The minutes of the meeting are extracted below.

Minutes:

> The Executive Director, Children, Young People and Families, Sheffield City Council, submitted a report concerning a response and progress update from the Health and Wellbeing Board to its Emotional Wellbeing and Mental Health Engagement Event with Chilypep, Sheffield Futures and Young Healthwatch in November 2014. The report included an update on progress relating to actions and service redesign following recommendations made through the CAMHS (Child and Adolescent Mental Health Services) scrutiny process.
>
> John Doyle, Director of Business Strategy, Children, Young People and Families, Sheffield City Council, presented the report and outlined progress, including the completion of an Emotional Wellbeing and Mental Health school pilot in 2014 to help test and define a model for Emotional Wellbeing provision and staff support. This had informed future services to support children and young people's emotional wellbeing and mental health. Funding had been identified to expand the pilot to 3 families of schools during 2015.

The Action Plan relating to the CAMHS scrutiny process was appended to the report submitted to the Board and summarised progress in areas including transitions, the role of schools and co-production.

Councillor Jackie Drayton informed the Board of key points arising from the workshop event, based on young people's experiences. These included the development of clear pathways, emergency support and the development of a holistic service for young people aged 16-25. Whilst there was much to do, there had been progressive work with the CCG and NHS Trust on the recommendations.

Resolved: that the Board

(1) Requests that a further review on progress and implementation be submitted to the Board during autumn 2015.

(2) Notes actions and service redesign being taken forward as an outcome of the CAMHS Scrutiny process.

(3) Thanks the Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee and the Child and Adolescent Mental Health Working Group for its work in relation to the review of emotional wellbeing and mental health provision

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

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

The Scrutiny Committee is being asked to:

- Note the update

Health & Wellbeing Board – Thursday 26th March 2015 - CAMHS Scrutiny Update

A sub group of the Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee convened a Child and Adolescent Mental Health Working Group to review emotional wellbeing and mental health provision. This group developed a number of service principles which required Sheffield Clinical Commissioning Group (CCG), Sheffield Children's NHS Foundation Trust and Sheffield City Council to work together to redesign and implement service changes in order to improve the provision of emotional wellbeing and mental health services for children, young people and families.

The following template provides an update on progress against the service principles identified. The newly established Emotional Wellbeing and Mental Health Executive Group has oversight of implementation of the Scrutiny Board recommendations and reports back progress.

	10 Principles for the Service recommended via Scrutiny	Update on Progress
➢	**The Pathway**	
1	**Communication** - is key at all stages of the process, this includes information on waiting times/ interim support /outcomes and reasons for case closure.	There is potential to develop an e-portal site which would host information on emotional wellbeing, as well as have links to training & development This will include referrals forms, exemplar referral forms, checklists to guide people's decision regarding what to do next and how to access provision. It would also host self-help guides to support step down from specialist care. The local authority and partner agencies has included the CAMHS provision in the local offer for children and young people with special educational needs, this is the place where information about provision is available, the local offer has been coproduced with families. The Specialist NHS CAMH Service agree it would be useful to include waiting time information in their acknowledgment letter to families and are instigating this change. Specialist NHS CAMHS offer access to their consultation line for accepted referrals as well as routinely offering information about self-help and other resources where appropriate. For specialist NHS CAMHS, cases are closed with agreement and understanding of the family. The referrer is always informed about the outcome of a case and the reason for closing the case. The Emotional Wellbeing and Mental Health pilot at Sheffield Park Academy last year included a pilot CAMHS step up and step down element i.e. support whilst on waiting list and following discharge (involving Primary Mental Health Worker in development of this). This is in response to the Emotional Wellbeing service* consultation held in OCT 2013.
2	**Clear information** – should be produced to outline the services available and the referral routes. This needs to be accessible to both those making referrals and those who access services (see point 10 co-production).	Specialist NHS CAMHS have a referral document for referrers and professionals. All specialist CAMHS teams have team leaflets but we agree that these should be more accessible to families. New leaflets are currently being produced with service users and which will be available this year - in written form and also on the Sheffield Children's website.

3	**Family assessment and confidentiality-** where possible, a family assessment should be offered to ensure a more holistic approach (this is not always possible as some young people will request confidentiality). There also needs to be a clear route for parents to pass on information confidentially throughout the process	The Specialist NHS CAMHS normal procedure is for a family based assessment with opportunity – as appropriate – for the young person or/and parents to be seen separately. In most cases, especially where the young person is older there will be a separate meeting for the young person. Specialist CAMHS provide parents/carers with information before they engage with the service and parents /carers are often offered their own appointment for a confidential meeting.
4	**Role of the GP**– GP referral notes should be transferred onto the Assessor and should be fully used as part of the assessment process. Communication channels between the GP and the Assessor should remain open.	Sheffield is one of 10 sites in England chosen for a GP Champion project, funded by the Department of Health and run by the Association for Young People's Health, Youth Access and RCGP. The 3 year project aims to bridge the gap between GPs and the voluntary youth sector and to "implement an innovative model for transforming the way public health services are delivered to young people, thereby improving their health outcomes". The Sheffield project, led by Interchange/Right Here working in partnership with Pitsmoor Medical Centre, focuses upon emotional wellbeing and mental health of young people. In Specialist CAMHS, referral information is always available and is used for the initial assessment. No referral can proceed without this but it is also extremely important that the professional undertaking the initial assessment hears the family's concerns in their own words. It will, however, be helpful to ensure that families understand this.
5	**Transitions** - there needs to be early preparation for those transitioning out of a service and clarity in terms of next steps.	There is an agreement that transition arrangements need to improve and following Scrutiny this issue will be looked at in more detail and reported back in the future. This is a national problem and Sheffield's specialist NHS CAMHS agree that this is an area of need and difficulty in Sheffield which, although good for a small number, needs to improve. CAMHS and the adult mental health service have been working to improve transitions and a number of events have been held or will be held this year, including contributions from service users.
6	**Services for those aged 16-25** - there should be a specially commissioned young	NHSS Clinical Commissioning Group, NHS CAMHS and Sheffield City Council are committed to working with their partners in adult mental health to achieve better transition and improve services. Some services within CAMHS are already provided up to age 18 for specific groups of children.

	adult's service for those aged 16-25, consideration should be given to having this as a community based service.	The CAMHS service has now been extended and is mobilised up to 18 years. This provision is being evaluated and impacts/outcomes monitored.
7	**Single point of referral** - there should be a single point of referral and standardised referral documentation, this process should assess the person and determine which pathway they go onto.	There has to be an acknowledgement that for certain groups of vulnerable children there is a necessity to have different referral process as some young people do not present to services in the traditional way (e.g. via Youth Offending Service, children with disabilities). There is a single point of referral with a single referral document for specialist NHS CAMHS which is co-ordinated with the CAMHS element of the MAST service. This is available electronically for all GP's and provides a simple, straightforward referral and service pathway. Confidentiality is a key issue for families who, quite rightly do not want their confidential details widely distributed without their consent. This applies to both Multi Agency Support Teams (MAST) and Specialist NHS referrals. Unfortunately, not all referrers are using the standard document which means that for confidentiality reasons some referrals which might benefit from the simple pathway we have devised cannot be processed as simply as we would like. Work is underway to address this and to ensure consistency in how referrals are completed. Given the volumes involved (as well as the confidentiality issues), it is not practical to have one access point for specialist NHS CAMHS and MAST. (MAST receives a very large number of non-mental health referrals and most referrals to Specialist CAMHS are entirely appropriate).
8	**Improving Access to Psychological Therapies (IAPT)** - consideration should be given to developing an IAPT service for young people.	CYP-IAPT (Improving Access to Psychological Therapy) for Young People is now available although it should be noted that CYP-IAPT is a different concept in comparison with IAPT for adults, which is a separate service. Sheffield is part of the national CYP-IAPT programme whose approach is to change or transform the way that CAMHS works – to ensure that we use the best possible evidence in our therapies and involve service users and carers.
➢	**Raising awareness amongst young people, effective signposting and involvement**	
9	**Role of Schools** - The role of Schools	There are important measures to improve access to emotional wellbeing and mental health support

