Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 12 April 2017 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, Lewis Dagnall, Mike Drabble, Adam Hurst, Douglas Johnson, Zahira Naz, Moya O'Rourke, Bob Pullin, Peter Rippon, Gail Smith 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
12 APRIL 2017

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

3. Exclusion of Public and Press
To identify items where resolutions may be moved to exclude the press and public

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

5. Minutes of Previous Meeting (Pages 5 - 10)
To approve the minutes of the special meeting of the Committee held on 8th February, 2017

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

7. Urgent Care Strategy - Sheffield Clinical Commissioning Group (Pages 11 - 24)
To receive a presentation by the Clinical Commissioning Group

8. Public Health Strategy for Sheffield (Pages 25 - 32)
Report of the Director of Public Health

9. Home Care Task Group - Formal Response (Pages 33 - 42)
Report of the Director of Adult Services

10. Shaping Sheffield Scrutiny Members Working Group (Pages 43 - 46)
Report of the Shaping Sheffield Scrutiny Members Working Group

11. Work Programme Review 2016/17
The Policy and Improvement Officer to report

12. Date of Next Meeting
The next meeting of the Committee will be held on a date to be arranged

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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 Audit and Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Special Meeting held 8 February 2017

PRESENT: Councillors Pat Midgley (Chair), Sue Alston (Deputy Chair), Pauline Andrews, David Barker, Lewis Dagnall, Adam Hurst, Douglas Johnson, Zahira Naz, Moya O'Rourke, Bob Pullin, Peter Rippon and Gail Smith

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Mike Drabble and Helen Rowe (Healthwatch Sheffield representative).

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 In relation to Agenda Item 6 (Shaping Sheffield – The Plan), the Chair (Councillor Pat Midgley), declared a personal interest as she was a member of the Manor and Castle Development Trust.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 Mike Simpkin (Sheffield Save our NHS) referred the Committee to the circulated document which included a series of six questions relating to:-

(a) The extent to which support for the Sheffield Plan (the Plan) would be taken as meaning acceptance of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) as a whole.

(b) The key elements of the financial strategy, when these would be made public and what were the detailed workforce implications of the Plan.

(c) How an integrated QIPP (Quality, Innovation, Productivity and Prevention) / CIP (Cost Improvement Programmes) programme would actually improve services.

(d) How the public could be assured that the Plan was not simply drawing the health system more closely to the policing of an increasingly draconian benefits system and thus damaging and discrediting the NHS.

(e) The public accountability in all of this.

(f) The Council's next steps in regard to this NHS planning process and the proposals for the integration of some commissioning functions and service provision.

4.2 In response, Councillor Cate McDonald (Cabinet Member for Health and Social Care) indicated that this was not an agreed plan but more of a process, with the Council's next steps being to consider and respond to it and indicate a set of priorities. She added that the Council did not support the STP, but was willing to work with the NHS to get the best outcomes for the people of Sheffield.

4.3 In response to further comments from the Chair (Councillor Pat Midgley), Peter Moore (Director of Integration and Strategy, Sheffield Clinical Commissioning Group (CCG)) stated that it was difficult to disentangle the Plan from the STP and highlighted the importance of recognising the financial challenges. He added that Sheffield had a positive Plan and that there was a need to ensure the creation of a tension between what the STP could deliver and what Sheffield could contribute, with a view to making the relationship more explicit. Greg Fell (Director of Public Health) added that the business end of the process had to be owned by Sheffield.

4.4 The Chair indicated that the remainder of Mr Simpkin's questions would most likely be covered in the discussion in the following item, but he would be allowed to respond afterwards.

5. SHAPING SHEFFIELD - THE PLAN

5.1 The Committee received a report of the Policy and Improvement Officer which included the Shaping Sheffield Plan (the Plan), together with an Executive Summary of it. This report was supported by a presentation, copies of which were circulated at the meeting.

5.2 In attendance for this item were Councillor Cate McDonald (Cabinet Member for Health and Social Care), Greg Fell (Director of Public Health) and Peter Moore (Director of Integration and Strategy, Sheffield Clinical Commissioning Group (CCG)).

5.3 The item was introduced by Peter Moore, who referred the Committee to the Plan, making particular mention of the case for change and commissioning intentions. He then gave the presentation which outlined why the Plan was important, the Sheffield Vision, a summary which set out four key aims and four key deliverables in year one, and a work plan listing what was to happen next, a main feature of which was a Shaping Sheffield event, which was to take place on 9th March 2017. Greg Fell emphasised that this was not a closed plan, but more of a process and that officers were open to ideas as to how this should proceed. He added that there wasn't a single "magic bullet" to solve issues such as governance.

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

- The Plan indicated a direction of travel, as it was not possible to map out all actions.

- There was a commitment to look at delays caused by non-elective admissions to hospital, with the aim being to get patients back home as soon as possible. The Plan was clear on this, in that it was about changing behaviours and there would be a review of all current urgent care. The City had a well-resourced group of services, which sat between GPs and A&E and these could be used better to free up GP time. This could be achieved by better use of community services and revamping the active support and recovery system, together with preventative work. There was currently a debate in the City on the model of GP operation, particularly in relation to forming them into bigger collaboratives. In relation to freeing up GP time, social prescribing could enable them to focus on medical issues, as well as addressing the issue of frail people being on medicine which they didn't really need. There was also a need to change the culture in relation to people being kept in hospital.

- Officers were mindful of the need to get the relationship between work and health right. It was about interventions to help people to get closer to work and progress could be made on this by bringing the GP and mental health services culture together. It should be noted that there was no intention for this initiative to be used as a mechanism to enforce benefit sanctions and that GPs would disengage if it became apparent that this was the case. The intention was to provide positive support.

- In relation to engagement around the Plan, an event had been held in December 2016 and other conversations were taking place in this regard. As with the Move More initiative, it was important to get the right individual to use ways to communicate and discussions were also being held on the use of technology. In relation to urgent care work, there had been engagement with the easy to reach, but there had been no feedback from the harder to reach and there was a commitment to target such individuals. The aim was to make things better for the people of Sheffield and the use of service improvement groups was an important feature of this. There was a need to work on the co-production of how services were put together, with health and social care being a priority which would be progressed.

