Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 14 September 2016 at 4.00 pm

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

The Press and Public are Welcome to Attend

Membership

Councillor Pat Midgley (Chair), Sue Alston (Deputy Chair), Pauline Andrews, David Barker, Mike Drabble, Adam Hurst, Douglas Johnson, George Lindars-Hammond, Anne Murphy, Shaffaq Mohammed, Zahira Naz, Moya O'Rourke, Bob Pullin and Garry Weatherall

Healthwatch Sheffield
Helen Rowe and Clive Skelton (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 Alice Nicholson, Policy and Improvement Officer on 0114 27 35065 or email alice nicholson@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
14 SEPTEMBER 2016

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

6. Development of a Public Health Strategy for Sheffield (Pages 5 - 32)
Report of Greg Fell, Director of Public Health

(In attendance for this item will be Councillor Cate McDonald, Cabinet Member for Health and Social Care and Greg Fell, Director of Public Health)

7. South Yorkshire and Bassetlaw Sustainability and Transformation Plan - Update (Pages 33 - 38)
a) Report of NHS Programme Director, South Yorkshire and Bassetlaw STP

b) Presentation by Will Cleary-Gray, Programme Director and Tim Moorhead, Chair, Sheffield Clinical Commissioning Group

8. Joint Health Overview and Scrutiny Committee - Commissioners Working Together Programme (Pages 39 - 48)
Report of the Policy and Improvement Officer

9. Work Programme 2016/17 (Pages 49 - 56)
Report of the Policy and Improvement Officer

10. Minutes of Previous Meeting (Pages 57 - 62)
To approve the minutes of the meeting of the Committee held on 13th July, 2016

11. Date of Next Meeting

The next meeting of the Committee will be held on Wednesday, 9th November, 2016, at 4.00 pm, 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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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee 14th September 2016

Report of: Greg Fell, Director of Public Health

Subject: Development of a public health strategy for SCC

Author of Report: Greg Fell
Tel : 0114 2057463
Mob: 07891 564912
Email : greg.fell@sheffield.gcsx.gov.uk

Summary:
This paper is the draft public health strategy for SCC, setting out an answer to a question of what Sheffield City Council as "a public health organisation" would look like. This follows the transfer of responsibility of "the public health function" to SCC from the NHS in 2013, and a period of integration. There has also been a 2015 review of this function. Iterations of this document have been to each of the PLTs on a number of occasions, and the feedback has been useful and constructive. The strategy has also been discussed in EMT, again with helpful feedback. The strategy attached incorporates that feedback.

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

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

The Scrutiny Committee is being asked to:

The committee is asked to consider the draft strategy in terms of the key messages, the length and depth, the specific areas suggested for early priority. Specifically feedback and comment is requested on whether the strategy provides a clear enough narrative and is appropriately ambitious.

Finally the committee is asked to consider issues of alignment of this work with other plans and strategies.

Background Papers: Draft Public Heath Strategy
Category of Report: **OPEN**

Report of the Director of Public Health –
Development of a public health strategy for SCC

1. Introduction/Context

1.1 The ambition is to achieve a strategy that sets the direction of travel for "Public Health" (in the broadest possible sense of the words) that doesn't override existing plans, but enhances them. The ambition is also to engage a wider set of stakeholders into "public health".

1.2 This strategy is a statement of intent and is deliberately not voluminous. It is not intended to replace existing plans and strategies, but to boost their implementation, to signal opportunities to further enhance progress against our priorities, and a tool to provoke debate on where more ambitious/radical approaches need exploring. This strategy should also be a tool to change the debate about "health" to something that is considerably wider than "health services" and considerably further upstream than the current debate.

1.3 The strategy was developed following a 2015 review of the public health function and some linked external work undertaken by the Kings Fund. Specifically

2. Structure of the draft strategy

2.1 Critical to the success of this strategy is the ability to shift the deployment of the current resource commitment (upstream), to maximise the health and well being impact of all SCC activities and to link agendas together that have not been historically linked.

2.2 The aim of this strategy is to increase healthy life expectancy by 1 year over the next 10 years, explicitly focused on improving fastest in those with lowest healthy life expectancy. If achieved this equates to 560,000 person years of illness and disability avoided. The benefits of this in terms of care costs avoided are obvious. It also equates to an impact on the productivity of the economy.

2.3 There are 4 objectives. The objectives reflect some substantial areas where we would like to see some progress.

2.4 There isn't a single big intervention that will resolve the challenges of the city in this area. An approach based on a range of interventions including education, service provision, regulation and structural or policy initiatives will be needed.

2.5 The strategy does not set out all the areas for detailed work on interventions beyond the headlines below. The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues.

2.6 Obviously this needs to link to, and influence a wide range of other strategies and programmes without rewriting them. The strategy is clear that the Public Health Grant (transferred from NHS in 2013) will not "solve" the health and well being challenges for the city; to meet that challenge it will be necessary to influence a much larger resource commitment.

2.7 The draft strategy has not yet been through the cabinet process and the purpose of bringing it to scrutiny is to solicit views from members of the committee on the content and aims set out. It is intended this draft will go to Cabinet towards the end of the year.

3 What does this mean for the people of Sheffield?

3.1 It is fair reflection that the strategy as it is currently drafted is not particularly public facing. This is an issue that will be addressed. The intention is to set out the position of SCC with regard to "public health" and provide a narrative for a debate.

3.2 The intention is to clarify the role of SCC as "a public health organisation" and push towards a more preventive approach.

3.3 Obviously there isn't a single intervention, or set of interventions that will by themselves address the central challenge of improving healthy life expectancy and health inequalities. The intention of the strategy is to begin to mobilise the resource deployment of SCC around the aims.

3.4 There is some further work to undertake around aligning this work with already existing (or developing) plans and strategies. There is also some further work to do around providing some specific examples & case studies.

4. Recommendation

4.1 The committee is asked to consider the draft strategy in terms of the key messages, the length and depth, the specific areas suggested for early priority. Specifically feedback and comment is requested on whether the strategy provides a clear enough narrative and is appropriately ambitious.
Finally the committee is asked to consider issues of alignment of this work with other plans and strategies.

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Sheffield City Council

DRAFT Public Health Strategy

5 Sept 2016

Greg Fell

Director of Public Health

Suggested foreword and intro

JM & or Cllr McDonald.

Executive Summary

Why this strategy

Sheffield City Council has made a commitment to becoming a public health organisation. This strategy aims to state the level of ambition contained within this commitment and set out a vision for the Council as an organisation focused on improving health outcomes and reducing inequalities.

The “aim” of public health has often been framed as something quite narrowly defined as “something the health sector does”. This is not the case in Sheffield. The aim of “public health” is to allow and enable people to be as healthy as they can because it is the right approach; because it will slow the rate of cost growth in the health and care sector and importantly – though often missed – as a healthy population is a core infrastructure investment for a vibrant economy.

This strategy is a statement of intent and is deliberately not voluminous. It is not intended to replace existing plans and strategies, but to boost their implementation, to signal opportunities to further enhance progress against our priorities, and a tool to provoke debate on where more ambitious/radical approaches need exploring. This strategy should also be a tool to change the debate about “health” to something that is considerably wider than “health services” and considerably further upstream than the current debate.

Focus of the strategy

The focus is on giving people in Sheffield **the best start in life** to **maximise their life chances**; considering the health dividend across all our work; and considering how we can best support people in Sheffield to live **longer and healthier lives, with an explicit focus on inequalities.**

Aim of the strategy

The aim of this strategy is to increase healthy life expectancy by 1 year over the next 10 years, explicitly focused on improving fastest in those with lowest healthy life expectancy. If achieved this equates to 560,000 person years of illness and disability avoided. The benefits of this in terms of care costs avoided are obvious. It also equates to an impact on the productivity of the economy.

Objectives

There are 4 objectives. The objectives reflect some substantial areas where we would like to see some progress. We will use the skills, expertise and resources we have to enable these outcomes to be delivered.

Objective 1 – **refresh and revise our approach to health inequalities**.

Objective 2– Optimise **health outcomes as an output of public service reform**, integrate health and well being as a **core consideration in all SCC policies and processes**; and **upgrading our approach to prevention** across the totality of SCC.

Objective 3 – Maintain and develop a **robust system to protect the population** from preventable infections and environmental hazards.

Objective 4 – Develop ambitious **policy and service based approaches to healthy lifestyles** to support people be as healthy as they can.

Areas of early focus

There isn't a single big thing that will resolve the challenges of the city in this area. An approach based on a range of interventions including education, service provision, regulation and structural or policy initiatives will be needed.

The commitment in this strategy is to moving the direction of the resource commitment towards prevention being the norm and focused effort across the council on achieving the aim of the strategy – that being improving healthy life expectancy and reduction of the gap between best and worst.

We have not set out all the areas for detailed work on interventions beyond the headlines below. The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues.

Who has what responsibility

Ultimately the Heath and Well Being Board is best placed to lead this agenda. The role of the DPH should be holding Sheffield City Council to account for delivery of improved healthy life expectancy and reduced inequalities, and providing support where this is needed. If the role of the finance director is to ensure an organisation stays within budget, the role of the DPH is to ensure health and wellbeing outcomes are achieved.

The challenge is on of maximising the health dividend of all activities of SCC across the totality of resource deployment, to link activities together and to develop whole system and cross sector approaches to “health” problems. Thus the key question is whether the resources used in the city address or are detrimental to the vision and aims, and the challenge is therefore to optimise the use of its £1.4bn budget, and associated purchasing power, to best improve health and address inequality.

Three key messages

This agenda stretches far beyond “health services” and interacts with almost all aspects of SCC. The agenda is considerably broader than “service provision”, policies and supportive environments can enable health.

Investment to achieve improvements in healthy life expectany are just that, an investment. That investment will have positive consequences on down stream health and care costs, and broader economic impacts.

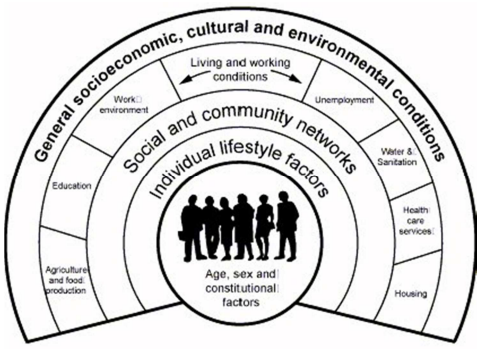
The critical challenge is how we deploy the resources of the city to address improvements in healthy life expectancy and health inequalities.