	needs to be increased to improve communication with young people and aid an early intervention / prevention approach. Schools need to consistently promote the services that are available i.e. through the School email services / intranet, and should have staff with the knowledge/skills to make referrals.	through schools. An Emotional Wellbeing and Mental Health school pilot was completed in 2014 to help test and define a model for Emotional Wellbeing provision and staff support in school. The pilot was offered to schools and through a selection process focusing on need and those schools best placed to undertake the pilot one secondary school selected. The pilot was delivered by Family Action (Targeted Mental Health in Schools) and Interchange Sheffield CIC at Sheffield Park Academy. This pilot has informed future services to support children and young people's emotional wellbeing and mental health. To further test the model funding has been identified to expand the pilot to 3 families of schools during 2015. It will be externally evaluated and its impact on referrals to specialist services analysed. There is a Personal Social Health Education Review underway which includes an emphasis on EWBM. There has also been a You're Welcome* inspection of CAMHS completed to identify appropriateness of young person friendly service. *You're Welcome are national standards to benchmark service delivery. It is implemented through young people 'inspecting' provision and service managers self-validating the views and outcomes of the service against national indicators/standards. The feedback from the young people is used to improve service provision and comparisons are made with the views of staff and service managers.
10	**Co-production** - young people who access the service and their carers need to be involved designing the service, including producing communication materials and performance monitoring criteria.	Work is currently happening in SCC with support of clinical and VCF partners to define a good practice model for involving young people in planning, commissioning and delivery of services – using the new Emotional Wellbeing Service and other service provision as a working example. Specialist NHS CAMHS agree that there are many benefits of participation for service users, for parents and carers and for the organisation. This approach is very much part of the service's ambitions – we have used feedback surveys and focus groups extensively over the years as well as involving service users and carers in recruitment. This approach is also integral to the CYP-IAPT programme and we will be further developing our co-production with service users and families. We will also be continuing our work with STAMP and other service user and parent/carer groups, for example, in our project to produce new leaflets.

	Other Areas for Further Discussion	
11	**Weighting of funding for the services across the 4 tiers** - funding is currently more heavily weighted towards tier 4, does this clearly reflect need in the City? And does it support the early intervention / prevention approach that is required?	Consideration is being given to how the Public Health Grant can support early intervention and prevention alongside existing activities such as MAST (Multi-agency support teams). Work is currently being undertaken to define an early intervention and prevention model for CYP EWB& MH in school as outlined in point 9. This is being informed by a Health Needs Assessment, stakeholder consultation, pilot programmes and good practice examples. The Health Needs Assessment has been completed and has included collecting all appropriate data to determine the needs and changes in emotional well being and mental health for young people across the city. It has looked at prevalence, risk factors and the evidence base for interventions which are effective. This information will influence any future service redesign and changes in provision. Interventions at Tier 4 reflect high cost of intervention and demand for service. Further information is required and potentially further analysis to better understand this issue. CCG will take findings of review and consider response. NHS England is the specialist commissioner for Tier 4 services so the interface between local commissioners and NHS England is important. NHS England are currently reviewing tier 4 provision due to rises in admissions. Specialist CAMHS intervention with serious mental health problems is an essential early intervention for the mental health of adults. Most adult mental health disorders can be traced to a start before age 18. Collectively, we need to ensure that children and young people with greatest need get a good, effective service which they can access readily. Sheffield Children's NHS CAMHS provide both the local specialist community service as well as the in-patient ('Tier 4') service.
12	**Understanding and co-ordination -** There appears to be a lack of understanding and co-ordination between the full range of services available i.e. mainstream, voluntary and community sector and those	Providers collectively agree that as an outcome of Scrutiny this is an area for further consideration and future work. SCC corporate training provides training to Residential workers on Emotional wellbeing for Looked after children.

	commissioned separately e.g. by Community Youth Teams – can you tell us what's being done to address this?	Community Youth Teams (CYTs). CYTs provide support to vulnerable young people and may identify young people with emotional wellbeing and mental health difficulties. The referral pathway and access to Primary Mental Health workers, particularly for CYT's is to be considered and clarified and where relevant further training offered. A number of services are currently being redesigned including the development of the Integrated Sexual Health Services (ISHS) and the Sheffield School Nursing Service. As part of the service design process clear thought will be given to ensure appropriate pathways are developed and an EWMH early intervention/prevention pathway is available so as organisations both statutory and voluntary are clear how to refer and signpost children and young people to access support. Within specialist NHS CAMHS there is a high level of co-ordination across teams and with in-patient care. The main agencies and services concerned with children's mental health, GP's, specialist CAMHS and the Sheffield City Council's MAST teams have also achieved a much better level of understanding and co-ordination by working together. This is being carried forward as part of the CYP-IAPT programme - although it is acknowledged there is still more to do. This level of co-ordination is more difficult with schools which are all separate entities. (There are very many more schools in Sheffield than there are specialist NHS CAMHS staff). Where services are separately funded and established this can lead to poor co-ordination or confusion – particularly where these projects have a mental health aspect which is not built into the provision in the planning stage. For specialist CAMHS, co-ordination can be a crucial part of what we do, especially for looked after children, children in need, children in trouble with the law, and those with severe learning disabilities. These referrals will start with a meeting designed to aid understanding and co-ordination'. Specialist CAMHS also provides extensive training for agencies across the city to help them understand mental health problems, specialist CAMHS and how to access these and co-ordinate their contribution including with other mental health services, including MAST. Over 200 staff across all agencies including the voluntary sector attended this training last year A range of more specialist training is also offered across agencies, for professionals and, for example with adoptive and foster carers. Over 300 staff including 68 foster-carers attended CAMHS training last year. Specialist training has also included infant mental health and theraplay.

13	**Ryegate –** can you give clarification in terms of the pathway for Ryegate patients to CAMHS?	Commissioners are starting to look at Pathways. NHS England is the lead specialist commissioner and this organisation has a key interface with Ryegate. Local commissioners are only at present working to a draft specification for children with complex problems to work to from NHS England and are awaiting further national guidance regarding improving pathways for families. This will help inform further work at Ryegate. Ryegate and CAMHS do address different patient groups with Ryegate specialising in developmental and neuro-disability problems, including children with severe disabilities and autistic spectrum disorders. A small number of Ryegate patients may have additional, serious mental health needs which require referral to CAMHS. These will often have severe learning disabilities and a serious mental health disorder or very challenging behaviour. Where a referral to CAMHS involves developmental problems or severe learning disabilities it may be re-directed to Ryegate or to a community Paediatrician but this is uncommon as most referrers are aware of this. However, these pathways can be better defined and streamlined and the Service intends to examine this.
14	**Performance monitoring –** the current framework was criticised for focusing on process and not outcomes - does this need revising?	Sheffield Clinical Commissioning Group as the commissioners of specialist NHS CAMHS pay keen attention to the performance of the service. This relies on a full range of performance information including both key process and outcome information such as how referrals are handled, how long people wait to access the service and how long they spend in it. The commissioners have also built into the service specification a requirement to use outcome monitoring and there is a move to commission for outcomes more. However, this is a complex area with the 'outcomes' being very different depending on the 'problem', (for example, depression, autistic spectrum disorder, psychosis etc.) or the patient (their age, looked after child status, whether the service user is the young person or parent/carer etc.). The national CAMHS Outcomes Research Consortium (CORC) of which Sheffield has been a member from the outset in 2004 has focussed on ensuring that outcome monitoring is a feature of services and is used to improve them. However, outcome measures are difficult to monitor and to identify outcomes which can be effectively measured, CORC caution against simplistic approaches and league tables,