- The Plan was about providing the best quality care in a time of financial restriction. However, this should be viewed as an opportunity to change the model, with relationships between individuals being a key feature.

- Current mechanisms were about payment by results. There was a need to base these on medical evidence. The demand for services was limitless and, with a performance incentive system, this meant that more money was in the hospital sector.

- In relation to expensive innovations, there was a need to have difficult conversations about what it was not desirable to implement, as some

innovations may not give a lot of gain.

- Local level resources were important in keeping people out of hospital and the Council was committed to working with the NHS in this regard.

- The CCG would be holding public meetings and there was a service user group which would be used in an endeavour to engage those who were hard to reach. It was important to find multiple routes of engagement.

- The size of the GP workforce was a major issue, particularly as investment was not forthcoming.

- Some concerns had been expressed that social prescribing, which was a big part of keeping people well, was being over-medicalised.

- Social prescribing was funded by the Council and through the Public Health budget, with the use of other primary community services being an important part of this.

- Funding for items such as public cafes was provided on short term contracts and, as a result, some of them had not been able to continue their operation.

- Some GPs bought into the idea of social prescribing but others did not.

- Officers were starting to look at the integration of primary care, particularly in relation to linking it with the voluntary sector.

- The urgent care system was complex and it was difficult to get to specifics. The model was there in terms of person centred care and there was the ambition to change how the system worked and how the money flowed, but organisations needed to change.

- Some behavioural change was already being seen with the CCG and the Council agreeing a pooled budget, and there had been some service redesign. People were getting expensive treatment in Sheffield and being looked after under social care. Officers were working with the Sheffield Health and Social Care Trust and providers on cost reduction, but it was still felt that outcomes were better for Sheffield residents. It was necessary to overcome organisational boundaries and important to respond and tackle issues.

- In relation to person centred care, the approach should be ‘what matters to you’ rather than ‘what’s the matter with you’.

- It was not thought that the Plan should be overly concerned with neighbourhood footprints being precise.

- Person centred care enabled people to engage more, positively affected the

ability to deliver and was important for GP consultations.

- One of the key reasons for having a single Plan was that Sheffield had a great range of public services and needed to determine its own destiny and this might mean differential access for social care. The most deprived used urgent care and the fundamentals of this were covered in the Plan.

- Picking out fine detail would make the Plan a very unwieldy document and Sheffield Save Our NHS was not in favour of putting down a set of metrics. The intention was to achieve a step change, eg. in relation to access rates, and target resources.

- There was a Plan for each of the priorities set out in the Executive Summary, eg in relation to inequality there was an existing Health Inequality Action Plan.

- The Tobacco Control Strategy aimed for 10% prevalence of smoking in the City.

- It was accepted that the Plan needed to use more plain language.

5.5 In response, Mike Simpkin indicated that the Plan covered much and there were lots of initiatives in Sheffield, but felt that it should be about preparing ways of improving existing services and suggested that some thought be given to marketing as opposed to consultation.

5.6 RESOLVED: That the Committee:-

(a) thanks Councillor Cate McDonald, Greg Fell and Peter Moore for their contribution to the meeting;

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

(c) requests that:-

(i) a small Task and Finish Group be set up, of approximately five Members, to consider the Committee's response to the Shaping Sheffield Plan and produce a summary of this for submission to Greg Fell and Peter Moore;

(ii) a briefing paper on progress on implementation of the Shaping Sheffield Plan be prepared at an appropriate time for circulation to Committee Members; and

(iii) consideration be given to inviting a grassroots practitioner to address a future meeting of the Committee in relation to their work.

6. DATE OF NEXT MEETING

6.1 It was noted that the next meeting of the Committee would be held on Wednesday, 15th March 2017, at 4.00 pm, in the Town Hall.

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Reviewing Urgent Primary Care across Sheffield

Kate Gleave

Dr Marion Sloan

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Definitions

Urgent Care – urgent but non-life threatening

Emergency Care – serious and life threatening needs/ needs an immediate response time

Urgent Primary Care – any patient contact requiring a same day appointment with GP/ Community service as defined by the patient