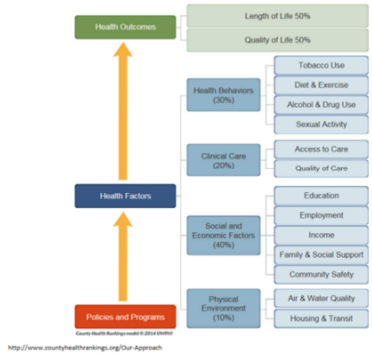
1 Introduction

Our approach to health and well being

Health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, as per the WHO definition. This is a broad an expansive definition and is taken to incorporate broader notions of “well being”. Importantly it a definition that requires a wider response than “health services”.

Twenty per cent of health outcomes, here measured by life expectancy and healthy life expectancy, are attributed to health care. The determinants of health also include health behaviours, social & economic factors, access to services and the environment, as illustrated below:





Accordingly, SCC has agreed to adopt a social model of health[1] [2]. This focuses the attention and locus on the upstream social and economic determinants of health. Within this there are a number of balances to be struck between different approaches, for example: the balance between areas of activity, for example the balances between

- social issues (jobs and poverty) and lifestyle issues (tobacco and physical activity),
- service provision and structural / policy solutions
- “treatment of here and now issues” and “prevention by going upstream”

A medically- and a socially-focused approach to health are not mutually exclusive, and different stakeholders may put different emphasis on one approach or the other. Different approaches are effective for achieving goals over different timeframes. These balances require constant attention, especially given that there isn’t a single intervention that will address the overall health and wellbeing challenge in its entirety.

There is also a tension inherent in the language of inequalities that may lead some to consider that “inequalities are not their business; its only about the 20%”. Health, and other inequalities, are a population level issue and are inextricably linked, as demonstrated by Marmot, Pickett, Piketty and many others.

What is “Public Health”

Here “public health” is defined as the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.

The “aim” of public health has often been framed as something quite narrowly defined as “something the health sector does”. This is not the case in Sheffield. The aim of “public health” is to allow and enable people to be as healthy as they can because it is the right approach; because it will slow the rate of cost growth in the health and care sector and importantly – though often missed – as a healthy population is a core infrastructure investment for a vibrant economy. Recent research[3] has highlighted that one in eight people are too ill or disabled to work by state pension age. This is obviously important from a wide range of viewpoints, it is also a redressable problem.

Background to this strategy

The Director of Public Health Report 2015[4] , the Joint Strategic Needs Assessment[5], the recommendations of the Fairness Commission[6], the State of Sheffield[7], the PHE Local Authority Health Profile[8], the Marmot Indicators[9], the locally produced lifestyle and mortality quilts and the Public Health Outcomes Framework[10] tell a consistent story about the key themes for health priorities. More recently SCC undertook an online survey to identify the key priorities as perceived by local stakeholders. In 2015, the Kings Fund supported a review of public health in Sheffield. This was set against their resource for local government focused public health[11]. This review identified a number of themes, with some detailed suggestions where we could adopt good practice from elsewhere.

What is the aim of this strategy? Why now?

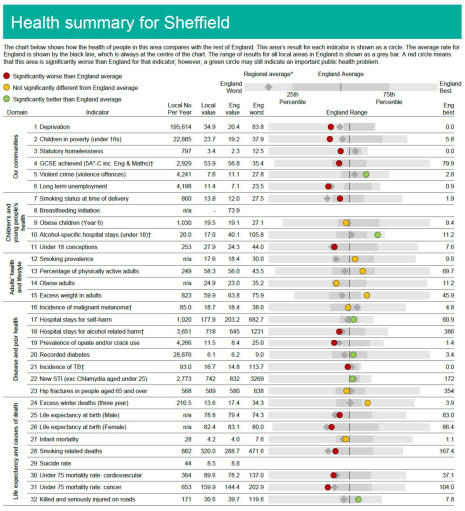
Sheffield City Council has made a commitment to becoming a public health organisation. This strategy aims to state the level of ambition contained within this commitment and set out a vision for the Council as an organisation focused on improving health outcomes and reducing inequalities. SCC has also made a commitment to becoming an organisation oriented around Prevention, this is a commitment in our developing Strategic Business Plan

This strategy is therefore a statement of intent, setting out what being “a public health organisation” looks like. It is deliberately not voluminous. It is not intended to replace existing plans and strategies, but to boost their implementation, to signal opportunities to further enhance progress against our priorities, and provoke debate on where more ambitious/radical approaches need exploring. It does, however, commit SCC to a number of specific and high impact interventions or broad directions of travel that should serve to institutionalise the focus on health outcomes and health inequalities.

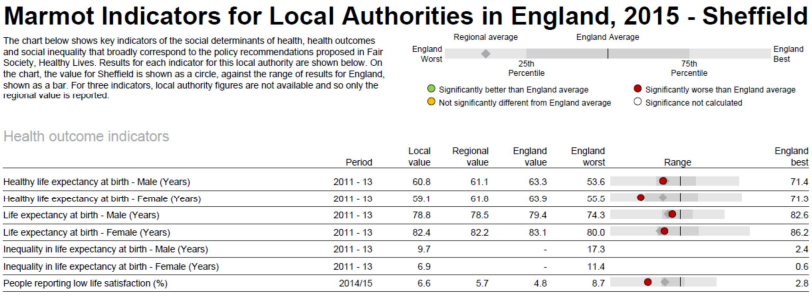
The development of the Sustainability and Transformation Plan, the Sheffield Place Based Plan and the SCC commitment to upgrading prevention combine to provide an opportune moment to define our approach to “public health” and set out some high level aspirations.

The health of the people that live in the city. The problem to solve.

The actions set out in the strategy are clearly focused on a clearly stated issue of avoidable illness and early death, and the consequences of both in terms of lost quality of life, lost economically productive years and pressure on health and social care services. Good health and well being is obviously important in its own right as a fundamental human need. The Public Health Outcomes Framework gives a snapshot of indicators of health and well being. The PHE Public Health Outcome Framework profile for Sheffield is below:



The 2015 Marmot Profile for Sheffield gives high level indicators on the wider determinants of health, health improvement, health protection, premature mortality.



Marmot Indicators for Local Authorities in England, 2015 - Sheffield

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that broadly correspond to the policy recommendations proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value for Sheffield is shown as a circle, against the range of results for England, shown as a bar. For three indicators, local authority figures are not available and so only the regional value is reported.

Regional average
England Average
England Worst
England Best
25th Percentile
75th Percentile
Significantly better than England average
Not significantly different from England average
Significantly worse than England average
Significance not calculated

Health outcome indicators

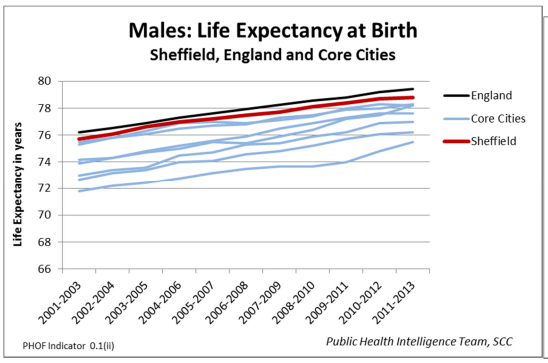
	Period	Local value	Regional value	England value	England worst	Range	England best
Healthy life expectancy at birth - Male (Years)	2011 - 13	60.8	61.1	63.3	53.6		71.4
Healthy life expectancy at birth - Female (Years)	2011 - 13	59.1	61.6	63.9	55.5		71.3
Life expectancy at birth - Male (Years)	2011 - 13	78.8	78.5	79.4	74.3		82.6
Life expectancy at birth - Female (Years)	2011 - 13	82.4	82.2	83.1	80.0		86.2
Inequality in life expectancy at birth - Male (Years)	2011 - 13	9.7		-	17.3		2.4
Inequality in life expectancy at birth - Female (Years)	2011 - 13	6.9		-	11.4		0.6
People reporting low life satisfaction (%)	2014/15	6.6	5.7	4.8	8.7		2.8

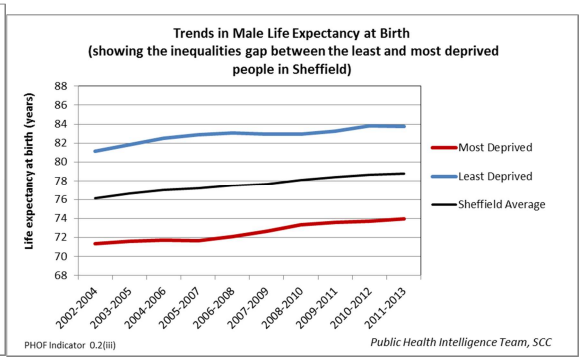
There are subsets of indicators in a number of domains – best start in life, enabling children and adults to have maximum control, fair employment and good work for all, healthy standard of living for all, and healthy & sustainable communities.

The Sheffield Joint Strategic Needs Assessment also sets this out in some detail with a range of specific data products.

Life expectancy

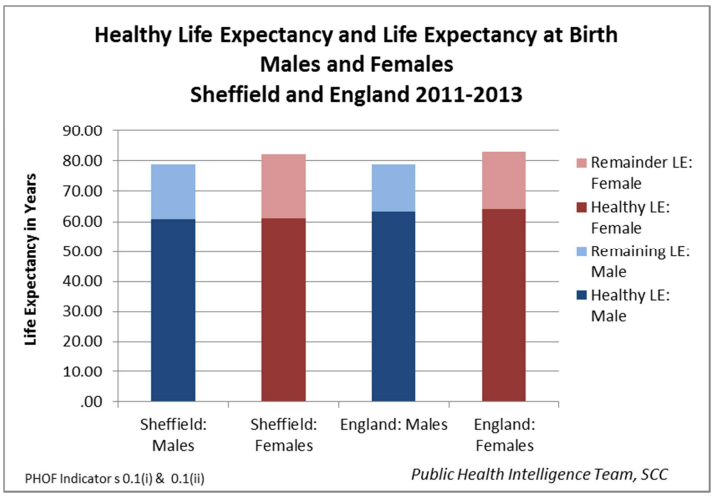
Life expectancy is increasing in Sheffield and compares well to core cities. Male life expectancy is shown here, female life expectancy data shows a similar picture. However there are still inequalities in life expectancy between the most and least deprived populations.





Healthy life expectancy is a more useful metric

Healthy Life Expectancy is a metric that incorporates the length of life, but also the number of years lived with poor health. For example, the graph below shows that for women in Sheffield average life expectancy is 82, but approximately 20 of those years are lived with poorer than optimal health.