		recommending that the outcome monitoring comes from a variety of sources. Nonetheless, Sheffield specialist NHS CAMHS and MAST use outcomes extensively to inform service provision and improvement. A major plank of the CYP-IAPT initiative of which Sheffield is a participant includes a requirement to use outcome measures. Sheffield is unique in being a partnership between the NHS specialist service and the Local Authority – both of whom use outcome measures already. The draft standards which Sheffield is contributing to, suggest that 90% of service users should have contributed outcome measures and that these are actively used to support improvement in practice. Nationally there is a focus to move towards mental health commissioning for outcomes. Both commissioners and services very much agree with this approach.
15	**Emergency situations –** does consideration need to be given to how the service responds in an emergency situation?	Specialist NHS CAMHS is responsible for all mental health emergencies relating to under 16's. For all these cases the primary access route is through Sheffield Children's Hospital Accident & Emergency Department. All emergency admissions are initially triaged by the A&E team and followed up as required by specialist assessment by a dedicated rota of CAMHS specialist and consultant child & adolescent psychiatrists. Where required, children will be admitted to a hospital ward for further assessment and intervention. Where indicated, specialist mental health in-patient care is sought and provided. This service is in place 24/7 throughout the year. In 2013 165 young people under 16 years were seen for specialist mental health follow-up having presented at A&E. This represents a 100% increase over a three year period.
16	**Advocacy and support –** availability of advocacy and support for patients and carers – is there scope for a commissioned advocacy service? And if so could it be involved in the performance monitoring?	There already are a range of ways in which we ensure effective advocacy for children and young people who access services. However, there is potential for development via early intervention/primary prevention work. This is an area that will be considered further and investigated. We would need to consider evidence base and need. If there is a specific need then this will have to considered against other competing priorities. The model of advocacy is important and potentially something which could be supported by work outside of clinical providers.
17	**Waiting Times –**	The NHS CAMHS service has worked with Sheffield CCG to introduce a new service model and re-organise the Service in order to impact on waiting times and to improve efficiency. This work has successfully reduced the waiting times.

		However, despite the efficiency gains made, referrals have continued to increase in number. Whilst we are looking at ways to address the parity of esteem issues, this is likely to represent a slow move of resources over time in order not to destabilise other services and to also ensure that this is done where investment in mental health improves outcomes overall. The use of outcome measures aims to improve effectiveness which will allow better use of resources, and by having bimonthly performance meeting that have both clinical and managerial input, we are in a position to identify and find solutions to significant problems that might arise in addition to informing how the service develops. At the time that the Scrutiny Committee launched its report some two years ago, the waiting lists for specialist NHS CAMHS were unacceptably long. This was a difficult time for CAMHS, the City and for children and parents following the impact of the economic downturn, significant cuts in specialist NHS CAMHS and the need to re-organise the Service. The Service consequently introduced a new service model and successfully reduced the waiting times with additional temporary funding from Sheffield CCG. In April 2012 there were 527 referrals waiting with an average (median wait) of 22 weeks. In April 2013 this had been reduced to just 102 referrals waiting with a median wait of only 5 weeks. However, although specialist CAMHS completed 11% more appointments since April 2013 (despite having lost the temporary staff), referrals have risen by 34% in the same period and the number waiting at December 2013 has risen to 212 waiting for 10 weeks as a median average. Specialist CAMHS continues to work closely with commissioners, GPs and the MAST teams but both services are under increasing pressure. Families who have been referred to specialist NHS CAMHS and, having been accepted, are waiting for a service are offered support through a consultation phone line and self-help advice if appropriate. Families are also asked to contact the service if their circumstances change which will also lead to re-prioritising if appropriate.

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Jayne Ludlam, Executive Director, Children, Young People and Families, Sheffield City Council
Date:	26 March 2015
Subject:	Response and progress update from the Health and Wellbeing Board to its Emotional Wellbeing and Mental Health Engagement Event with Chilypep, Sheffield Futures and Young Healthwatch in November 2014 *Including CAMHS Scrutiny response and update on progress*
Author of Report:	Bethan Plant, 0114 293 0133

Summary:

This paper provides a brief account of progress to date and a response to how those issues identified by the young people who facilitated the emotional wellbeing and mental health engagement event in November are being addressed.

This outline is to be approved by the Board and shared with the organisations and young people who led and participated in the engagement event.

In addition appended to the paper is an update for the Board on progress on actions and service redesign following recommendations made via the CAMHS scrutiny process.

Recommendations:

- Agreement from the Board to agenda a further review on progress and implementation during early summer 2015.
- To note actions and service redesign being taken forward as an outcome of the CAMHS Scrutiny process.

Response and progress update from the Health and Wellbeing Board to its Emotional Wellbeing and Mental Health Engagement Event with Chilypep, Sheffield Futures and Young Healthwatch in November 2014

1.0 SUMMARY

Health and Wellbeing Board members were impressed with the commitment, honesty and passion shown by the young people who facilitated the Emotional Wellbeing and Mental Health (EWBMH) engagement event in November 2014. The accounts and experiences which the young people shared emphasised the need for the Health and Wellbeing Board to continue to prioritise Emotional Wellbeing and Mental Health so as to ensure improved outcomes and experiences for those young people using mental health services. A one-page summary from the event was published on the Board's website.[1]

2.0 ACCOUNT OF PROGRESS TO DATE

This gives a brief account of progress to date and a response to how those issues identified by the young people are being addressed. As a result of the issues the young people raised a new Emotional Health and Wellbeing Executive Group has been established. This group will be jointly chaired by Sheffield City Council and NHS Sheffield CCG to provide a partnership focus to all actions that will impact on the delivery of EWBMH. The Executive Group will oversee the delivery and implementation of a new EWBMH Action Plan which is addressing the following priorities:

Positive mental health and resilience including early intervention and prevention

- The young people consistently identified the gap in addressing EWBMH in school & youth settings and supporting children and young people to develop resilience in schools. There was acknowledgement that there continues to be a strong focus on attainment and achievement in school settings and in some cases a loss of the wider pastoral support to address emotional wellbeing and mental health needs. As a result a commitment is given through the delivery of high quality Personal and Social Health Education (PSHE) to support schools to deliver a robust EWBMH offer. The EWBMH school toolkit will be refreshed and new lesson plans and resources developed ready for implementation in September 2015. Through the Citywide Learning Body schools will be asked to consistently deliver EWBMH input through the PSHE curriculum and using the new toolkit and material provided.
- Young people commented that they 'want someone to help', someone who they can turn to for information and support with low level mental health issues (e.g. family breakdown, exam pressure etc.) A new primary mental health intervention will be piloted and further tested in 3 families of schools using a school based 'hub' model. This is to expand and build on the pilot delivered at Park Academy in 2014 and will help all partners including Sheffield City Council, NHS Sheffield Clinical Commissioning Group

[1] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/events/engagementevent.html.

and schools to make the right decisions about investments for young people's services in the future. The new service is currently being mobilised and will be operational from April 2015. The providers Interchange and Family Action will deliver the Emotional Health & Wellbeing Service through Community Youth Teams and schools offering counselling, signposting and a whole school approach to support settings to provide help, advocate for young people and improve their resilience and emotional wellbeing.

- The evaluation and outcomes of the service offered across the three families of schools will contribute towards the development of a business case focusing on improving accessibility, pathways and the potential redesign of EWBMH provision. This business case will be presented to the Children's Trust Executive Board (CTEB) in the future.

Young People Approaching Adulthood

- The new Executive Group will include a work stream focusing specifically on provision for 16-18 year olds. Its focus will be to ensure appropriate support for young people already engaged in specialist services, the development of a clear Pathway and 'step down' for those young people transitioning out of specialist provision. The current extension of CAMHS from 16 to 18 years will be evaluated to review the delivery model and experiences of young people aged 16+ using CAMHS services.