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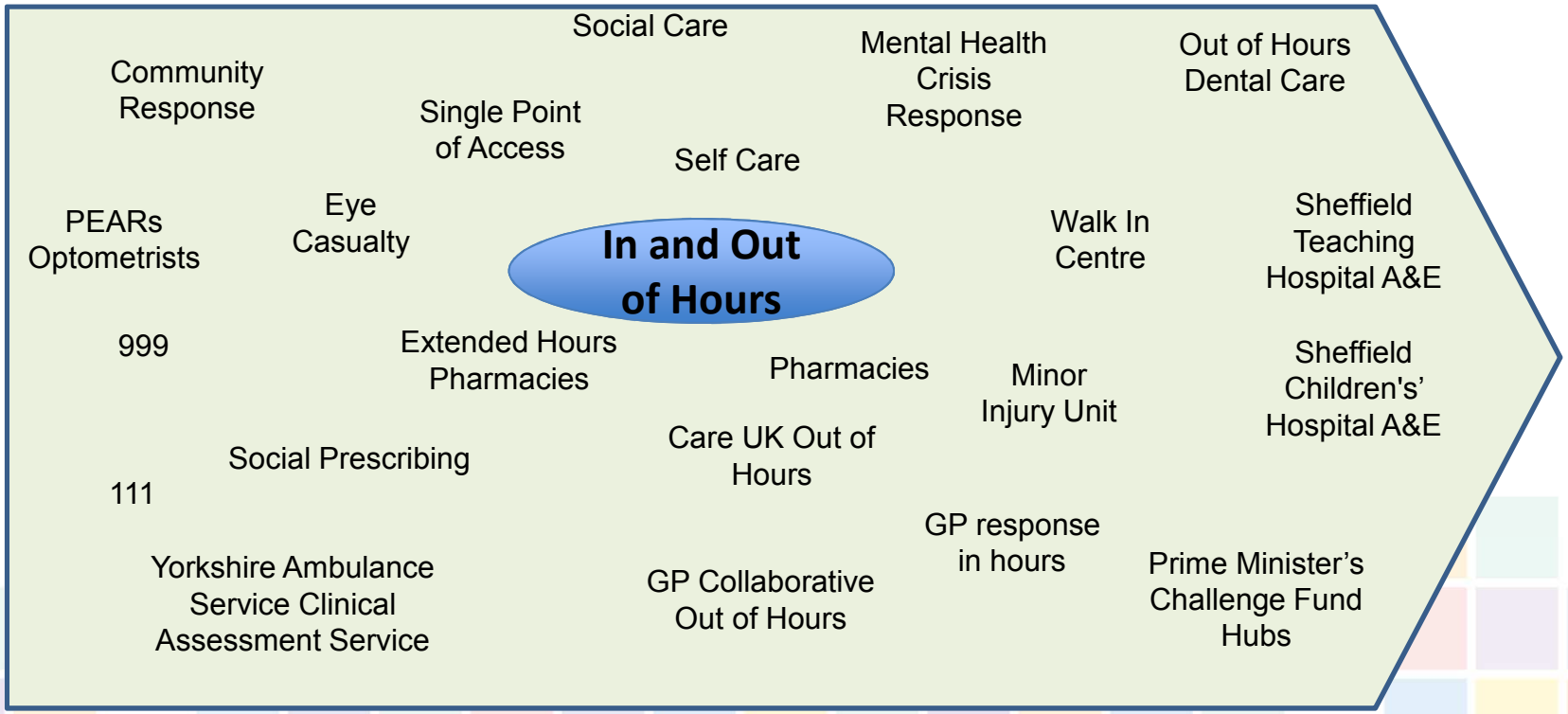
Urgent Primary Care in Sheffield: current overview



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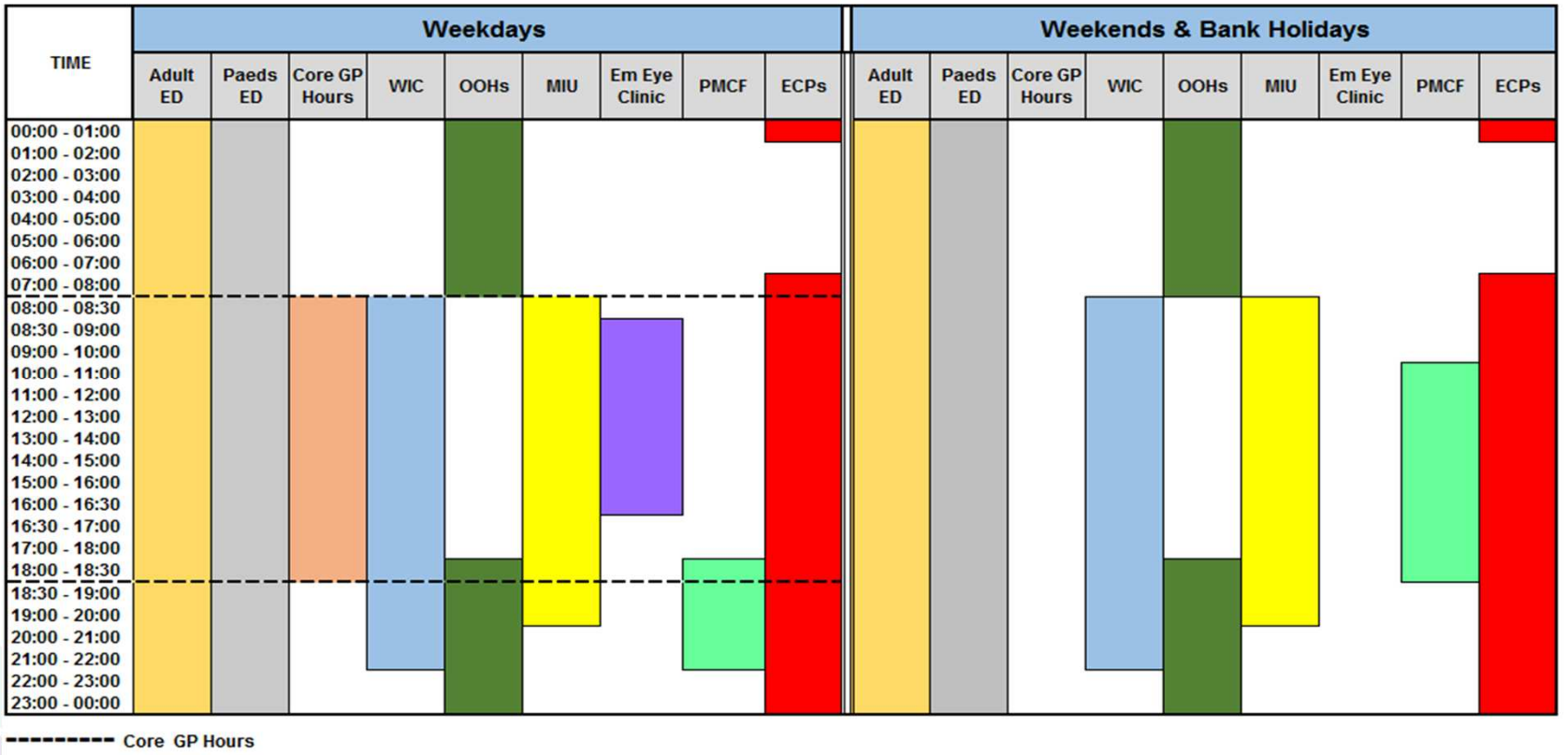
Current Urgent Primary Care Opening Hours



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Key issues

- Reduce duplication and simplify access
- Reduce pressure in A&E departments and improve performance
- Reduce inequalities
- National drivers
- Deliver care more locally and appropriately
- Provide value for money and support sustainably resourced primary care