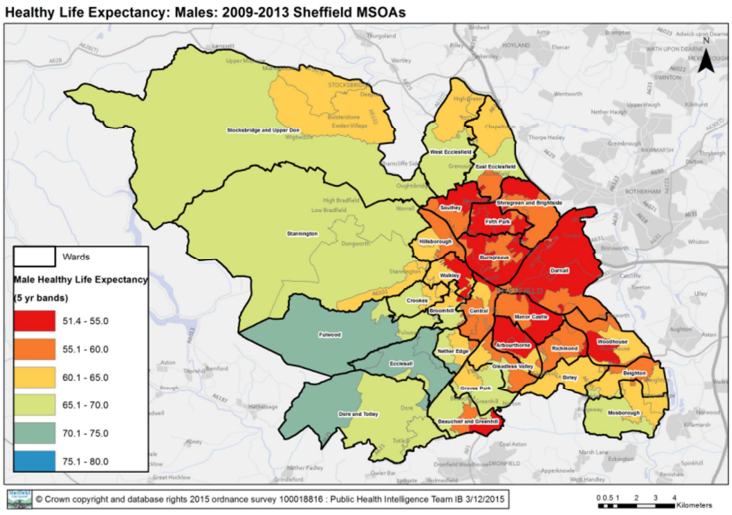
Healthy Life Expectancy is not improving and inequality persists

Healthy life expectancy is not increasing – this is a key challenge. As is often reported this avoidable illness and early death is not equitably distributed in any population. Considering the proportion of people with multiple conditions, at age 50-54 18.3% of the population have

more than one condition morbidity in least deprived populations compared to 36.8% in most deprived. Unlike life expectancy, healthy life expectancy is not increasing in Sheffield.

	Sheffield HLE Female	England HLE Female	Sheffield HLE Male	England HLE Male
2009-11	61.2	64.2	59.3	63.2
2010-12	61.4	64.1	60.6	63.4
2011-13	59.1	63.9	60.8	63.3

There is a c20-25 year gap between most and least deprived people in Healthy Life Expectancy, as indicated below.



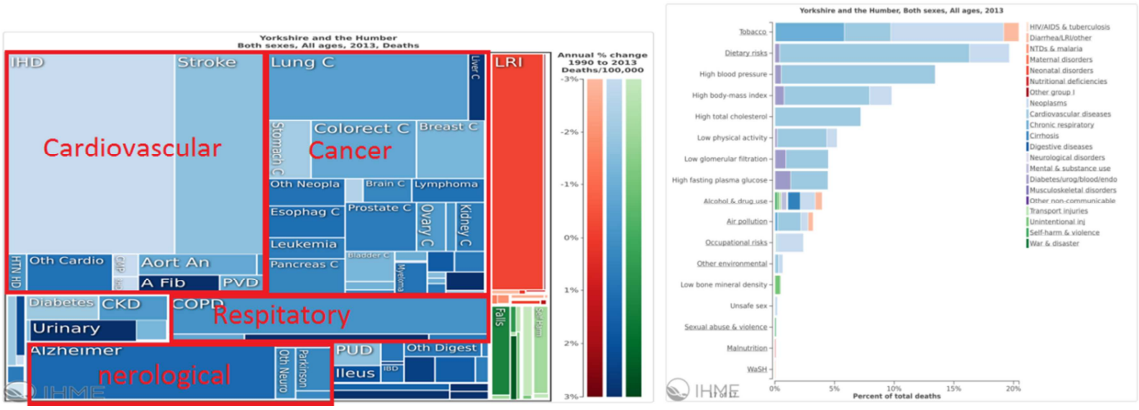
The data for female healthy life expectancy shows a similar pattern.

There are similar patterns in what is called multi mortbidity – or when people have multiple long term health conditions. We can see a 10 – 15 year difference in the age of onset of People living in the most deprived neighbourhood develop multiple morbidities 10-15 years before those in the least deprived. As many of the illnesses are preventable, this brings into question the “ageing population” issue and suggests that it is avoidable illness that causes problems, rather than age per se.

These gaps in life expectancy and healthy life expectancy do not just apply to geographically defined populations. There are also substantial differences in the life expectancy in other vulnerable groups including those with a learning disability or with a serious mental health problem, and other populations with multiple disadvantage, and the wider population.

Causes of death.

Most of the deaths in any population are attributed to cancer or cardiovascular disease, as is illustrated below alongside the immediate risk factors ranked:

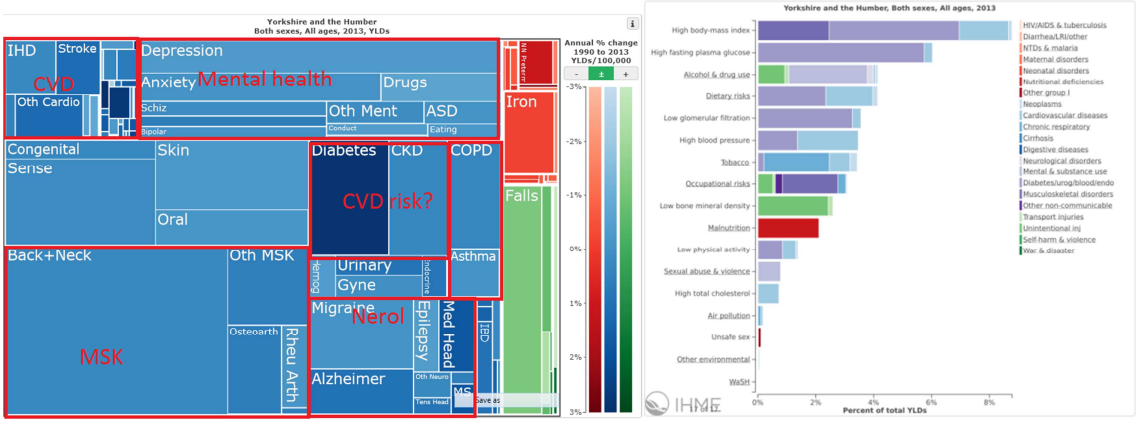


When considering early death (under 75), the same pattern holds true.

The immediate risk factors for those deaths are well documented and highlighted below:

Avoidable illnesses – Years Lived with Disability

The pattern of illness is different to causes of death; there are many things that lead to lost quality of life that don't actually kill us. This is illustrated below using the metric of Years Lived with Disability (YLD) to quantify, again alongside the immediate risk factors:



Accordingly, the immediate causes of those years lived with disability are different to causes of death.

2 What is the vision, aim and objectives

The overall vision is to improve healthy life expectancy, and to reduce inequality in healthy life expectancy between best and worst.

The focus is on giving people in Sheffield **the best start in life** to maximise their life chances; considering the health dividend across all our work; and considering how we can best support people in Sheffield to live **longer and healthier lives, with an explicit focus on inequalities.**

Aim – what outcome are we seeking to change

The outcomes this strategy is most focused on are healthy life expectancy and the inequalities between best and worst.

We will aim to increase healthy life expectancy by 1 year over the next 10 years, explicitly focused on improving fastest in those with lowest healthy life expectancy.

If achieved this equates to 560,000 person years of illness and disability avoided. The benefits of this in terms of care costs avoided are obvious. It also equates to an impact on the productivity of the economy.

Objectives of the SCC Public Health Strategy

There are 4 objectives. The objectives reflect some substantial areas where we would like to see some progress:

We will use the skills, expertise and resources we have to enable these outcomes to be delivered.

Objective 1 – **refresh and revise our approach to health inequalities**.

Objective 2– Optimise **health outcomes as an output of public service reform**, integrate health and well being as a **core consideration in all SCC policies and processes**; and **upgrading our approach to prevention** across the totality of SCC.

Objective 3 – Maintain and develop a **robust system to protect the population** from preventable infections and environmental hazards.

Objective 4 – Develop ambitious **policy and service based approaches to healthy lifestyles** to support people be as healthy as they can.

3 The underpinning principles of the public health strategy for SCC

The principles that underpin implementation are:

The following principles will underpin implementation of this strategy:

- A **balance is needed across people focused services & policy approaches.**
- We should actively seek to encourage **an environment that is as healthy as it can be, to support the healthy choice being the easiest or default** option.
- **At every turn and every decision we will push upstream;** we should examine all our activity to determine whether an upstream approach could have achieved better outcomes more efficiently.
- **Interventions should be balanced across a short, medium and long term pay off**.
- All interventions should be aiming to **reduce demand for downstream services.**
- **Proactive interventions in early years, and with families, represents the best value investment for improving the health of future generations, and achieving short term gains.** Ignoring this sets up future demand and avoidable poor outcomes. We should seek to optimise the potential in the first 1001 days. This is the "best start in life is the best value" principle.
- **We should challenge investments that have little evidence of effectiveness or value for money**, but we will **support evaluation of innovations** where there is little or no evidence.
- **We will systematically consider health and well being outcomes, and inequalities across all of our major processes and functions.**
- SCC will look to **work with people and communities by using a co-production approach** wherever possible.
- We will look to **build on existing assets and strengths in individual people and communities**.
- We will **work with people and communities based on an understanding of their individual context** and starting position.
- We will aim to **increase community engagement and empower individuals and communities**.
- We are actively changing the way we do business, **seeking to treat adults as responsible citizens.**
- We **encourage new partnerships and new stakeholders** to be involved in the pursuit of improved health and wellbeing in the city that may not have been explicitly involved in the past. These include, but are obviously not limited to, the fire service, the police, trade unions, business leaders, better incorporating the knowledge that rests within the universities and higher education sectors.

4 Areas of early focus

There isn't a single big thing that will resolve the challenges of the city in this area. An approach based on a range of interventions including education, service provision, regulation and structural or policy initiatives will be needed.

The commitment in this strategy is to moving the direction of the resource commitment towards prevention being the norm and focused effort across the council on achieving the aim of the strategy – that being improving healthy life expectancy and reduction of the gap between best and worst.

We have not set out all the areas for detailed work on interventions beyond the headlines below. The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues.

Objective 1- refresh and revise our approach to health inequalities.

- **Develop a revised approach to health inequalities. Agree, develop and begin to implement a refreshed approach to health inequalities.** This should be led and owned by the HWBB, with a role to holding the system to account not for the "activity" but for the outcomes.
- Where new resources are available they should be unequivocally focused on what will make most progress on health inequalities. New resources, as and where they are available, should be focused on where the need is greatest. The Health and Well Being Board have agreed a **principle of implementing effort and change where greatest need is identified.** There is intent to see the **distribution of primary care and GP services to match needs** and levels of disadvantage across the city.
- **Develop policy and structural approaches to lifestyle and lifestyle factors** (as opposed to individual level interventions)
- Ensure a **community development based approach**, building on the strengths which communities have, developing resilience and promoting greater community spirit.
- In particular there should be an **early focus on targeted cardiovascular risk management** as something with a short term return.
- Ensure focused effort on the **employment and purchasing power of SCC the NHS** and other large organisations for optimising social value and addressing inequalities. This obviously incorporates the work around ethical procurement.