Development of community based support (Tier 3.5)

- Working with NHS Sheffield CCG the development of community based support as an alternative to hospital care is being explored so as to offer improved local community mental health services. This is in response to recognising that inpatient provision isn't always most appropriate or necessarily best tailored to young people's needs.

Services for Vulnerable C&YP

- In most instances the best place for children and young people experiencing severe mental health problems is to remain in Sheffield and close to home. The priority is to support the needs of vulnerable children and young people (particularly Children in Care) and reduce the number of children and young people who are placed out of city for their care.

Engagement and Participation

- The Board engagement event highlighted how powerful and important the views of children, young people and families are. The Executive Group is committed to hearing the voice of children and young people through using existing engagement structures. The engagement work led by the executive group will look to implement a new EWBMH local campaign. This will provide positive stories from young people and be used in schools and youth settings to reduce stigma, dispel myths and improve communication regarding EWBMH. This group will also continue to ensure the role of the 'Young Commissioners' in the development of EWBMH service provision. The young commissioners played an essential role in the recent commissioning of the EWBMH Service (described earlier) having active involvement in the procurement process, interviewing potential providers, informing the service model and selecting Interchange and Family Action as our preferred providers.

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The Health and Wellbeing Board is committed to continue to prioritise EWMB. The young people involved in the engagement event from Chilypep, Sheffield Futures and Young Healthwatch are invited to ask for regular updates, get involved or challenge progress.

3.0 RECOMMENDATIONS

- Agreement from the Board to agenda a further review on progress and implementation during early summer 2015.
- To note actions and service redesign being taken forward as an outcome of the CAMHS Scrutiny process.

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Briefing for Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
22nd July 2015

Subject: Urgent Care Review

Contact Officer: Emily Standbrook-Shaw, Policy & Improvement Officer
emily.standbrook-shaw@sheffield.gov.uk
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Overview

Sheffield CCG is currently undertaking a review of all the urgent care services in the city. There are several aims to the review including the integration of services, enabling senior decision makers to see patients early and improving the care for the frail elderly.

They are currently involved in public engagement around some of the principles that patients would like to see for the future local healthcare system. It is possible that to achieve this, they may need to reconfigure some services.

Two CCG Governing Body reports are attached, which give an overview of the process followed to date. Further information can be provided if required.

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:

- Note the update

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Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Outline Proposal to Review Urgent Care Services

Governing Body meeting

5 February 2015

Author(s)	Alastair Mew, Senior Commissioning Manager, and Management Lead for the Urgent Care Portfolio Dr StJohn Livesey, Clinical Lead for the Urgent Care Portfolio
Sponsor	Dr Zak McMurray, Clinical Director

Is your report for Approval / Consideration / Noting

The report is for consideration and approval.

Are there any Resource Implications (including Financial, Staffing etc)?

This review will form the core of the Urgent Care portfolio's workload.

Additional funding will be required to ensure successful public and patient engagement.

Depending on discussions within the proposed governing body sub group additional funding may also be required to fund an 'external critical friend'.

Audit Requirement

CCG Objectives

This review and resulting recommendations will support all four of the CCG's core objectives.

Equality impact assessment

An Equality Impact Assessment will be undertaken as part of the review.

PPE Activity

A core element of the review will be to actively engage with patients, carers and the public with findings used to inform any future changes.

Recommendations
The Governing Body is asked to: • Support the proposal for a review of citywide urgent care services. • Comment on and support the underlying set of principles outlined. • Agree to a six month extension of the contract for the Walk in Centre services at Broad Lane. • Comment on the review process, project structure, governance and timescales proposed. • Receive an update paper at the May Governing Body meeting.

NHS
Sheffield
Clinical Commissioning Group

Outline Proposal to Review Urgent Care Services

Governing Body meeting

5 February 2015

1. Introduction

Demand and pressure on urgent care services continues to increase in Sheffield, in common with the national picture. Local services are not uniform which can make it difficult for patients to navigate to the most appropriate place of care, first time and there is some duplication in use of resources. Our urgent care system increasingly struggles to meet demand and deliver clinically effective and safe services, which provide the best patient experience. Current estimates, based on local audits, for Sheffield suggest that around 11% of adults and 40% of children presenting to Urgent Care services could be effectively managed in General Practice.

In order to address these issues it is proposed that a review of citywide urgent care services is undertaken via formal engagement with patients, public, clinicians and other key stakeholders including existing service providers. The review and engagement will seek to understand the outcomes required by local people when making use of urgent care services, test out a number of key principles which are outlined below and will seek to assess options for improvement within existing resources.

It should be noted that this work will be supported by and interface with our proposals around Active Care and Recovery which is part of the shared Health and Care commissioning programme and as such these two service design models must be mutually supportive and consistent to patients and service providers. We will ensure in our programme structure that sensible interplay between the two programmes is factored into our planning.

The outcome of this work will be reported to the Governing Body during 2015/16 and will present a number of potential options for future urgent care in Sheffield with the aim of ensuring sustainable, outcome focused and best value local services, informed by appropriate public engagement and consultation. Appendix B sets out a proposed timetable.

Finally, it is worth recognizing the potential for collaboration across other CCGs and communities even for our own local service changes. The national; urgent care guidance which will be released during the Summer of 2015 may require greater sub-regional scaling of services and this will need to be reflected in the programme and where necessary utilise “Working Together” commissioner and provider programmes to expedite this.

This paper sets out:

- the background,
- the proposed scope of the review,
- proposed underlying principles that underpin delivery of Urgent Care

- a summary of the proposed approach,
- timescales and supporting governance structures.

The paper concludes with a number of recommendations for Governing Body to consider.

2. Background

2.1 National Context: Five Year Forward View

In October 2014 NHS England published the Five Year Forward View, which sets out how the health service needs to change to respond to the demands now placed upon it. It argues for a more engaged relationship with patients, carers and citizens to promote wellbeing and prevent ill-health.

There is an intention to support redesign of Urgent and Emergency Care provision:

'Across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.'

Five year forward view executive summary October 2014.

Furthermore, the five year plan outlines some bold initiatives to enhance service delivery, including the concept of new care models:

1. **Multispecialty Providers** – large group practices that could deliver a wide range of services including urgent care outside hospital and local
2. **Integrated Primary and Secondary care services** with consultant provision locally
3. **Networked urgent and emergency care.**

Appendix A provides more detail from the Five Year Forward View

2.2 Key Local Issues:

In terms of local context, whilst the number of presentations of more serious type one accident and emergency (A&E) attendances has remained relatively static, there is evidence that the demand for urgent care treatment for more minor ailments and concerns continues to increase. In Sheffield, it is clear that a proportion of patients will always simply "turn up" at A&E for care.

Recent audits suggest that a sizeable proportion of these patients could be managed more effectively in General Practice and previously there have been several attempts to integrate the skills of a GP into A&E. These did not succeed for a number of reasons but a consistent theme has been insufficient volumes of patients to ensure long term sustainability.

3. Summary of Scope of Review:

It is proposed that in order to address key issues surrounding the fragmentation of current urgent care services, ensure alignment with the Five Year Forward View and ensure long term sustainability and viability, that all local urgent care services should be reviewed.

This will be through detailed discussions with stakeholders and patients and an options appraisal developed.

At this point it is considered that well developed and complementary primary care services are vital to ensuring the resilience and sustainability of urgent care services. The review will therefore assess the potential impact on primary care and link into the current local work surrounding the Prime Minister's Challenge which is looking to increase availability of primary care in evenings and weekends and also explore the potential for further developments.

It is anticipated that the review will establish any benefits and or dis-benefits of increased integration and co-location of services and clinical professions (physical or virtual).