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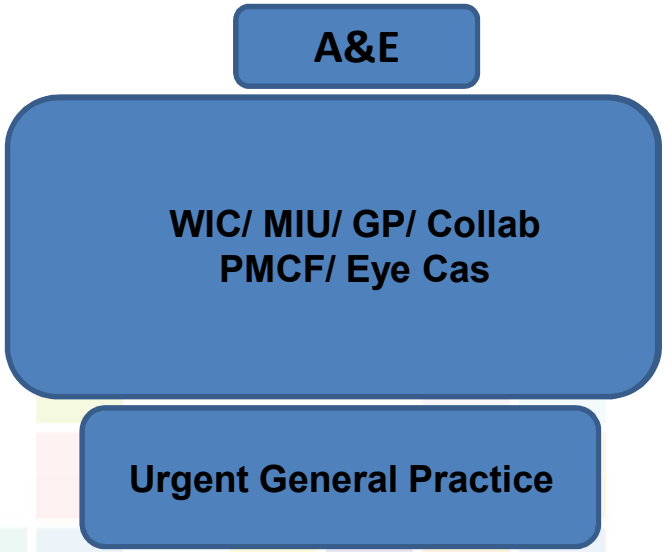
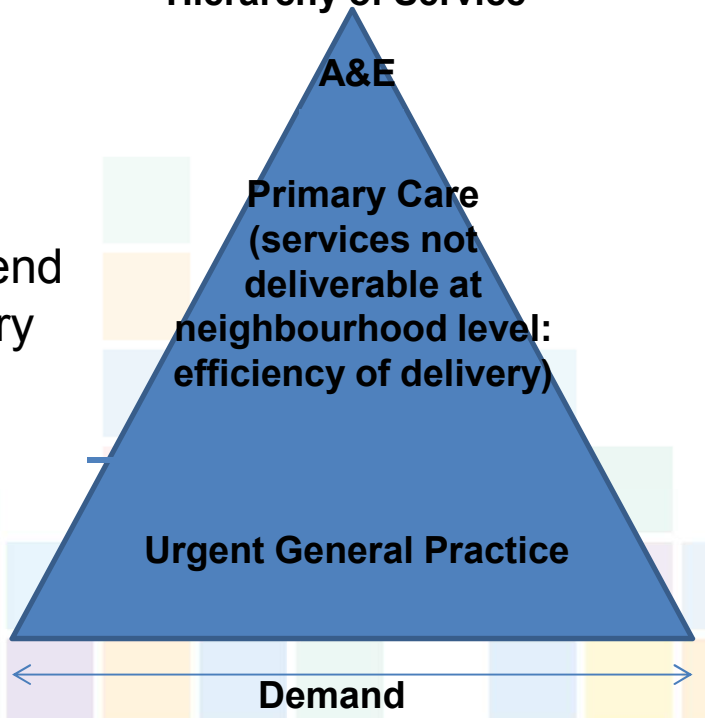
Adjusting investment to meet patient need

Current Hierarchy of Service



Estimated that £14m of this urgent care spend is urgent primary care

Future Hierarchy of Service



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What want to achieve

- Our new model of urgent care will provide care where needed in the most appropriate setting that is easy to understand and to access for both patients and clinicians.

- Reduce the number of entry points to services and ensure that they are configured in a way that best meets the population needs.

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The Process

Phase 1 – developing urgent care strategy

- Based on engagement with local people to understand their experiences of using urgent care services.
- Set out intention to reorganise local urgent care services to make the system less confusing and easier to use
- Consideration of siting an urgent care centre at A&E for those who continue to attend with non-emergencies.

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Phase 2: Developing options

Carrying out additional engagement to inform development of options

- To understand reasons behind current usage and potential impact of any changes to current system, including inequalities
- Focus on specific groups - homeless people, people dependent on drugs and alcohol, deprived communities, vulnerable people
- Working with organisations supporting these communities to reach them - using questionnaires, individual interviews and focus groups.
- Getting feedback from front-line staff working with these communities..

Work with GPs and neighbourhoods

- To understand patient needs and demands and professionals' views
- Linking into other programmes of work e.g. Active Support and Recovery

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Principles for options

- Based on what we need in 5 years time, not what we have now
- Consider the whole Sheffield population needing/ accessing primary urgent care (for clinical or social reasons)
- Incorporate the national ‘must dos’
- Reflect the interdependencies with other SCCG programs and national drivers