Objective 2 –Optimise health outcomes as an output of public service reform, integrate health and well being as a core consideration in all SCC policies and processes; and upgrading our approach to prevention across the totality of SCC.

Public service reform is a high priority for the public sector as a whole in Sheffield, and across the country as a whole. There exists currently an openness to new ways of working and innovative approaches; this represents an opportunity to prioritise health and wellbeing with these. To this end we should seek to:

- Across groups of indicators within the Public Health Outcomes Framework develop a **short briefing setting out the evidence base for the main interventions that will improve that outcome, and the state of implementation**. This would focus on what investments leads to maximum impact, maximum return on investment. This will include learning from elsewhere in the UK and across the world. This should address the question of the evidence base to whether our current (and future) priorities and investments will achieve the impact and outcomes we want.
- **For each major area of SCC service delivery, policy or strategy, establish a review – re-asking (given the evidence) are we implementing the right set of interventions to maximise <u>health</u> and return on investment.** Consider a whole system approach[12] to these areas – for example poverty, mental well being, housing, transport, employment and skills, healthy ageing, economic development. Consider the **establishment of a series of learning events from other places and other cities and industries exploring different perspectives and approaches to well being.** This will include seminars with leading academic thinkers. For example there may be significant opportunities to learn from other European Cities on spatial planning. This may be under the auspice of the HWBB or the Sheffield Partnership Board.
- **Ensure long term health and well being is a core feature of the redevelopment of the Sheffield plan and economic policy**. Build **health impact assessment into planning processes and developments** in a way that is practical, pragmatic and supportive, learning from other places both in the UK and in Europe.
- Consider the merits of a **health in all policies approach** across SCC. This may involve consideration of **health outcomes on the "organisational balance sheet"** in the same way as financial outcomes are considered. Consider the merit of appointing an **officer to lead on "healthy urban planning"** to coordinate work in this area.
- **Optimise the health and wellbeing potential of business rate localisation and devolution**, possibly through further devolution of powers and responsibilities from central government.

- Through PSR and other means s**upport the establishment of a substantial "prevention" structural fund**, using this to support moving commissioning decisions away from demand management towards improving health and reducing inequalities.
- **Support the NHS to give prevention a radical upgrade** and **transform the Health delivery mode**l to move the health and care system towards a place based population focused model based around "wellness".
- Maximise the **potential of citizen contact with public services to improve health through making every contact count and similar approaches.**
- Have a **strong training and development function both for SCC staff and within our communities** that enables the above to happen. Maximise potential within customer contacts to reinforce health and well being messages
- Continue the current path of **establishing community and neighbourhood approaches** as the key delivery mechanism; especially focused on an explicit community development approach. Continue to provide training to community members where necessary to enable this to happen.
- Maximise the health and well being opportunities though the development of the **private rented sector housing strategy, and the housing sector more broadly**, both planning for future need and in terms of housing quality.
- Develop a **coherent and strategic work and health strategy** to bring together multiple strands around employment and health.

Early wins in this space are suggested as the work and health agenda, the licencing process and regulatory system, transport planning and air quality – especially active travel, and the work SCC has committed to around streamlining prevention.

Objective 3 – Maintain and develop a robust system to protect the population from preventable infections and environmental hazards

Protecting the population of Sheffield from preventable infections and environmental hazards remains a critical aspect of preventative work. We will deliver this by:
Working through the Health Protection Committee to provide leadership and strengthen assurance arrangements for preventing and responding to health protection incidents and communicable disease outbreaks.
Reduce risks to the health of the population through vaccination and screening programmes and seek opportunities through targeted work to protect the health of those most at risk of infections and environmental hazards, including TB, sexually transmitted infections and HIV.

Objective 4 – Develop ambitious policy and service based approaches to healthy lifestyles.

There is a need for both policy level interventions and services to support individuals. Community engagement and outreach are often a vital component of behaviour change interventions and support from peers who share similar life experiences can be a powerful tool for improving and maintaining health. Behaviours are determined by a number of factors, particularly commercial, social and economic influences; in acknowledging this we should:

Review and refresh our strategies around food, tobacco, move more, and alcohol.

Increase the emphasis given to **policy level approaches as a free tool for behaviour change is more efficient and more equitable**.

Develop a "heart of Sheffield" project to coordinate work in this area.

5 Outcomes and indicators

As set out above the desired outcome is a 1 year improvement in healthy life expectancy over the next decade. This can be achieved by increasing the population average, it can also be achieved by focusing on inequality and areas or populations where healthy life expectancy is unacceptably low.

Being outcomes focused

Being outcomes-based means starting any process with the outcomes we want to achieve and working back from there to determine activity, not starting with the "what do we do now". If we want to achieve improvements in life expectancy and health inequality, we shouldn't start an improvement process by considering small chunks of discrete areas. In some areas the response is about developing an analysis or a narrative, in others it may be about developing service models, ensuring high and equitable coverage of high value interventions, developing health enabling policies or designing evaluations and cost benefit approaches. What matters most is the outcome that is achieved, the method – whether this be policy development, regulatory issues, or service delivery is secondary to the outcome.

Indicators of success, measurement and targets.

Within this there are indicators that may be most important and moveable. The public health outcome framework, and the Marmot indicators will be used in the main. Both the absolute position of an indicator relative to others and the trajectory is important.

The areas where it is recommended early focus is given include:

- a 10% population prevalence in smoking over the next 10 years (currently 17%) with a reduction in gap between highest and lowest of 50%.
- a 15% of the population being inactive (currently 30%) with a 50% reduction in the gap.
- Aim to improve school readiness at the end of Reception and entry into Year 1 at four: 66% > 75%
- Increased the number of people who are currently long-term unemployed moving into economic activity or meaningful occupation by x,000 people by 2021
- Reduce the number of young people Not in Employment, Education or Training (NEET) by x%pts by 2021
- Reduce the prevalence of cold related illness by x% pts. Reduce to zero the number of people discharged into a cold home when the cold increases the risk of readmission; Reduce Fuel Poverty from 10.9% to the national average of 10.4%
- Aim to achieve 10 conceptions / 1000 girls aged 15-17 by 2020

Note – targets may be needed around other areas / may keep / may ditch

6 The role of Sheffield City Council in improving public health

Public health "function" and "services" and "public health"

The Health Select Committee have recently reviewed the transfer of public health responsibility to Local Government[13]. The report highlighted many strengths and positives resulting from this transfer. Arguably the report did over focus on "the public health grant" and a narrowly defined set of functions. This is not the approach being taken in Sheffield.

"Public Health staff" don't have a monopoly on "public health", it is a collective responsibility for the council as a whole, and beyond this – a social movement rather than a group of funded services or expertise.

Many staff will have a part to play in the delivery of this strategy, including the specialist public health workforce (defined here as those posts currently funded by the public health grant).

The distributed model of public health expertise in SCC

Responsibility for public health rests with Local Government; this has always been the case. It is clear there is a great deal of good work happening. The transfer of some functions from the NHS in April 2013, gives added impetus for addressing the challenge. The aim of this strategy is to accelerate this work and ensure the "health dividend" of SCC is fully realised – especially linking agendas together and testing / challenging whether current resource deployments are focused on prevention as best they can.

Public health is the responsibility of the whole of Sheffield City Council, and other organisations beyond this; therefore we do not have a centralised public health department but have deliberately embedded public health expertise across the organisation to work alongside and seamlessly with all functions. We have adopted a similar approach in our support to and interaction with the VCS, the NHS, PHE and other organisations.

This embedded model only works if the organisation responds to the challenge of improving healthy life expectancy. Services or staff funded by the public health grant will not by themselves meet the challenge. The responsibility of public health expertise is to apply a systematic methodology to test whether the totality of a service or sector is achieving a desired objective.

Public Health Services

Public health funding is used to provide or commission some services, such as stop smoking, weight management or sexual health services; these are often considered "public

health". However, other services also make a substantial contribution to the health of the public, for example general practice, cardiology, housing support or welfare benefits advice. Services funded through the public health grant are far from the only services that have an impact on health and well being outcomes.

The "public health approach"

A key contribution of public health specialists is in the application of a skill set to an issue. The skill sets that are applied to these areas have been published many times[14]; these are best summarised as:

- **Epidemiology** – a short hand term for the methods used to describe "need", "demand" or both. This covers what do we know about a given problem, how frequently it occurs, in which groups, how it is changing, what causes it and what outcomes it leads to.
- **Evidence and evidence based policy and practice** – given a particular health and well being problem, what does the available evidence tell us is the best way to prevent this problem or to meet this need as efficiently and equitably as possible.
- **Economic analysis** – what is the most cost effective way of addressing a problem, that will lead to the optimal return on any investment of money, time or human resource. Economic analysis will also enable a better understanding of where costs and benefits fall.
- **Evaluation** – the use of a range of skills and techniques to test whether a service, programme or policy is achieving the expected goals.
- **Ethics** – given all we know, what is the "right" thing to do to optimise the health of the population as a whole, and to minimise inequality.

The role of the specialist public health workforce is moving from one of provision and/or commissioning of 'public health' services and one of using public health skills to strategically support the whole council (and other organisations) to have maximum impact on the health and wellbeing of the population through the totality of the city's resources. Implementation of this strategy should move us significantly in that direction.

The key contribution of public health staff is the application of this set of skills and methods to an issue or problem. The approach can be applied from areas as diverse as "tacking poverty" to "planning for hyper acute stroke care". A key role of public health staff is to apply the methodology systematically to immediate and more upstream determinants of the health of the people of Sheffield.
The Public Health task is therefore one of helping, supporting, injecting new ideas and fresh approaches to enable each and all of those systems to give us better health and wellbeing outcomes. This may, however, imply using expertise to ask challenging questions of current

models and testing whether current commitments really deliver improved outcomes and value. There is also a role to connect systems together in a way they may not have been historically connected.

Leadership of "public health"

Leadership of public health is currently a shared responsibility with a number of individuals and groups playing a part. The Health and Wellbeing Board is the body best placed to lead the development of the public health as a whole. Recent research commissioned by the Local Government Association[15] has shown that Health and Well Being Boards considered to be operating effectively count "clarity of purpose" as a key factor in their development.