The review will also consider key linkages both in and out of hours. Efforts will be made to identify comprehensively all relevant elements, including pharmacy, ambulance services, Active Recovery and the Better Care Fund.

As part of this review workforce will also be considered in terms of the supporting professions and how they can best be utilized across the local urgent care system.

For clarity, current services considered to be included within the scope of this review at this stage are adults and children's accident and emergency units, the Walk in Centre at Broad Lane, the GP Out of Hours collaborative and the Minor Injuries Unit and Eye Casualty Unit at the Royal Hallamshire Hospital.

The CCG is party to the regional 111 contract with YAS. This cannot be included within the scope of the review but the review must consider how local services should appropriately interface with the 111 service.

At this stage no transportation services are part of the scope of the review, although regional work to look at the long term service model for ambulance services will be informed by it.

The review will be set in the context of consideration of the Five Year Forward View for Sheffield, which as agreed at the last Governing Body meeting will be a joint engagement exercise with providers and social care.

3.1 Proposed principles underpinning future services:

Following discussion with clinicians in the CCG, it is proposed that in order to ensure that future service developments and supporting clinical pathways are sustainable, deliver best value and the outcomes sought by local people a number of key principles will be adopted as part of the review. It should be noted that these local principles are consistent with those set out in the recent NHS England urgent and emergency care review.

Proposed principles:

General:	• Support the local delivery of the NHS Constitution • Reflect the outcomes needed by local people
Location:	• Accessible • Convenient • Close to or in the home
Pathways & Configuration:	• Well signposted & safe • Easy to navigate • Seamless integration & transportation between services & providers • Shared ownership primary/acute & health/social/voluntary
Contacting Services:	• Promotion of initial care in community • Single point of contact 24/7
Service Provision:	• Evidence based and safe • Rapid access to senior decision maker • Clear self-care information via number of modalities – web, phone etc. • Consistent citywide offer • Real time information available shared by all providers • Appropriate care provided by appropriate professional in appropriate location
Resilience & Continuity:	• Able to meet fluctuations in demand • Supports professional training and development
Financial:	• Cost effective and financially sustainable

The review will start with testing the principles proposed and agree a final set of principles to underpin the development of options to be evaluated.

3.2 Views of patients and other key stakeholders:

The importance of gathering the views of patients, public, service providers and other key stakeholders cannot be underestimated. Also, considering the level of public interest in urgent care services there is a need to ensure clear support from the public and clinicians for the proposals that will come from this review. In order to ensure that this review and resulting proposals are fully informed by local views a full engagement and communication plan will be developed. At this stage, it is expected that this will follow a similar model to the recent successful work undertaken in musculoskeletal services and link closely with the 'involve me' network. It is possible, depending on the proposals arising, that a further formal period of consultation will also be required. Proposed timescales for this are outlined in **Appendix B**.

4. Project Structure and Governance

A formal project management approach will be followed in order to ensure that key timescales are met and provide assure Governing Body that a robust and comprehensive engagement and analysis has been undertaken.

Considering the likelihood of external scrutiny, the importance and high profile of local services it is important that the review and engagement processes is led by Executive and Clinical Governing Body level members of the CCG.

It is therefore suggested that that a sub group of Governing Body support this area of work. At this stage it is envisioned that this would be a small core group co-chaired by a lay member and an executive director, supported by the urgent care management and clinical leads with additional elements from the CCG in attendance as required (quality, contracting, finance etc.). It is hoped that Healthwatch will be able to also attend this group in order to provide the patient voice and continue their highly valued role as 'critical friend'.

At this stage there is clearly no requirement for external consultancy support. However, building on the learning from the successful recent MSK work support from an external critical friend was invaluable in providing the patient voice from an external and national perspective which complimented the support provided by Healthwatch and so seeking similar input may be something that the sub group may also wish to consider.

4.1 Timescales

A high level project plan is outlined in **Appendix B** and it outlines the two key phases of work.

The first phase will ensure sufficient time for horizon scanning of other health economies, robust analysis of current services, collection of current patient views and feedback (compliments and complaints, patient opinion etc.), a set of proposed options based on the evidence and the development of a comprehensive communication and engagement plan.

The second phase ensures a sufficient length of time for a rigorous and comprehensive engagement to take place around the options and meets any external requirements should a formal consultation be considered necessary. The timing of this second phase is also cognizant of the upcoming general election and purdah requirements and is also

planned to conclude in time to dovetail with the development of commissioning intentions for 2016/17 and the timetable for contract discussions.

It should be noted that the Walk in Centre (WIC) contract expires on the 31st of March 2016. This contract was awarded as a result of a competitive procurement. Whilst ideally we would wish to be in position to notify the provider of our future commissioning intentions by 31 March 2015 the proposed timescales for the engagement will make this virtually impossible. Therefore, in order to give appropriate lead time to any change in service arrangements it is proposed that the provider be offered a six month extension to their existing contract to the 30th of September 2016 to enable service continuity whilst any recommendations are developed.

5. Recommendations

The Governing Body is asked to:

- Support the proposal for a review of citywide urgent care services.
- Comment on and support the underlying set of principles outlined.
- Agree to a six month extension of the contract for the Walk in Centre services at Broad Lane.
- Comment on the review process, project structure, governance and timescales proposed.
- Receive an update paper at the May Governing Body meeting.

Paper prepared by Alastair Mew, Senior Commissioning Manager, and Dr StJohn Livesey, Clinical Lead for the Urgent Care Portfolio

On Behalf of Dr Zak McMurray, Clinical Director

January 2015

Appendix A

NHS Five Year Forward View: October 2014

Page 21: New care model - urgent and emergency care networks

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system.

This will mean:

- Helping patients gets the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.

- Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

- Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

- Proper funding and integration of mental health crisis services, including liaison psychiatry.

- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

Appendix B High Level Project Plan and Timescales:

Key Task	Feb. 2015	Mar. 2015	Apr. 2015	May. 2015	Jun. 2015	Jul. 2015	Aug. 2015	Sept. 2015	Oct. 2015
Phase 1: Paper to GB for approval (public session)	☆								
Workstream 1: Undertake baseline analysis of local services (via data analysis and conversations with providers)	→	→	→						
Workstream 2: Undertake horizon scanning of urgent care services in other health economies	→	→	→						
Workstream 3: Stakeholder mapping and develop communications and engagement strategy/plan	→	→	→						
Sign off of communications and engagement strategy, revised principles and proposed options supported by the evidence for consultation by CCG Governing Body				☆					
Phase 2: Undertake formal communications and engagement with patients, public and key stakeholders including providers				→	→	→	→		
CCG GB sub group oversight meetings		☆	☆	☆	☆	☆	☆		
Final recommendations to CCG GB sub group								☆	
Options paper with recommendations to CCG GB									☆

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Update of Review of Urgent Care Services

Governing Body meeting

J

7 May 2015

Author(s)	Alastair Mew, Head of Commissioning (Urgent Care) Dr StJohn Livesey, Clinical Director for the Urgent Care Portfolio
Sponsor	Dr Zak McMurray, Medical Director

Is your report for Approval / Consideration / Noting

The report provides an update of progress following the paper received in February and seeks approval for continuation.

Are there any Resource Implications (including Financial, Staffing etc)?

This review will form the core of the Urgent Care portfolio's workload.

The review will be a major call on the public and public engagement team. The capacity of the team will need to be reviewed to ensure that it can meet this and other demands on in in 2015/16.

Depending on discussions within the proposed governing body sub group additional funding may also be required to fund an 'external critical friend'.

Audit Requirement

CCG Objectives

This review and resulting recommendations will support all four of the CCG's core objectives.

Equality impact assessment

An Equality Impact Assessment will be undertaken as part of the review.