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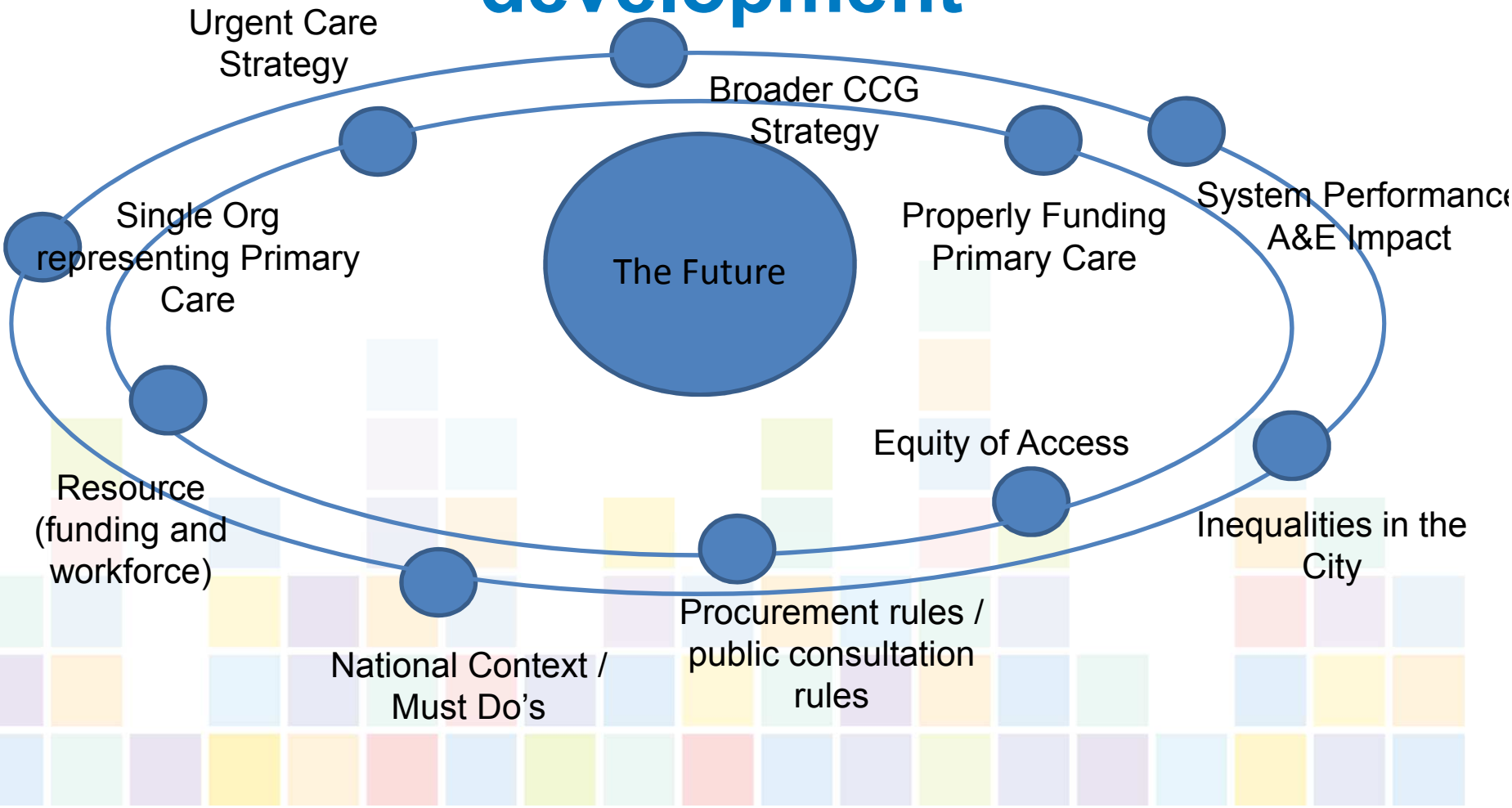
Factors contributing to option development



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Phase 3: Consultation plans

- Planning to formally consult on options
- Working on basis of June-Sep – 14 weeks as over summer holiday period
- Will include extensive range of activities to inform local people of the options and enable them to give their views
- Include focus on reaching ‘seldom heard’ and vulnerable groups
- Full analysis of feedback to be produced to inform decision-making

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Discussion

- Are there any other issues or principles we should be considering?
- Any suggestions for things to build into the consultation plan?
- Working with you

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Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee 12th April 2017

Report of: Greg Fell

Subject: PUBLIC HEALTH STRATEGY

Author of Report: Greg Fell, Director of Public Health

Summary:

Sheffield CC Cabinet have agreed a Public Health Strategy, which aims to describe the ambition of SCC to redress the 25 year difference in healthy life expectancy through the totality of SCC's functions (not just the Public Health Grant). A key feature of the strategy is focused on the concept of Health in All Policies, which considers how to maximise the health gain from policies and service areas that are not traditionally considered as "health" related. The acid test of adoption of a principle of Health in All Policies will be that all areas of decision making and resource commitment systematically consider health and wellbeing outcomes, and inequalities, across all decision making processes. To truly deliver a Health in All Policies approach it will be necessary to change the way the organization thinks and does its business. The Committee are asked to consider how the Council can best develop this approach.

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

Reviewing of existing policy	**x**
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:

- Give consideration to where energy should be focused first – i.e. of the 10 areas set out in section 3 of the strategy (section 2.1 of this paper), where are there obvious opportunities to focus energy first? Are there other areas we should be looking at too?

- Consider how best to ask other cabinet members or directors to Scrutiny to describe how they are improving health and wellbeing in all SCC processes and policy areas. This may involve working through each portfolio in turn.
- Consider how other scrutiny committees can ask questions about health and wellbeing in their existing processes.

Background Papers:
Sheffield City Council Public Health Strategy

Category of Report: OPEN

Report of the Director of Public Health

Public Health Strategy

1. Introduction/Context

1.1 SCC Cabinet have agreed a Public Health Strategy. The original ask of the Leader of the Council and Chief Executive was to describe what SCC as a "public health organization" would look like, to transform 'public health' from an NHS facing model to a local government facing one, and to set out a strategy that described the ambition of SCC to redress the 25 year difference in healthy life expectancy through the totality of SCC's functions (not just the PH Grant). The strategy is now agreed and published. Some further work will be done to turn this into a public facing document.

1.2 The approach **taken in the strategy** is, deliberately, tipped away from an NHS centric model of public health, though that model still has significant merit. This is an effort to redress the balance in approach to "public health", while being mindful of the large gravitational pull of the NHS and the potential in terms of the staff that work in it. We have, however, made a concerted effect to shift the balance of the discussion and narrative on health away from the NHS and more towards other issues.

1.3 A key feature of the strategy is focused on the concept of Health in All Policies. Health in All Policies is a mechanism to 1) make explicit, and **2) increase** (*rather than describe the current*), the health gain from policies and service areas that are not traditionally considered as "health" related. One of the aims is to ensure the health and inequalities impact is on the balance sheet in a visible and tangible way. In this way we will challenge the way the existing resources are committed. The point of such approaches is using such frameworks to **challenge existing** resource commitments **and do better** with a view to delivering more health return with them than is currently the case. Many of the processes in place will continue to happen; the challenge and opportunity is to maximise the wellbeing generated by those processes above what might have otherwise been the case.

1.4 In this way we can seek to create health & wellbeing, something at least as sensible and as practical as simply avoiding disease.