The role of the Director of Public Health

The DPH is the lead officer holding Sheffield City Council to account for delivery of improved healthy life expectancy and reduced inequalities. This role should provide challenge where necessary and support with technical skills where needed, develop skills and competencies within SCC and other organisations, develop positive and productive relationships, and bring innovative new ideas to the fore.

If the role of the finance director is to ensure an organisation stays within budget, the role of the DPH is to ensure health and wellbeing outcomes are achieved.

A key task for the Director of Public Health is to transform public health delivery by achieving true integration of public health staff into all areas of the organisation. This is intended to enable SCC as a whole to develop new partnerships, be entrepreneurial with policy and develop new thinking to impact existing areas of interest as well as health and wellbeing outcomes.

It is important to be clear that the Director of Public Health can't direct and control all aspects of this agenda, nor should they try to. Similarly the Director of Public Health doesn't have "the answer" to the problem; the role is to set a framework and a culture and to orchestrate the right response to the challenge, so that "the answer" is generated by the Council as a whole.

The "public health grant"

The Public Health Grant cannot by itself address the public health challenges of the city. The purpose of the public health grant is to leverage change and to enable fresh and challenging approaches to be tested and applied.

The "public health budget"

The way in which the public sector, the private sector and the voluntary and community sector broadly pursues its business will have a substantial impact on the determinants of health; for example, the way we plan the city from a built environment and transport

perspective, the way we shape the economy, or the way we try to redress poverty with evidence based interventions.

Sheffield City Council has set out its ambition to be a public health organisation, so the challenge is therefore to optimise the use of its £1.4bn budget, and associated purchasing power, to best improve health and address inequality. This is best framed as not about "new resources" but as about maximising benefits from existing commitments, and then changing the nature and shape of those commitments over time to optimise outcomes. Thus the question on "the public health budget" is best framed as "is SCC using its power to best improve the trajectory of health and wellbeing indicators, to redress health inequality and to optimise the health dividend (or the health return on investment) through the right interventions".

It is true that resources hang over all other issues, this is inescapable. The key consideration is making optimal use with the resources we DO have rather than what we don't have; and being mindful of impact on health and inequalities where there is a need to reduce resource commitments. In an era of shrinking resources we need to consider the resources that are already in the system and whether they are contributing to the desired outcome.

The approach to reform should be wide ranging and consider health in its broadest possible sense, with the key question being whether the £1.4bn of SCC resource commitment, the £4.3bn of public spend in Sheffield, or the totality of the economy of Sheffield, is optimally spent to maximise outcomes and minimise inequality.

The task is one of reimagining health in a city, setting out from a health perspective what sort of city we want in 1, 2, 5, 10 and 20 years, and what investments and changes we need to make now to achieve this.

Interfaces with other strategies and processes

There is an obvious interface with other plans, including the Health and Well Being Strategy, the 2014 Health Inequalities strategy, the NHS Sustainability and Transformation plan, the SCC Corporate Plan, the Best Start Strategy and existing service plans in many services and portfolios that will contain significant services and policy areas that impact on health.

The challenge we set ourselves is to be bold and specific about the impact we are seeking to have; linking agendas together where they have not been historically linked, asking ourselves challenging questions to enable the willing to do the right thing; to stretch ourselves to go further than others and to include both short and long term actions and institutionalise our focus.

Other stakeholders

This is a strategy for SCC. Our ambition is to engage a wider set of stakeholders into “public health”. We should obviously reflect the ambition for 'public health' across the totality of the system, there should be contributions from the NHS, VCS, the universities both as major employers and in terms of knowledge transfer, schools and many others.

7 Risks to the delivery of the intentions in this strategy

The key question is whether the deployment of resources across SCC contribute or are to the detriment of the aim of increased healthy life expectancy and inequality. It is accepted trade offs are often necessary. Often the execution of “public health” has been about challenging vested interests and as ever the demands of the short term thinking dominates agendas and resources. These are not easy challenges.

Challenging the language of “public health” as something that is only about “lifestyles and health care” is an issue that requires constant attention; as does the narrative that “health” is equivalent to “NHS”. Lifestyles, and care is important; life chances are more important.

Health and well being remains one of the core objectives of SCC. This strategy will support the achievement of that objective. It is a challenging agenda in difficult times. To achieve it we need to pay more than occasional attention to “public health” and be considerably more expansive than “the public health budget”. Essentially we need to achieve the full integration of a way of thinking and doing business into the whole of SCC. Most of those that “do” the activity of “public health” do not have public health in their job titles, nor should they.

The process of business rate localization, and the potential loss of the ring fence on the public health grant presents significantly more opportunities than threats; as does the NHS STP process.

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[1] http://sheffielddemocracy.moderngov.co.uk/Data/Cabinet/20120125/Agenda/11%20New%20Arrangements%20for%20Public%20Health%20in%20Sheffield.pdf
[2] http://sheffielddemocracy.moderngov.co.uk/documents/s9992/Social%20Model%20of%20Public%20Health.pdf
[3] https://www.tuc.org.uk/equality-issues/age-equality/one-eight-people-are-too-ill-or-disabled-work-state-pension-age-says
[4] https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/social-care-health/public-health/Director-of-Public-Health-Report-2015/Director%20of%20Public%20Health%20Report%202015.pdf
[5] https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/social-care-health/health-wellbeing-board/JSNA-2013-Report/JSNA%202013%20Report.pdf
[6] https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/legal-justice-rights/fairness-commission/Fairness-Commission-Report/Fairness%20Commission%20Report.pdf
[7] https://www.sheffieldfirst.com/key-documents/state-of-sheffield.html
[8] www.health**profiles**.info/
[9] www.lho.org.uk/LHO.../Marmot/MarmotIndicators2014.aspx
[10] http://www.phoutcomes.info/
[11] http://www.kingsfund.org.uk/publications/improving-publics-health
[12] For example in mental health - https://jimmcmanus.wordpress.com/2016/01/08/a-whole-system-approach-for-mental-health/
[13] http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/public-health-report-published-16-17/
[14] the Faculty of Public Health sets out the broad skill base that a person registered (UK PH register or GMC register) public health specialist should have - http://www.fph.org.uk/curriculum_2015 /
Skills For Health sets out a knowledge and skills framework more broadly https://www.healthcareers.nhs.uk/about/resources/public-health-skills-and-knowledge-framework
[15] http://www.local.gov.uk/web/guest/health-and-wellbeing-boards/-/journal_content/56/10180/7788025/ARTICLE

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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee 14th September 2016

Report of: South Yorkshire and Bassetlaw STP

Subject: Update on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Author of Report: Will Cleary-Gray, Programme Director

Summary:
This paper is to update the OSC on the developing South Yorkshire and Bassetlaw Sustainability and Transformation Plan and inform them of next steps for engagement.

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

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

The Scrutiny Committee is being asked to:
The Committee is asked to note the update and next steps

Background Papers:
N/A

Category of Report: OPEN

South Yorkshire and Bassetlaw Sustainability and Transformation Plan – an update

1. Introduction

1.1 In January 2016 health and care organisation across England were asked to come together to develop sustainability and transformation plans (STP) to take forward the Five Year Forward View strategy for England; building on existing work already taking place in local communities.

Led by Sir Andrew Cash, 17 of South Yorkshire and Bassetlaw's health and care, education and research organisations are working together to improve local services for our combined population.

2. South Yorkshire and Bassetlaw Sustainability and Transformation Plan

2.1 There have been some big improvements in health and social care in South Yorkshire and Bassetlaw in the last 15 years. People with cancer and heart conditions are experiencing better care and living longer, waits are shorter and people are more satisfied. We are proud of our local services and the huge progress we've made so far.

However, people's needs are changing, new treatments are emerging, the quality of care is variable, and preventable illness is widespread.

With this, and the need to develop a local STP, in mind, over the last few months, we've been working with patient groups, the voluntary sector, hospitals, GPs, local councils, commissioners of services and the universities to discuss what needs to happen in South Yorkshire and Bassetlaw.

We are in the very early stages of looking at how we can address the challenges facing our health and care services and improve the health of our population.

We have a strong community of stakeholders, including more than 10,000 voluntary sector organisations, 208 GP practices, five local authorities, five clinical commissioning groups, five acute hospitals, two of which are integrated with their community services, two associate acute hospital trusts, four mental health providers, five Healthwatch organisations and two ambulance services. We are also working closely with our STP associate partners in North Derbyshire and Mid-Yorkshire. We employ 74,000 staff across health and social care and administer £3.9bn public funds each year.

Our thinking starts with where people live, in their neighbourhoods focusing on people staying well. We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we are better meeting the health and care needs of people in their homes and clinics. We want care to flow seamlessly from one service to the next so people don't have to tell their story twice to the different people caring for them, and everyone is working on a shared plan for individual care.

At the same time, we agree that everyone should have better access to high quality care in specialist centres and units and that, no matter where people live, they get the same standards, experience, and outcomes for their care and treatment. We will do this by working together more closely, by developing a networked approach to services.

We also believe that people with mental health and learning disabilities must be treated with the same respect and regard as those with physical health issues, and as well as committing to ensuring they have the same access to services, we want to improve their life chances.

Developing and supporting our staff is the only way we will achieve these ambitions. We envisage a flexible workforce that comes together in neighbourhood hubs and specialist centres to offer people the best and most appropriate care.

2.2 **We want to improve the quality of care people receive**

We want to make sure that the care people receive is always high quality – regardless of where they live, which medical professional they see, and whether they are treated at a GP surgery, care home or elsewhere.

We know that quality, experience and outcomes can vary and we know that care can be disjointed from one service to another because our many organisations don't always work as closely as they should. We have some good Care Quality Commission feedback for our organisations but we also know there are some areas for improvement. And we also know that people want their health and care support and treatment in a place and at a time that is right for them. For many, this means care that is provided at home, or closer to home, and not in a hospital.

We want the same quality of service for people, as close to them as possible. Doing this jointly means a better solution for everyone – whether people live in Staveley, Shafton, Sharrow or Shireoaks.

2.3 **We want to improve health and wellbeing for everyone**

In South Yorkshire and Bassetlaw, people are living longer, but we have high levels of deprivation, unhealthy lifestyles and too many people dying prematurely and from preventable diseases.

Poor eating habits can lead to weight gain, which in turn can result in serious complications like type 2 diabetes. Smoking and alcohol consumption, which are particular issues in our region, are also harmful and can increase the risk of cancer. We also know that there are higher than average deaths in people under the age of 75 from cancer, heart disease and serious mental illness.

Our levels of childhood poverty are significantly higher than the national average and the gap is widening. We also have significant deprivation and inequalities, with a difference in healthy life expectancy of more than 20 years across our area – and we have higher than the national average of teenage conceptions and mums smoking during pregnancy.