PPE Activity

A core element of the review will be to actively engage with patients, carers and the public with findings used to inform any future changes.

Recommendations
The Governing Body is asked to: • Comment on the review process to date, project structure, governance and timescales proposed. • Support the continuation of the review and receive an options paper for Sheffield's urgent care services at the Governing Body meeting in October.

NHS
Sheffield
Clinical Commissioning Group

Update of Review of Urgent Care Services

Governing Body meeting

7 May 2015

1. Background

In February 2015 the Governing Body received a paper proposing a review of urgent care services in the city. This was in the context of demand and pressure on urgent care services continuing to increase in Sheffield, in common with the national picture. It was acknowledged that local services are not uniform which can make it difficult for patients to navigate to the most appropriate place of care, first time and that there is some duplication in use of resources.

The paper also put forward the view that current estimates, based on local audits, for Sheffield suggest that around 11% of adults and 40% of children presenting to Urgent Care services could be effectively managed in general practice.

In order to address these issues Governing Body supported a proposal that a review of citywide urgent care services is undertaken via formal engagement with patients, public, clinicians and other key stakeholders including existing service providers.

Specifically, in February the Governing Body also supported the proposed scope of the review, a set of proposed underlying principles that underpin delivery of Urgent Care, a summary of the proposed approach and timescales and supporting governance structures.

This paper seeks to outline a summary of the work to date and approval to continue the work as per the timescales outlined and agreed in February and request that Governing Body receives a paper outlining a number of options and recommendations in October.

2. Scope of the Review and the Wider Context

In February the scope of the review was detailed and agreed. For clarity these are summarised again below and should be viewed in the context of the high level project plan in appendix A.

In order to address key issues surrounding the fragmentation of current urgent care services, ensure alignment with the Five Year Forward View and ensure long term sustainability and viability, all local urgent care services will be reviewed. This will be through detailed discussions with stakeholders and patients and an options appraisal developed.

At this point it is still considered that well developed and complementary primary care services are vital to ensuring the resilience and sustainability of urgent care services. The review will therefore continue to assess the potential impact on primary care and link into the current local work surrounding the Prime Minister's Challenge Fund (PMCF) which is looking to increase availability of primary care in evenings and weekends and also explore the potential for further developments. However, Governing Body is asked to note that

whilst the award of the PMCF is a fantastic opportunity for Sheffield to test new approaches to providing care the single year of funding will create significant challenges in terms of the time available to develop evidence to support future funding.

It is anticipated that the review will establish any benefits and or dis-benefits of increased integration and co-location of services and clinical professions (physical or virtual).

The review will also consider key linkages both in and out of hours. Efforts will be made to identify comprehensively all relevant elements, including pharmacy, ambulance services, Active Recovery and the Better Care Fund.

As part of this review, workforce will also be considered in terms of the supporting professions and how they can best be utilised across the local urgent care system.

For clarity, current services considered to be included within the scope of this review at this stage are adults and children's accident and emergency units, the Walk in Centre at Broad Lane, the GP Out of Hours Collaborative and the Minor Injuries Unit and Eye Casualty Unit at the Royal Hallamshire Hospital.

The CCG is party to the regional 111 contract with YAS. This cannot be included within the scope of the review but the review must consider how local services should appropriately interface with the 111 service.

At this stage no transportation services are part of the scope of the review, although regional work to look at the long term service model for ambulance services will be informed by it.

The review will be set in the context of consideration of the Five Year Forward View for Sheffield, which as agreed at the last Governing Body meeting will be a joint engagement exercise with providers and social care.

The review and engagement will seek to understand the outcomes required by local people when making use of urgent care services, test out a number of key principles (see appendix B) and will seek to assess options for improvement within existing resources.

It should be noted that this work will be supported by and interface with our proposals around Active Care and Recovery which is part of the shared Health and Care commissioning programme and as such these two service design models must be mutually supportive and consistent to patients and service providers. We will ensure in our programme structure that sensible interplay between the two programmes is factored into our planning.

The outcome of this work will be reported to the Governing Body during 2015/16 and will present a number of potential options for future urgent care in Sheffield with the aim of ensuring sustainable, outcome focused and best value local services, informed by appropriate public engagement and consultation.

Finally, it is worth recognising the potential for collaboration across other CCGs and communities even for our own local service changes. The national urgent care guidance which will be released during the Summer of 2015 may require greater sub-regional scaling of services and this will need to be reflected in the review and where necessary utilise "Working Together" commissioner and provider programmes to expedite this.

3. Proposed principles underpinning future services:

In February the Governing Body supported a number of proposed principles in order to ensure that future service developments and supporting clinical pathways are sustainable, deliver best value and the outcomes sought by local people (see Appendix B). It was noted that these local principles were consistent with those set out in the recent NHS England urgent and emergency care review.

The review has currently started to test the proposed principles in early discussions with key stakeholders and in wider conversations with other CCGs and external experts. It is proposed that a final set of principles will be agreed by the Governing Body sub-group supporting this work (chaired by the CCG Medical Director) and that these will underpin and inform the development of options to be evaluated.

4. Project Structure and Governance

As outlined in February a formal project management approach has been adopted in order to ensure that key timescales are met and provide assurance to Governing Body that a robust and comprehensive engagement and analysis has been undertaken.

In order to ensure that the three workstreams outlined in the high level project plan have sufficient support and scrutiny two working groups have been set up. The first having an operational focus supporting workstreams one and two and the second focusing on the third workstream communications, engagement and patient experience. Both groups have been formally constituted with terms of reference and membership clearly defined and documented. Formal notes and action points are taken at all meetings which are co-chaired by the Head of Commissioning (Urgent Care) and the Clinical Director for the Urgent Care Portfolio.

Considering the potential scale of the proposed changes, the likelihood of external scrutiny and the importance and high profile of local services the review is also being supported and scrutinized by a sub group of Governing Body. The group meets on a formal basis and is co- chaired by the CCG's Medical Director and a Governing Body lay member along with the CCG's Chief Nurse and Quality Lead ensuring that as the review and its recommendations develop that clinical quality and the patient voice are fully considered and that the review's risk log is regularly and formally scrutinised. The group is supported by the urgent care management and clinical leads with additional elements from the CCG in attendance as required (quality, contracting, finance etc.). Healthwatch have also been invited to attend this group in order to provide the patient voice and continue their highly valued role as 'critical friend'. (See Appendix C for a diagram illustrating the governance structure).

At this stage there is no requirement for external consultancy support. However, building on the learning from the successful recent MSK work support from an external critical friend was invaluable in providing the patient voice from an external and national perspective which complimented the support provided by Healthwatch and so seeking similar input is something that the sub group is still considering.

5. Understanding the Local Situation Within the National Context

5.1 Public Health Support and Initial Analysis

To date, there has been significant support provided by the public health team with key meetings attended in order to ensure a population health perspective. National data on the changing patterns of urgent care use over the last decade has been analysed and is currently being summarised in to an accessible format which will be used to support and provide context to on-going and future discussions with stakeholders, patients and members of the public.

Briefly summarised, the initial findings show that:

1. Demand has gone up dramatically across ALL aspects of urgent care (not just A&E, but also ambulance services / emergency calls / GP consultations).
2. This increase in demand far outstrips what we could put down as a result of an "aging population".
3. The majority of this increased utilisation of urgent care is for less severe presentations / minor illnesses.
4. There is a strong association between deprivation in an area and increased use of urgent care services.

The public health team is now analysing Sheffield specific data for similar trends to try and identify if Sheffield is in any way different from the national picture and this work is being complemented by benchmarking analysis provided by the CCGs Intelligence Unit.

It should be noted that it is harder to draw conclusions for this local data as it contains much more variation and is more subject to changes in the way that it has been collected. However, to date there are no specific areas where Sheffield should be considered significantly different from the national patterns (when we consider our population is slightly more deprived than the national average).