2. Starting point for implementing

2.1 There is no intention to write a detailed action plan. A detailed action plan may actually be a barrier to success as opportunism is likely to be the winning strategy. Implementing Health in All Policies will take many forms. There isn't a single idea or policy option that will achieve the goal. The specific 10 areas highlighted in the strategy are one place to start, and focused on obvious opportunities, easy wins – in

terms of where health gains can be made with limited changes to existing arrangements, and areas with significant gain potential. These are listed below:

1. **Best Start** – pre birth to primary school education. The first 1001 days.
2. comprehensive **work and health** strategy
3. potential for **sustainable economic growth** to improve better health outcomes and redresses inequalities.
4. the **City for All Ages Strategy** and refresh our approach to healthy ageing.
5. optimise the health & wellbeing opportunities around **land use planning; population density and mix, transport planning including active travel** by adopting a healthy town framework.
6. development of an **Air Quality** Strategy for Sheffield.
7. support the **NHS with the reform and transformation** agenda as articulated in the Sheffield Place Based Plan.
8. review and redevelop the **Sheffield strategy for open space and green space,** bringing together our approach to the **Outdoor City, parks, Move More** and other agendas
9. maximise the health and wellbeing opportunities through our **housing strategy**, and development in the housing sector more broadly.
10. develop a strategy for **mental wellbeing,** building on, and complementing the Mental Health Strategy.

2.2 Obviously where opportunities naturally arise on account of external or internal events we will take them. We will also seek to engineer opportunities. 'Policy windows' may only be open for a short time. They may revolve on an unexpected crisis, budget process, and community demands.

2.3 Gaining traction on the way that large resource commitments influence long term wellbeing and inequality outcomes, in the face of immediate demand led pressures, and reconsideration of core statutory duties is the key resource challenge.

2.4 There is a need to ensure the right machinery to make change happen. Arguably that may become a little bureaucratic but without machinery the strategy may never get beyond bold words. Eight ideas to develop implementation where it may be possible to demonstrate progress through a Health in All Policies approach are set out below:

- **Build health impact assessment into planning processes and developments in a practical way**, based on best practice. Linked to this, develop common monitoring and evaluation tools.
- **Ownership** – it only matters if others share the vision and general approach. Ownership of a large group of stakeholders matters. Persistence and presence across all parts of the organization will be needed.
- **There may be merit in reconsidering the question of the purpose of "commissioning" in some areas,** including what outcomes we want to achieve and whether there are more strategic uses of resources to get those outcomes.
- **Be clear about expectations** - should key policy or service areas set and publish health and wellbeing objectives, take reasonable steps to meet objectives, and write an annual statement in which if we don't meet objectives we state why.
- **In some areas it may be necessary to change how success is measured in big systems, how Return On Investment is considered and what lessons can be learned from elsewhere in the world** or other relevant sectors. An example of this might be reconsidering how "success" is measured in transport policy, and the incorporation of health impact into economic success measures and evaluation models. A second example would be the consideration of the long term health impact of economic policies. The RSA Inclusive Growth report (among others) has noted that a healthy population is core to economic productivity, but is often missing from calculations.
- **Engaging citizens in this agenda is important, and we could do better.** We need to think through how we can better engage individuals in the factors that influence their health. Health is NOT solely the product of our own choices. But as individuals, we can influence these decisions as voters, consumers, employees and shareholders if we understand the problem. How can we equip citizens to be just as (or perhaps more?) prepared to lobby their politicians over the levels of nitrous oxides on their local streets or the lack of street level activity in their housing estates, as the closure of an A&E?
- **Supporting community based co-design to define and solve "problems". Starting with the problems as defined by communities themselves, rather than the problem as perceived by the authorities.** The five a day message will have little traction in a food desert: improving access to health services for depression and anxiety is necessary but if for instance, the root cause of

people's anxiety is lack of housing security, a pill or talking therapies isn't going to solve it.

- **Aligning wider policies with improving health**. There is consensus that the decisions that influence job supply, housing quality, or our ability to lead active lives are going to have more impact on our health than whether we fund a new treatment or build a new hospital.

3 What does this mean for the people of Sheffield?

3.1 Success only happens if the approach is institutionalized. The acid test of adoption of a principle of Health in All Policies will be that all areas of decision making and resource commitment systematically consider health and wellbeing outcomes, and inequalities, across all decision making processes. To truly deliver a Health in All Policies approach it will be necessary to change the way the organization thinks and does its business.

3.2 For example, the expectation would be that transport policy and investments in this area will deliver health gain (and vice versa) and that should be led from within that part of the council.

3.3 Using this example further: developing a win/win approach is important. Success should be defined as both "how can health support successful transport policy" AND "how can transport policy deliver health outcomes". The language used may be important: the use of "health" language usually defaults to health care services, so we could consider using "wellbeing instead" as that is an outcome that is universally accepted.

3.4 It is of note that Government have attempted this in the past with a Cabinet Office led approach to health policy, over time this defaulted to a DH led approach. Similar was seen in South Australia where "better health" was a prime concern of the Premier. Similarly here we should be mindful that the responsibility is organisational, not solely the DPH.

3.5 Similarly the work of the planning or licensing committee should consider the possible health gain, or loss, associated with decision making. In this way "health" becomes business as usual for the council. This is a long term project and the difficulty shouldn't be under estimated. Success involves changing cultures, standard operating procedures for a city and challenging the status quo. There are obviously trade-offs and compromises are always necessary.

4. Recommendation

The committee is asked to:

- Give consideration to where energy should be focused first – i.e. of the 10 areas set out in section 3 of the strategy (section 2.1 of this paper), where are there obvious opportunities to focus energy first? Are there other areas we should be looking at too?
- Consider how best to ask other cabinet members or directors to Scrutiny to describe how they are improving health and wellbeing in all SCC processes and policy areas. This may involve working through each portfolio in turn.
- Consider how other scrutiny committees can ask questions about health and wellbeing in their existing processes.

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

Report of: **Phil Holmes, Director of Adult Services**

Subject: **Home Care Task Group Report - formal response**

Author of Report: Andy Hare, Strategic Commissioning Manager.

Summary:
This report details responses to the recommendations made by the Scrutiny Committee's Task Force on Home Care which was presented to Cabinet in 2016. Ten recommendations were made which were split into the following areas: Assessment, Strategic Approach to Commissioning, Working with Providers and User Focussed Services. This paper offers responses to each recommendation in turn, in some cases describing work that has already taken place, is underway or is planned in the Communities Portfolio.