Many of these can be prevented by different lifestyle choices and keeping a check on our health.

Our health and care services want to support people more to do this – by making it easier to get expert advice and to access free healthy living schemes. We also want to support people to connect with and develop local links and networks in their neighbourhoods, building trust and understanding across communities. The simple fact is that a healthier population is a happier population – one which relies less on the NHS and other care services to treat problems that could have been prevented.

2.4 **We want to ensure our services are efficient**

Along with health and care services across the country, we face financial pressures and our hospitals and other organisations are struggling to balance their books. There are a range of causes for this, including rising demand for care among our population and that many people now often have more complex health conditions, such as obesity and heart disease, which require more complex treatment.

Extra money has been provided for our NHS organisations but we still estimate a gap of around £727 million in the next four years. We believe there's more we can do to alleviate some of the financial pressures over the next four years. We need to find new and better ways to meet the needs of local people and do things more efficiently and with less waste. This doesn't mean doing less for patients or reducing the quality of care. Rather, it means more preventative care, and bringing care out of hospitals and closer to home.

2.5 **What next?**

We have been asked by NHS England to present a high level financial analysis of the gap in resources in mid-September. By mid-October, we expect local conversations with patient and voluntary groups and partners to have progressed across all our areas to a place where we have more detailed plans and our final submission will be on 21 October.

We then expect to pre-consult on the plan widely with the public in the New Year.

From October, we are starting formal consultation on proposals to hyper acute stroke services and children's surgery and anaesthesia services across our region. Both these proposals are based on reviews which showed that people have different experiences and receive different standards of care depending on where they live. Both theses reviews are examples of some of the work to improve services across South Yorkshire and Bassetlaw and will lead to more sustainable services for Stoke and Children's care.

3 What does this mean for the people of Sheffield?

3.1 We believe that to improve care for the people of Sheffield (and South Yorkshire and Bassetlaw as a whole), health and care services need to work more closely together, and in new ways.

By working in this way, we will also be able to contribute to the region's economic growth, helping people to get and stay in work. As well as supporting their health and wellbeing, this will help to keep South Yorkshire and Bassetlaw economically vibrant and successful.

4. Recommendation

4.1 The Committee is asked to note the update and next steps

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Briefing for Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 14th September 2016

Report of: Policy & Improvement Officer

Subject: Joint Health Overview and Scrutiny Committee 2016 – Commissioners Working Together Programme

Author of Report: Alice Nicholson, Policy and Improvement Officer
alice.nicholson@sheffield.gov.uk
0114 273 5065

NHS England and NHS Sheffield CCG formally requested that local authorities in the 'Commissioners Working Together' programme area establish a Joint Health Overview and Scrutiny Committee to consider proposed substantial variations to local health services. Council agreed on 4th March 2016 to participate in this. The last meeting was on 8th August 2016 the minutes of that meeting are attached to this report for information and the full papers can be found here .

The Scrutiny Committee is being asked to:

- This briefing is provided for information only

Category of Report: OPEN

DONCASTER METROPOLITAN BOROUGH COUNCIL

COMMISSIONING WORKING TOGETHER JOINT REGIONAL OVERVIEW AND SCRUTINY COMMITTEE

MONDAY, 8TH AUGUST, 2016

A MEETING of the COMMISSIONING WORKING TOGETHER JOINT REGIONAL OVERVIEW AND SCRUTINY COMMITTEE was held at the OAK HOUSE, BRAMLEY, ROTHERHAM, S66 1YY on MONDAY, 8TH AUGUST, 2016, at 3.30 pm.

PRESENT:

Chair – Councillor R Blake

Councillors Rachael Blake (Doncaster MBC), Elizabeth Rhodes (Wakefield MDC), Stuart Sansome (Rotherham MBC), Jeff Ennis (Barnsley MBC), Colleen Harwood (Nottinghamshire County Council), Pat Midgley (Sheffield City Council) and Sean Bambrick (Derbyshire County Council)

ALSO IN ATTENDANCE

C Rothwell Doncaster MBC
A Wood Wakefield MDC
J Spurling Rotherham MBC
A Nicholson Sheffield CC
A Morley Barnsley MBC
M Gately Nottinghamshire CC
A Fawley Nottinghamshire CC
J Wardle Derbyshire CC
W Cleary-Gray Commissioners Working Together
H Stevens Commissioners Working Together
S Jones Commissioners Working Together
G Venables NHSE Clinical lead for Stroke work stream
T Moorhead Clinical Lead for Children's Services work stream
J Pederson Doncaster CCTG
M Ruff Sheffield CCG
M Ezro Wakefield CCG
C Edwards Rotherham CCG
S Allinson North Derbyshire CCG
A Knowles NHS England
L Smith Barnsley CCG

APOLOGIES:

Apologies for absence were received from Councillors

1 Apologies for Absence.

There were no apologies for absence

2 To consider the extent, if any, to which the public and press are to be excluded from the meeting.

None

3 Declarations of Interest, if any.

There were no declarations of interest.

4 Minutes of the Meeting held on 23rd May, 2016.

The minutes of the meeting held on 23rd May, 2016 were agreed as a correct record.

5 Commissioners Working Together HASU (Hyper Acute Stroke Unit) Stage 3 Detailed Option Appraisal.

Graham Venables, Clinical lead for Stroke work stream provided a presentation relating to a review of hyper acute stroke services across South Yorkshire, that had been undertaken over the past 18 months.

Consultation had been undertaken with doctors, nurses and healthcare staff in hospitals, NHS staff who commission hospital and GP services and data and clinical experts about what the future for critical care stroke patients might look like in the region.

The Committee learnt:-

- If HASU centres admit less than the best practice minimum of 600 per unit but over 1,500 then there is a risk of burn out.
- Doctors, nurses and healthcare staff all agree that the way critical care for stroke patients is provided across the region won't meet their high standards in the future – this needs to change. There were currently unsustainable medical rotas.
- More stroke doctors and nurses to run the services were required – there were not enough locally or nationally
- There is low QUALITY of care (SSNAP data) across 4/5 hospitals
- Patients need GOOD care for the first 72 hours (hyper acute stage)

The Committee was provided with details of the appraisal process and preferred options for moving the service forward over the next 5 years.

It was recommended that the services change by adopting a system wide solution, working together better for the benefit of every stroke patient in South Yorkshire and Bassetlaw and North Derbyshire.

Based on feedback from doctors, nurses and regional and national clinical experts, the following option would allow this, with further work being carried out to consider the second option in the future.

A number of options had been discounted by the working group leaving two preferred options:

OPTION 1

The proposal is that if you live in South Yorkshire and Bassetlaw and North Derbyshire and have a stroke, you would receive hyper acute stroke care in:

•Chesterfield Royal Hospital
•Doncaster Royal Infirmary
•The Royal Hallamshire Hospital, Sheffield

This would mean that Barnsley and Rotherham hospitals would no longer provide hyper acute care for people who have had a stroke.

Chesterfield was not a part of this review as it is sited within the East Midlands region.

OPTION 2
The proposal is that if you live in South Yorkshire and Bassetlaw and North Derbyshire and have a stroke, you would receive hyper acute stroke care in:

•Doncaster Royal Infirmary
•The Royal Hallamshire Hospital, Sheffield

This would mean that Barnsley, Rotherham and Chesterfield hospitals would no longer provide hyper acute care for people who have had a stroke.

Chesterfield was not a part of this review as it is within the East Midlands region and so this element is subject to decision elsewhere. However, we will need to talk to people about this possibility as part of our consultation process.

It was stressed that stroke care was divided into three phases:

1. Every person enters the acute critical care unit where the physical status is monitored;

   When they are stabilised they move into:-

2. Rehabilitation in hospital; and

3. Phased return to home.

It was stressed that to deliver a sustainable stroke response service the following support was required Consultant, training staff, nurses, continence advisers and social workers. Early assessments were essential
Following the presentation, Councillors undertook discussion on the following areas:

<u>Staffing, funding and skills shortage</u>
Concern was expressed that many doctors could train for Acute stroke care however there was not the funding in place for them to do so.

It was highlighted that one of the reasons to consolidate the Hyper Acute Stroke Units was to address the skills shortage, which was increasing year on year. It was

reported it was not just a local issue but a national problem and the position had been forwarded to the Department for Health as a real worry.

The proposals for the next five years would provide security for the region with staff, for example in Rotherham staff would be offered to undertake skills they have learnt in high functioning teams and trained for, in Sheffield or Doncaster hospitals.

The service was reviewed to plan a future model, with week on week intense provision and workforce challenges no one could be certain of the exact requirements. Sometimes staff could be difficult to recruit in Yorkshire but this was due to personal issues rather than medical issues. There was a lot of attraction for medical staff in stroke care provision towards the end of people's careers.

It was recognised by professional bodies who work in the health field there was a shortage of funded opportunities for stroke positions. and that some of the funded training posts in London could not be filled and the money was transferred to the Yorkshire region.

It was reiterated that there were no proposals to change the number of consultants but for them to move to different locations across the region.Proposals would provide a much more sustainable service and provision.

First 72 hours of care

It was noted that to reduce the number of stroke patients dying with pneumonia, a swallow test must be undertaken immediately. Early intervention with such a test stops incidents of this nature.
When a person has a suspected stroke the first responder does an initial assessment before a patient is transferred to hospital, with times and standard that have to be met. Ambulance staff undertake informal assessments to ensure the information is available for clinicians on arrival at hospital. Once a patient arrives the meet and greet team take them from the ambulance direct to the CT scan area.
In response to queries raised, Aspirin was not administered in the ambulance and it was noted that Newcastle hospital were currently investigating use of this treatment.

Travel times to hospital/repatriation to local area and home

In response to questions and concerns raised by the Committee, it was explained that the worst case scenarios of travel time by ambulance have been considered and meet the 45 minute deadline taking into account variable with travel/road conditions and weather. It was explained that someone from Bassetlaw would be transported to Doncaster within the 45 minute and in reality could reach Leeds in this timeframe.
At this point some Members highlighted that there had been difficulties with ambulance response times and how this would impact on the 45 minute time frame.

The Committee expressed concern that generally people who had strokes were older, meaning relatives would have to travel a long distance to undertake visits. The proposals would provide initial treatment for patients at one of the three or two hospitals for the first 72 hours following which, they would be repatriated to the area where they live for the recuperation period. During pre-consultation stage outcomes were clear that people would be willing to travel the distance to the proposed hospital sites.

Members fully understood that from a clinical point of view it was more advantageous for a patient to be transferred to strengthened Hyper Acute Stroke dedicated hospitals for the first 48 to 72 hours, and were assured that they would not be moved unless their condition was stable and allowed the patient to be transferred.