In terms of summarising the evidence and learning from existing literature a literature review has been produced detailing which interventions have been tried to reduce unscheduled attendance at emergency services. A further literature review is also being finalised examining the impacts of GP Walk-in Centres on urgent care use.

5.2 Placing Sheffield in the Regional and National Context

In order to understand the regional context and identify areas of best practice the project team has met with the urgent care leads of the South Yorkshire and Bassetlaw and Working Together area. Wider discussions with a number of CCGs have also taken place across the north of England.

5.3 Views of local patients and other key stakeholders:

The importance of gathering the views of patients, public, service providers and other key stakeholders cannot be underestimated (see Appendix D for a summary of the communications and engagement approach). Also, considering the level of public interest in urgent care services there is a need to ensure clear support from the public and clinicians for the proposals that will come from this review. In order to ensure that this review and resulting proposals are fully informed by local views current complaints and compliments data is being collected and analysed from the Sheffield Teaching Hospitals, Sheffield Children's Hospital, the Care Trust and patient opinion and this will be coupled

with a full engagement and communication plan has been. At this stage, it is expected that this will follow a similar model to the recent successful work undertaken in musculoskeletal services and link closely with the 'involve me' network. It is possible, depending on the proposals arising, that a further formal period of consultation will also be required.

The approach and activities planned by NHS Sheffield CCG to engage with the public around the Urgent Care Strategy Review builds on the engagement work carried out in 2014 to support the development of musculoskeletal services and the principles developed by the Patient Engagement and Experience Group, ensuring that the engagement plan adopts a robust, locally tried and tested approach.

Adhering to the tri-phased approach to engagement agreed by Governing Body, plans are being developed in a considered way allowing key identified datasets including an Equality Impact Assessment to be analysed to influence the focus and content, and allow effective targeting, of engagement activities.

The Experience Based Design and Co-design approaches will enable decisions to be made on a much richer quality of feedback from the public. These approaches will allow both emotional impact to be identified and a greater deal of reflection of plans and ideas to happen by both professionals and patients and the public.

The addition of plans to utilise patient to patient methods of engagement with the upskilling of patients to act as ambassadors for change is another bold approach that has been included within the engagement activities. This will allow us to multiply the reach of our messages and engagement whilst also providing extra credibility in the community.
Key members of the project team are to undertake bespoke media training to equip them with the skills to effectively engage with the media to ensure positive perceptions of messages and proposals.

In a break from the regular approach to developing a joint Communications and Engagement plan, distinct plans for both Communications and Engagement have been written to concentrate on their strengths as specialities. The two plans have now been brought together to coordinate activities.

6. Timescales and Next Steps

A high level project plan is outlined in Appendix A and it outlines the two key phases of work.

The first phase has now completed and has enabled sufficient time for horizon scanning of other health economies, analysis of current services, collection of current patient views and the development of a comprehensive communication and engagement plan.

It is now proposed that Governing Body supports the project moving to the second phase in order to ensure a sufficient length of time for a rigorous and comprehensive engagement to take place around the options and meets any external requirements should a further formal consultation be considered necessary. The timing of this second phase has also been cognizant of the general election and purdah requirements and is also planned to conclude in time to dovetail with the development of commissioning intentions for 2016/17 and the timetable for contract discussions.

7. Recommendations

The Governing Body is asked to:

- Note and agree the completion of first phase.
- Comment on and support the project structure, governance arrangements and timescales.
- Support the proposal to move to phase 2.
- Receive a paper outlining a number of options and recommendations in October.

Paper prepared by Alastair Mew, Head of Commissioning (Urgent Care), and Dr StJohn Livesey, Clinical Director for the Urgent Care Portfolio.

On Behalf of Dr Zak McMurray, Medical Director

April 2015

Appendix A High Level Project Plan and Timescales

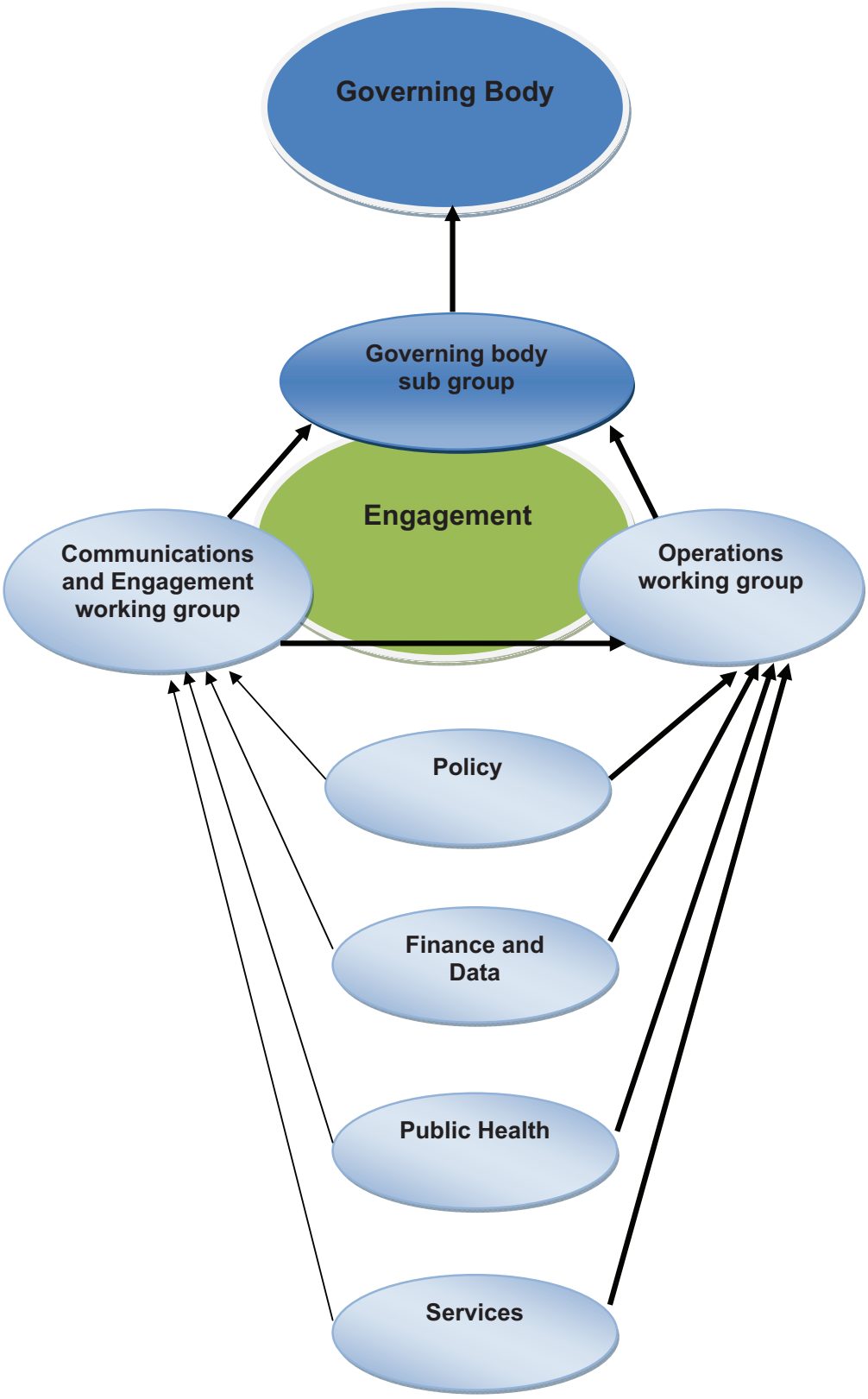
Key Task	Feb. 2015	Mar. 2015	Apr. 2015	May. 2015	Jun. 2015	Jul. 2015	Aug. 2015	Sept. 2015	Oct. 2015
Phase 1: Paper to GB for approval (public session)	☆								
Workstream 1: Undertake baseline analysis of local services (via data analysis and conversations with providers)	→	→	→						
Workstream 2: Undertake horizon scanning of urgent care services in other health economies	→	→	→						
Workstream 3: Stakeholder mapping and develop communications and engagement strategy/plan	→	→	→						
Sign off of communications and engagement strategy, revised principles and proposed options supported by the evidence for consultation by CCG Governing Body				☆					
Phase 2: Undertake formal communications and engagement with patients, public and key stakeholders including providers				→	→	→	→		
CCG GB sub group oversight meetings		☆	☆	☆	☆	☆	☆		
Final recommendations to CCG GB sub group								☆	
Options paper with recommendations to CCG GB									☆