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	
Response to Scrutiny Task Group Report	➨
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	

The Scrutiny Committee is being asked to:
Consider this report and provide views and comments and any further recommendations.

Background Papers:

The original report is available on the Council's website.

Category of Report: OPEN

1. Introduction/Context

The Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee established a cross party task and finish group to look at home care, and make recommendations focused on improving the quality of home care services in Sheffield. This is the formal response from officers to the Home Care Task Group Report [1], which was presented to Cabinet in March 2016 and made a series of recommendations covering assessment, strategic commissioning, working with providers and user-focussed services. The response has been collated from the work of officers who specialise in each area and is structured to mirror the format of the original report.

2. Main body of report for consideration

Home Care continues to present significant challenges to Sheffield commissioners. We continue to face an increase in demand for services in the context of less money being available to the Council, a situation mirrored in other local authorities across the country. There is widespread concern about inadequate funding of social care generally, concern that has been increasingly reflected in media news stories locally and further afield. Market stability has been in serious jeopardy with some loss of quality, brought about by staffing shortages and exacerbated by CQC imposed embargoes. Two large providers have voluntarily left the city and others have had to fold for various reasons. Waiting lists soared to unprecedented levels during 2016.

In Sheffield, we are also aware of our poor relative position in league tables which measure user satisfaction with social care arrangements. We need to improve.

Despite this, we have made a number of positive changes to home care and the way that we use it and have more improvements in the pipeline. These are described in the responses to the recommendations below. We are now most definitely on an upward recovery curve. There has been a cost to this but the outlook is far less bleak than it seemed only a few months ago.

[1] Link to the original report

This paper will now move on to respond to the recommendations made in the original report. The Task Group's recommendations appear in *italics*

Assessment

Recommendation 1

The Council should continue and accelerate its work to make the assessment and review process more person-centred, based on continuous dialogue with service users and their families.

The Council has just consulted on significant changes to social work teams which are proposed to be implemented by August 2017. These changes include:

1. Developing locality teams that will enable stronger connections with people in the neighbourhoods where they live
2. Transforming Care teams to work intensively with the most dependent adults with learning and physical disabilities, to help them live more connected and inclusive lives
3. A 0-25 team to support young people with disabilities as they move into adulthood.

Alongside this the Council is also developing a new Case Management system for introduction in April 2018 and is simplifying processes and reducing bureaucracy in preparation for this.

Recommendation 2

The Council should work with other agencies to improve information sharing between care workers, social workers and health professionals to ensure that service users are receiving joined up services. This should include sharing Care Plans with home care providers from the outset.

The new Case Management system referred to above will significantly help with information sharing. In the meantime, providers now receive more information from the outset.

Strategic Approach to Commissioning

Recommendation 3

The new commissioning model must have flexibility built in to enable us to respond to fluctuations in demand across the city.

Commissioners have designed an improved model which will be used in the refreshed specification being tendered over the summer. This contract will start in October 2017. For the first time the model acknowledges the different challenges facing providers in different parts of the city. Demand, travel time and availability of workers have been taken into account.

Contract areas in south-west Sheffield have been taken out of the general contracts approach and tendered separately as block contracts. . This gives the provider responsibility to recruit adequate numbers in those “hard to recruit” areas in return for a guaranteed payment.

Across the rest of the city, we will designate one or more “primary” providers who will be expected to take on all new work in a particular area, but only up to a specified number of hours. We accept the providers’ assertion that compulsion to take on packages can cause problems, for example having to pressurise workers to take additional hours, often resulting in call cramming and a resulting drop in quality, or to use excessive numbers of agency staff. This approach will give us rapid pick up but also offer some assurance to providers that they will not be stretched unexpectedly beyond their normal operating conditions.

To back up the primary roles, we will also be tendering for a new Framework. We anticipate admitting at least 20 providers on to this Framework, although potentially the number could be much greater. These providers will be offered packages which can’t be picked up by the primary providers. This may be because they have already reached their hours limit, or for other reasons such as CQC embargoes. Brokers will work closely with the market to help smaller companies build up rounds of work at a sensible pace, thereby maximising market capacity without jeopardising quality. All providers will work to the same specification with the same quality standards.

We have for the first time, set contract fees using a “Cost of Care” model developed by Commissioners. This has been broadly welcomed by providers who agree that it offers a fair price; one which enables them to pay workers at a legal, market rate. Each area of the city presents its own challenges and the model takes into account the varying amounts of travel time carers need, moving from house to house in the course of their work.

Recommendation 4

The new commissioning model must drive and incentivise quality in services, and should therefore take account of the recent NICE guidelines, particularly around 30 minute minimum calls.

We have already taken steps to reduce the use of short calls (under 30 minutes) as recommended in the NICE guidelines. It is very difficult to measure the impact of the changes but assessors are now using a stricter set of conditions before commissioning short calls. We are under no illusions that this can be achieved quickly or easily. Many care packages still have short calls included and until all these have been reviewed, there will be therefore a legacy of short calls in older packages for 12 months or so.

Calls under 30 minutes will in future only be use if three conditions are met:

- the home care worker is known to the person **and**
- the visit is part of a wider package of support **and**
- it allows enough time to complete specific, time-limited tasks or to check if someone is safe and well.

Other elements of the NICE guidelines have also been considered during the development of the specification and we now consider it to be harmonious with those guidelines. For example, there is an expectation that providers will act in way which protects the dignity of service users by using small teams of carers and keeping people informed of changes to the staff team. We have also built in the flexibility for providers to change care plans around according to the needs of the person on the day and to “bank” hours for later use.

While the content of the Specification is aligned with NICE guidelines, we acknowledge there is an ongoing challenge to ensure our 'micro commissioning' i.e. the assessments completed by social workers, is similarly harmonious. Commissioners and Assessment & Care Management will continue to work closely to deliver this aspiration once the new contracts are in place.

Recommendation 5

That Sheffield should move towards an outcome based commissioning approach; however a phased introduction may be required to allow for further work to be done to identify and mitigate the risks of such an approach.