It was explained that if a patient from the Barnsley area was treated initially at Sheffield, for recuperation they would not be transferred to a ward at Sheffield, but back to Barnsley hospital.

With regard to returning home following treatment, the Committee highlighted that good partnership working needed to be in place.

Treatment that could be provided by a Hyper Acute Stroke Unit

With two or three centres one of the treatments provided could be blood clot sucking undertaken via a catheter via the artery to brain.

Consultation

The Committee was assured that when consultation was provided to members of the public it would give details of all options for discussion.

Standard of care

It was noted that the time it takes for a stroke patient to be properly assessed has not changed in the last 7 years, and that was not acceptable. There have been areas and standards of improvement but these would be difficult to sustain and it was stressed that nobody in the Stroke service provision arena would accept low standards.

Cross Boundary issues

Members stressed there could be cross boundary capacity issues and stressed that full consultation be undertaken to ensure all parties were aware of the current situation.

Issues relating to Pinderfields and Chesterfield Royal Hospitals were raised by Members but it was noted that this was outside the jurisdiction of this collaborative to discuss the position.

RESOLVED:- that the above discussion, progress of the work and implications for moving forward through NHSE Level 2 Assurance and towards public consultation for the options in October, be noted.

6 Commissioning Working Together Overview and Scrutiny Outline Report.

RESOLVED that Members noted the items to follow.

7 Draft Consultation Documents: - Providing hyper acute stroke services in South Yorkshire and Bassetlaw and North Derbyshire; and Providing Children's Surgery and Anaesthesia Services in South and Mid Yorkshire, Bassetlaw and North Derbyshire.

The Committee was reminded that at its meeting in May, it was agreed that the consultation process be undertaken. The Consultation information circulated with the

agenda was noted but Members requested if examples of the final consultation literature and how it would be publicised, be circulated to each individual authority giving them an opportunity to comment. It was recognised that Councillors knew their individual areas well and could advise on the best places to publicise the information.

The Committee continued by requesting that the consultation period be extended by 2 weeks to 20th January, to take account of the Christmas period as many people would be more focused on the festive season.

It was also stressed that the literature should be written in plain English to ensure maximum participation, for example, surgery be described as planned or emergency.

RESOLVED that:

A. The public consultation material and locations be circulated by the end of August to each local authority of the WTP Overview and Scrutiny Committee, for their individual input and comments;
B. The material for public consultation be provided in plain English and translation availability, to ensure a good understanding of what is being consulted on by all members of the community; and
C. consideration be given to formal consultation on preferred option being extended to conclude on 20th January, 2017.

8 Dates and Times of Future Meetings.

Venue - It was discussed that Oak House at Junction 1 of the M18, Bramley was a preferred site for future meetings.

Administration - With regard to servicing the next meeting, officers expressed a wish to meet prior to setting arrangements for the next meeting.

RESOLVED that: the next meeting be held sometime in November following agreement on Administration arrangements with the Scrutiny Officers.

9 Joint Commissioners and Provider Working Together Programmes Non-Specialised Children's Surgery and Anaesthesia - Options Appraisal.

The Committee received a presentation from Tim Moorhead, Clinical Lead for Children's Services work stream.

The Committee learnt that:-

- Medical Directors and Chief Executive Officers identified children's surgery as a priority;
- The service had been reviewed identifying current provision, standards and pathways of care and included discussions with doctors, nurses anaesthetists, managers, patients and clinical experts in other parts of the country;
- Investigated the numbers of children requiring surgery and the opportunities around wider geographical provision;

- Discussed with providers of surgery who agreed it was important to work together as a network of providers to share skills and expertise and to plan more care together as close to home as possible;
- Investigated models of changing some for the pathways of care for out of hours urgent care to provide sustainable care pathways that met national standards

The main message was that the current service could not be sustained whilst meeting national standards and the Committee discussed the proposals for consultation detailed in the presentation and supporting papers. The following areas were discussed:

- Elective/non elective surgery – including less non elective sites that could provide surgery particularly for under 3 years old and where a child needs to stay on an inpatient ward for recovery. The proposals would be for most areas to have elective planned surgery within their local hospital site unless it was a very specialist surgical procedure;
- Patient transport to and from hospital;
- Yorkshire Ambulance Service – response to child emergencies. The Committee requested that the agreed 45 minutes to transfer to hospital time be inserted into to the documents; and
- The development of 'hubs' over fewer sites so that children requiring surgery out of hours urgently get the standard of care they need.

RESOLVED: that the above discussion and the progress of the work and implications for moving forward through NHSE Level 2 Assurance and towards public consultation on the options in October, be noted.

CHAIR:_____ DATE:_____

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 14th September 2016

Report of: Policy & Improvement Officer

Subject: WORK PROGRAMME 2016/17

Author of Report: Alice Nicholson, Policy and Improvement Officer
alice.nicholson@sheffield.gov.uk
0114 273 5065

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

The work programme contains a number of items and possible Committee dates are suggested. The work programme ideally should aim 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.

The Scrutiny Committee is being asked to:

- Comment on the proposed work programme
- Identify priorities for inclusion on agendas
- Identify items for written briefings

Category of Report: OPEN

Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee Draft work programme 2016/17	
Meeting Dates 2016/17	*13 July 2016*, *14 September 2016*, 9 November 2016, 11 January 2017, 15 March 2017, 12 April 2017

Last updated: 6th September 2016

Please note: the draft work programme is a live document and so is subject to change.

Topic	Reasons for selecting topic	Lead Officer/s	Agenda Item/ Briefing paper
Wednesday 16th July 4-7pm			
Discussion item			
CQC Inspection Reports - Sheffield Teaching Hospitals NHS Foundation Trust	*To consider local inspection report outcomes - to consider recommendations to the provider direct or as part of QA activity. Brief committee of local announced inspections*	*STH NHSFT - TBC*	*Agenda Item*
Draft Work Programme	*To consider the Committee's draft work programme 2016/17*	*Alice Nicholson - Policy & Improvement Officer*	*Single Agenda Item*
Task Group 2016/17 - scope	*To consider scope of a task group that enhances the QA sub-group approach within the joint themes of Performance and Patient Experience*	*Alice Nicholson - Policy & Improvement Officer*	*Agenda Item*
For information			
Quality Accounts –membership of sub group 2016/17; QA submissions 2015/16	*For information - responses to NHS Trust QA's*	*Alice Nicholson - Policy & Improvement Officer*	*Briefing Paper*
JHOSC - The Commissioners Working Together Programme	*To update the committee - Chair is member*	*Alice Nicholson - Policy & Improvement Officer*	*Briefing Paper*

Primary Care Strategy - CCG (Katrina Cleary)	*This item is for information - At its meeting in March 2016 the committee considered Access to GP and requested that this be presented/forwarded when available*	*http://www.sheffieldccg.nhs.uk/Downloads/CCG Board Papers/May 26 2016/PAPER D Primary care strategy for Sheffield.pdf*	*Briefing Paper*
Wednesday 14th September 4-7pm			
South Yorkshire and Bassetlaw Sustainability & Transformation Plan (STP)	Consideration of this service response to NHS Plan - 5 year forward view - footprint is SY & Bassetlaw: The Committee to receive a report and presentation update on the STP. The Committee to consider the Sheffield Place Plan at the meeting 9th November 2016	Will Cleary-Gray, Programme Director (Sheffield CCG)	Single Agenda Item
Public Health Strategy SCC	The Committee to receive a report and presentation on the development of a public health strategy for Sheffield CC; Public health is a core aspect of Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee activity - public health and its wider determinants underlay tackling health inequalities	Greg Fell - Director Public Health	Single Agenda Item
JHOSC - The Commissioners Working Together Programme	To update the committee - Chair is a member	Alice Nicholson - Policy & Improvement Officer	Briefing Paper
Work Programme	To consider the Committee's work programme 2016/17	Alice Nicholson - Policy & Improvement Officer	Single Agenda Item

Task Group			
Task group – main topic for 2016/17: Examining performance with patient experience/performance – including Quality Accounts	A proposal for a task group that examines performance, gathers evidence of patient experience. To integrate with Quality Accounts activity, a further enhanced approach on previous years, priority topics: Hospital environment - especially A&E and Weston Park including patient/carer/visitor experience and responding to CQC Inspection outcomes; Accessing the right services first time (including but not exclusively GP access) - inform Sheffield CCG Primary Care and Urgent Care strategies	Alice Nicholson - Policy & Improvement Officer	Task Group: Aug-16 to Mar-17
Future items to be scheduled - scope to be determined			
Dental access and dental health	A select Committee approach to hear from appropriate commissioners (NHS England), providers (NHS & private) and users on access to dental services and the dental health of children in particular - date to be determined	TBC **Jan-17/Mar-17**	single agenda item in the style of Select Committee
CQC Inspections	1. Yorkshire Ambulance NHS Trust inspection from 13.09.2016 - report of inspection when available; 2. CQC visits to GP - report of Sheffield CCG **Jan-17**	1. YAS NHS Trust; 2. Director of Nursing, Sheffield CCG	Agenda Items

PREVENT	The PREVENT task group of Safer and Stronger Communities Scrutiny and Policy Development Committee recognised that there was a particular aspect of PREVENT that needed further consideration and was more suited to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee. **Work in progress to determine scrutiny style, when and scope - date not fixed.**	Appropriate organisation(s)/officer(s) to be determined	TBC
CAMHS	There is an NHS procurement of CAMHS Tier 4 - full NHS timeline for each package not known yet - South Yorkshire will be one package; a topic of interest to the Committee a previous Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee Task Group reported March 2014. **Work in progress to determine scrutiny style, when and scope - date not fixed.**	Appropriate officer(s) to be determined when further information/timeline known	TBC
Dementia Strategy	Raised as a public question 23.03.2016 for inclusion in work programme. **Work in progress to determine scrutiny style, when and scope - date not fixed.**	Appropriate organisation(s)/officer(s) to be determined	TBC
Health & Wellbeing Board	It is understood the terms of reference are to be reviewed, this item could consider new terms of reference and the 5 outcomes of Sheffield Health & Wellbeing Board.	Appropriate officer(s) to be determined	Briefing on review and/or agenda item for discussion and consideration