Appendix B Principles:

Proposed Principles Supported by Governing Body in February:

General:	• Support the local delivery of the NHS Constitution • Reflect the outcomes needed by local people
Location:	• Accessible • Convenient • Close to or in the home
Pathways & Configuration:	• Well signposted & safe • Easy to navigate • Seamless integration & transportation between services & providers • Shared ownership primary/acute & health/social/voluntary
Contacting Services:	• Promotion of initial care in community • Single point of contact 24/7
Service Provision:	• Evidence based and safe • Rapid access to senior decision maker • Clear self-care information via number of modalities – web, phone etc. • Consistent citywide offer • Real time information available shared by all providers • Appropriate care provided by appropriate professional in appropriate location
Resilience & Continuity:	• Able to meet fluctuations in demand • Supports professional training and development
Financial:	• Cost effective and financially sustainable

Appendix C Governance Structure Supporting Urgent Care Review:



Appendix D Communications and Engagement Summary

1. Introduction

Demand and pressure on urgent care services continues to increase in Sheffield, in line with the national picture. Our urgent care system increasingly struggles to meet demand and deliver clinically effective and safe services, which provide the best patient experience.

i) With a backdrop of the national and local conversation about the Five Year Forward View, patients, carers and the public must form an integral role in the development of plans for Urgent Care if the future system is to be fit for purpose and utilised as clinicians and NHS managers hope. This document outlines the initial scope for conversations with local people, as well as the legal framework for which those conversations should happen. It also takes into account the pre-election period from 30th March – 7th May 2015.

2. Background

October 2014 saw NHS England publish the 'NHS Five Year Forward View' which sets out how the health service needs to change and adapt if it is to successfully meet and respond to the increasing demands and complexities placed upon it. The report promotes the need for an even closer relationship with patients, carers, and the public to achieve wellbeing and better prevention. The report goes on to state the need for better integration between A&E, GP out of hours, urgent care centres, NHS 111 and ambulance services.

NHS Sheffield CCG Governing Body have made the decision to formally undertake a city wide review of urgent care services in an attempt to better understand the outcomes required by local people who use such services. The review will seek to engage with patients, public, clinicians and other key stakeholders including existing service providers.

The current situation clearly shows that pressure and demand on the system is significant and continuing to rise. The aims of the review will highlight the significant pressure and demand points on local urgent care services and how they can be managed to deliver clinically effective and safe services in order to provide the best patient experiences.

3. Scope

i) Scope of the Urgent Care Review

The overall aim of this stage of the Urgent Care Review is the development of potential options for a future sustainable, outcomes-based, best value system that addresses the outcomes required by local people, tests out key principles and considers options for improvement within existing services. This is based within the context of Active Care and Recovery proposals and shared health and social care commissioning.

ii) Scope of this communications and engagement plan

This plan details the process we will follow for collecting data about patient experience on urgent care. It also gives details of engagement methodology and techniques for exploring overarching principals about the future of urgent care in Sheffield, with a view to developing more specific messages and options for formal consultation after October 2015.

4. Legal Framework

i) Gunning Principals

The four 'Gunning Principals'1 are recommended as a framework for all engagement activity but are particularly relevant for consultation and would be used. They are that we engage:

- When proposals are still at the formative stage
- Sufficient reasons for proposals to permit intelligent consideration
- Adequate time for consideration & response
- …must be conscientiously taken into account

ii) Transforming Participation

NHS England published 'Transforming Participation In Health and Care – The NHS Belongs To Us All'2 in September 2013 which states how the vision for patient and public participation, outlined in the NHS Constitution and Health and Social Care Act 2012, will become a reality. It states that there are six key requirements for NHS commissioners:

- Make arrangements for and promote individual participation in care and treatment through commissioning activity
- Listen and act upon patient and carer feedback at all stages of the commissioning cycle – from needs assessment to contract management
- Engage with patients, carers and the public when redesigning or reconfiguring healthcare services, demonstrating how this has informed decisions
- Make arrangements for the public to be engaged in governance arrangements by ensuring that the CCG governing body includes at least two lay people
- Publish evidence of what 'patient and public voice' activity has been conducted, its impact and the difference it has made
- CCGs will publish the feedback they receive from local Healthwatch about health and care services in their locality

[1] http://www.adminlaw.org.uk/docs/18%20January%202012%20Sheldon.pdf

[2] http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

iii) Health and Social Care Act 2012

The Health and Social Care Act 2012 makes provision for Clinical Commissioning Groups (CCGs) to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners. It also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution – and to promote awareness of the NHS Constitution. Specifically, CCGs must involve and consult patients and the public:

- In their planning of commissioning arrangements
- In the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
- In decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSCs) on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

iv) The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, which are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations.

v) The NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains a number of patient rights which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- The development and consideration of proposals for changes in the way those services are provided, and in the decisions to be made affecting the operation of those services

5. Target audiences (not exhaustive)

i) Public

- The general public in the widest sense – all people in Sheffield and nearby surrounding areas
- Patients who use urgent care services
- Carers of patients

ii) Key Local Partners

- STH Board/Executive
- SCH Board/Executive
- SHSCT – including the Clover Group
- Sheffield City Council
- Healthwatch Sheffield
- GP Provider Board
- Sheffield Pharmacies
- YAS Board/Executive
- NHS 111
- Broad Lane

iii) External - Partner organisations and wider links

- Sheffield City Council Public Health, Community Wellbeing Team including Health Trainers
- Related projects
- Universities, Sheffield Hallam, Sheffield University, ScHARR
- Voluntary, Community and Faith (VCF) Sector
- Chamber of Commerce
- Sheffield International Venues
- MPs
- Local Medical Council (LMC)
- LDC
- LPC
- LOC
- Health and Wellbeing Board
- Patient Advice and Liaison service (PALs)/ Patient Public Involvement (PPI)
- Community and social groups
- Current service providers
- Caldicott Guardians

iv) External – Organisations

- NHS Rotherham CCG
- NHS Doncaster CCG

- NHS Barnsley CCG
- Monitor
- NHS England
- South Yorkshire Operational Development Network - Urgent Care
- Yorkshire and Humber Trauma Network / Group
- Regional Critical Care Development Network / Group
- Urgent Health UK
- Care UK
- Patient UK
- Sight Support Sheffield
- Age UK Sheffield
- Disability Sheffield

v) External – Hard to reach groups and communities

These groups would come under the 'general public' heading, but are unlikely to access the information about the review but should be aware and given the opportunity to input in to the engagement activity. These include:

- People of specific age groups – need to understand which age groups use urgent care services the most
- Black, Asian and Minority Ethnic (BAME) groups
- Young families and new parents
- Public in the areas of the city with highest levels of deprivation/ poorest health
- Those with no fixed abode
- Gypsy and traveller communities
- People with sensory impairment
- People with physical, learning and cognitive impairment
- Communities new to the city and those where English is not the first language (these will be a key group as these groups may be regularly presenting in Urgent Care settings when their clinical need may be best cared for elsewhere in the system).