Future items - including 2015/16 follow on			
Quality Accounts 2017- draft responses	Sub-group report back on responses to NHS Trust QAs 2017	Alice Nicholson - Policy & Improvement Officer **Mar-16**	For information
PMCF evaluation	At its meeting in March 2016 the committee considered Access to GP and requested that this be presented/forwarded when available	Steven Haigh - Primary Care Sheffield **Nov-16**	One-off agenda item for information
Better Care Fund	Following consideration of the Better Care Fund at its meeting in November 2015, the committee wanted to look at it again in the future, focusing on whether the programme is achieving its intended outcomes and savings	Peter Moore/Joe Fowler - joint commissioning **Nov-16**	One-off agenda item for discussion and consideration
Adult Social Care Performance	At its meeting in January 2016, the Committee welcomes the approach being taken to improve adult social care performance, and requested that the Director of Adult Services provide a further update in a year's time.	Phil Holmes **Jan-17 (or Mar/Apr 17)**	One-off agenda item – discussion and consideration or for information
Quality Care Provision for Adults with a Learning Disability in Sheffield	In January 2016, the Committee considered improvements and action plans following reviews of Council and Care Trust learning disability services. The Committee requested a further update on progress in 12 months from the Director of Adult Services	Phil Holmes **Jan-17 (or Mar/Apr 17)**	One-off agenda item – discussion and consideration or for information
Home Care task group - response to report	recommendations to Cabinet 9th March 2016 - response due no later than December 2016	TBC **Dec/Jan-16**	One-off agenda item for discussion and consideration

Training session			
Adult Safeguarding	A training/ awareness session for all members of the Committee to be scheduled outside of set meetings – to enhance scrutiny role in Adult Safeguarding in line with protocol.	Simon Richards – Head of Adult Safeguarding **Oct-16**	separate training session

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

SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 13 July 2016

PRESENT: Councillors Pat Midgley (Chair), Sue Alston (Deputy Chair), Pauline Andrews, Mike Drabble, Adam Hurst, Douglas Johnson, George Lindars-Hammond, Anne Murphy, Zahira Naz, Bob Pullin and Garry Weatherall

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe and Clive Skelton

.....

1. INTRODUCTION

1.1 The Chair, Councillor Pat Midgley, welcomed everyone to the meeting and, on behalf of the Committee, expressed her thanks to Councillor Jackie Satur for her previous service to the Committee. She also thanked Alice Riddell (Healthwatch Sheffield) for her contribution and welcomed Clive Skelton as a Healthwatch Sheffield Observer.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Councillors David Barker and Shaffaq Mohammed.

3. EXCLUSION OF PUBLIC AND PRESS

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

4. DECLARATIONS OF INTEREST

4.1 In relation to Agenda Item 7 (Care Quality Commission Inspection Report 2016 – Sheffield Teaching Hospitals NHS Foundation Trust), Councillor Sue Alston declared a Disclosable Pecuniary Interest as she was an employee of the Sheffield Teaching Hospitals NHS Foundation Trust, but felt that her interest was not prejudicial in view of the nature of the report and chose to remain in the meeting, but take no part in consideration of the item. In addition, Councillor Douglas Johnson declared a personal interest in Agenda Item 7, as he was employed by a firm of solicitors who were taking legal action on behalf of a client against Sheffield Teaching Hospitals NHS Foundation Trust.

5. MINUTES OF PREVIOUS MEETINGS

5.1 The minutes of the meeting of the Committee held on 23rd March 2016, were

approved as a correct record and, arising from their consideration, it was noted that the final version of the Sheffield Clinical Commissioning Group (CCG) Primary Care Strategy 2016 was included in the agenda pack for information and that the Policy and Improvement Officer would check as to whether this had received final approval from the CCG and let Members know.

5.2 The minutes of the meeting of the Committee held on 18th May 2016, were approved as a correct record.

6. PUBLIC QUESTIONS AND PETITIONS

6.1 There were no public questions raised or petitions submitted from members of the public.

7. CARE QUALITY COMMISSION INSPECTION REPORT 2016 - SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

7.1 The Committee received a report of the Policy and Improvement Officer on the Care Quality Commission (CQC) Inspection Report on Sheffield Teaching Hospitals NHS Foundation Trust (the Trust) which had been undertaken in December 2015, with the final reports being produced in June 2016. This was supplemented by a presentation on the CQC report.

7.2 In attendance for this item were Dr David Throssell (Medical Director) and Sandi Carman (Head of Patient and Healthcare Governance) of the Sheffield Teaching Hospitals NHS Foundation Trust.

7.3 Dr Throssell took Members through the presentation which provided an overview, a grid of results for each of the sites covered, highlights of the report's main findings, areas of outstanding practice which had been identified, areas where further improvements had been recommended and the next steps. He indicated that the overall rating for the Trust was "good" and that an Action Plan had been submitted to the CQC, which covered all "must do" and "should do" items detailed in the final reports, and that this would be monitored.

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

- The fact that the Jessop Wing was not treated as a separate site for the purpose of the final reports was not an indication that it was subject to a less rigorous inspection. The decision to incorporate the Jessop Wing in the Royal Hallamshire Hospital final report had been made by the CQC.

- It was accepted that end of life care was the biggest concern arising out of the inspection and that there was still much to do to create a Trust wide strategy and ensure there were effective monitoring processes in place. There was now a focus on this and there were physicians trained in palliative care throughout the departments and also a specialist palliative care outreach team, which provided a seven day service across the organisation.

- Responsiveness was about compliance with targets such as the limit of four hours waiting at Accident and Emergency (A&E) and the timeliness of response to events such as outbreak of gastroenteritis. In assessing this, the CQC looked at complaints, talked to patients and analysed patient feedback.

- As some people attended A&E rather than visit their GP, consideration was being given as to how unnecessary visits to A&E could be prevented. GPs periodically worked in A&E, where their ability to assess patients without resorting to exhaustive investigation was extremely valuable. The concern was that GPs working regularly in A&E might become more ed dependent on investigations, which was more typical of a hospital doctor's approach to patient assessment. One idea under consideration was to have a GP centre close to A&E.

- The fact that the urgent and emergency services rating was not as good at the Northern General Hospital (NGH) compared with the Royal Hallamshire Hospital was a reflection of the more comprehensive A&E service at NGH. It should be borne in mind that due to the nature of the service A&E never closed. It was noted that 70% of acute trusts were categorised as "requiring improvement" across the board, and A&E services were a common contributor to these "requires improvement" ratings. In terms of patient impact, more patients were waiting longer than the four hour target at A&E, with those with less serious injuries waiting longer. There was a national shortage of doctors trained in emergency care and a critical mass was required to provide the required level of service, so as a result the main A&E facility in Sheffield was located at the NGH to ensure effective use of resources.

- There was a consultant available at A&E until midnight and one on call thereafter. The staffing profile at any one time was designed to meet demand, which meant that there were fewer medical staff on duty in the middle of the night. Medical staffing rotas were, however, under review at the present time.

- The extension of visiting times at the Weston Park Hospital was being looked at, but one issue which restricted flexibility around this was a shortage of physical space to accommodate visitors in ward areas. This issue was an important driver for the planned refurbishment of facilities across this hospital site.

- Many of the contracts for patient access to television had been set up several years ago and some of these prevented the use of other means of access. Some consideration was now being given to the use of wi-fi as a means of accessing the media.

- In relation to directing people away from A&E towards the use of GP services, any education was helpful and work was going on with the local authority and CCG in this regard. The Prime Minister's Challenge Fund had also been

used to introduce later GP appointments at four hubs. In addition, cross-boundary work had been undertaken as part of the Sustainability and Transformation Plan to look at areas of high A&E usage.

- It was anticipated by the Trust that the GP out of hours service would be inspected at a later date.

- Since the inspection, the nursing vacancies at Weston Park Hospital had been filled and the situation was being monitored.

- At the Weston Park Hospital the majority of patients were there for curative treatment, not end of life care. The dedicated palliative unit was at the Macmillan Centre at NGH. Staff involved in end of life care on the unit all had specialist training, but all staff had some training in end of life care.

- Additional lessons had been learned from discussions with the CQC inspectors and also from an inspection which Dr Throssell had chaired in another Trust.

- The analysis of the correct level of nurse staffing was complex and included a number of factors such as patient acuity and dependency. The CQC looked at the number of nurses against the funded complement and if the actual number was below that figure, the conclusion would be that that hospital was not fully staffed. It should be borne in mind that the funded complement was an in-house view. For the future, a new metric was being introduced nationally which related to patient contact hours. Furthermore, what was viewed as the appropriate number of nurses for particular ward areas may change on a daily basis.

- If an Urgent Care Centre was put in place near A&E, there would be a need for education to direct people to it. The Committee could help in getting this message out, as could the Public Health Service. The Prime Minister's Challenge Fund could also be used, but it should be noted that the funding to support this was time limited.

- The Action Plan arising from the inspection contained deadlines, the latest of which was March 2017, but it was felt that the estates work on the Weston Park Hospital would take longer. In relation to the Urgent Care Centre, discussions were ongoing but a clearer picture should emerge in two to three months. Some of the actions in the Plan would relate to a reconfiguring of services for the emergency care pathway.

7.5 RESOLVED: That the Committee:-

(a) thanks Dr David Throssell and Sandi Carman for their contribution to the meeting; and

(b) notes the contents of the report, presentation and the responses to questions.

8. DRAFT WORK PROGRAMME 2016/17

8.1 The Committee received a report of the Policy and Improvement Officer which set out the Committee's Draft Work Programme for 2016/17.

8.2 RESOLVED: That the Committee:-

(a) notes the Draft Work Programme 2016/17 as set out in the report;

(b) agrees to hold a one hour meeting, to which all Committee Members are invited, on Wednesday, 31st August 2016, to agree the scope of the Committee's Task and Finish Group; and

(c) requests that Members wishing to suggest any topics for consideration at the meeting on Wednesday, 31st August 2016, send details of these to the Policy and Improvement Officer by e-mail, for circulation prior to the meeting.

9. QUALITY ACCOUNTS 2015/16 - QUALITY ASSESSMENT SUBMISSIONS

9.1 RESOLVED: That the Committee notes the contents of the Quality Accounts 2015/16 – Quality Assessment Submissions report.

10. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - COMMISSIONERS WORKING TOGETHER PROGRAMME

10.1 RESOLVED: That the Committee notes the contents of the Joint Health Overview and Scrutiny Committee 2016 – Commissioners Working Together Programme report.

11. SHEFFIELD CLINICAL COMMISSIONING GROUP PRIMARY CARE STRATEGY 2016

11.1 RESOLVED: That the Committee notes the contents of the Sheffield Clinical Commissioning Group Primary Care Strategy 2016 report.

12. DATE OF NEXT MEETING

12.1 It was noted that the next meeting of the Committee would be held on Wednesday, 14th September 2016, at 4.00 pm, in the Town Hall.

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