The new specification strongly signals to the market that the next 3-4 years will see a major change in the way that services are commissioned and delivered to enable a much more flexible, person centred approach to become the norm. We intend to test out ways of working in a more outcomes focused way with less reliance on strictly prescribed time/task based packages. We understand why this is important and that unless a service truly focuses on the impact on the individual, it can't properly be called person-centred. It is not acceptable to deliver a homogenised service that people have to fit into, and the specification leaves plenty of scope for moving towards this aspiration and away from the old style 'task and time'.

We agree with the assertion that this will require a phased introduction. A system wide change is needed which will requires a review of charging processes as well as a fundamental shift in the way support plans are developed and structured.

<u>Working with providers</u>

Recommendation 6

Commissioners should work with providers to address workforce issues including terms and conditions, workforce development and workforce planning.

Commissioners recognise the importance of addressing workforce issues in the home care market. Wages are still only just above minimum wage levels for a very physically and emotionally demanding job. People can work in other parts of the service sector for the same money but with considerably less stress and pressure. Keeping people in the industry is a major challenge for providers and commissioners need to offer as much support as possible.

The Council has in the past set up and funded a number of recruitment events as well as placing adverts in the local press to attract new entrants into the care sector

The cost of care model mentioned above offers providers no excuse to not reward care workers with a fair rate of pay. Wages are unlikely to get very far above minimum levels but no worker should have to work for an effective hourly rate below legal levels once travel time has been accounted for.

Money is not often cited as the main factor in poor retention rates. Workers seek job satisfaction and support from their employer. The contract backs up CQC requirements for worker to have regular supervision meetings and the opportunity to meet with their co-workers for mutual support and to address any questions or concerns which arise during the course of their work.

The new specification will include specific requirements on the provider to ensure that their workforce is properly supported to develop the skills and knowledge carry out their role to a high standard including induction training (to incorporate the ne Care Certificate and regular updates and refresher training.

The widespread use of zero-hour contracts in the care industry has been cited as a deterrent to people coming to work in social care. In practice many providers have now started to offer fixed or guaranteed hour contracts and some workers, prepared to sacrifice flexibility for income security, are taking this up. The new contract asks that providers to offer a “reasonable number” of weekly hours to workers where feasible.

Providers bidding for the tender will be asked to describe step they will take to recruit and retain a high quality workforce and the responses will automatically form part of their contract.

Recommendation 7

Commissioners should continue to develop a mature relationship with providers, ensuring that monitoring processes are robust, proportionate and efficient.

Providers and commissioners are in the same business of ensuring the best possible service is delivered. The last 12 months have already seen a big improvement in relationships. Communication has been more open and whilst there are different perspectives on some issues, mutual trust and respect has developed. The specification has been strengthened to demonstrate that Commissioners are committed to continue working in partnership with Providers in delivering high quality Services. By sharing key objectives and communicating regularly and clearly, concerns and potential problems can be dealt with early, before they affect service quality.

Commissioners will continue to have a strong focus on developing relationships with providers and providing support around improving and maintaining quality and performance across the diverse market. The contracts team also provides a support service around CQC compliance, particularly supporting the smaller providers to prepare for inspections by the regulator. The overall aim is to ensure we have a diverse range of good quality providers. This has been evidenced in improvements in CQC ratings. Each provider has an allocated officer who regularly visits branch to ensure they have a relationship with and are available for support as and when required. A recent provider survey results were positive, particularly around the relationships. One comment received was "*The contracts team are approachable responsive and helpful. They assist with guidance and support at all times. I feel the team is extremely valuable with a consistent approach to homecare"*

Recommendation 8

Commissioners should work closely with providers to find ways of building flexibility into service delivery.

As mentioned under recommendation 4, we have allowed considerable flexibility for providers within the specification to team and ladle hours between visits in order to best suit the changing needs of service users. This can be done without reference back to assessors as long as the overall size of the care package is not exceeded.

Clearly there are some limitations to this because an unplanned change in call duration will have a knock on effect for the next person to be seen; punctuality and flexibility do not always sit comfortably together.

User Focused Services

Recommendation 9

The new commissioning framework should result in home care services that are consistent, reliable and flexible, and based on continuous dialogue with service users and families about what their needs are.

Recommendation 10

Commissioners should develop a mechanism for routinely collecting service user feedback on home care, as well as feedback from people who receive a direct payment.

Whilst some progress has been made in this area, further development is required. The team is in discussions with Healthwatch about developing a robust mechanism for collecting feedback from people who receive home care; this will be a priority for the team over the next year.

3 What does this mean for the people of Sheffield?

The aim of the recommendations in the Home Care Scrutiny Report was to improve the quality of home care services for Sheffield People.

4 Recommendation

That the Scrutiny Committee receives this report and offers its views and comments and any requests for further information to the officers present.

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 12th April 2017

Report of:	Shaping Sheffield – Scrutiny Members Working Group
Subject:	SHAPING SHEFFIELD: THE PLAN – SCRUTINY MEMBERS WORKING GROUP RECOMMENDATIONS
Author of Report:	Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee Shaping Sheffield Scrutiny Members Working Group

At its meeting on February 8th 2017 the Scrutiny Committee received a report from council officers recommending it offers its support to *Shaping Sheffield: The Plan*, which has been jointly produced by Sheffield City Council officers and NHS bodies in Sheffield.

The committee expressed concerns about the plan and established the Members Working Group to further examine the document.

The Members Working Group reaffirmed the view expressed in committee that there is a welcome intention behind the plan – the achievement of better coordination on health and care challenges between the Council, the NHS and the wider community. Given the severity of these challenges it is very important, as has been recognised, to win public support for *Shaping Sheffield.*

The Working Group have now drafted their recommendations, these are being shared with the scrutiny committee for approval, to be forwarded to Sheffield Place Based and Director Leads.

The Scrutiny Committee is being asked to:

- Approve the draft recommendations to be forwarded **(Appendix A)** and provide any comment / feedback

Category of Report: OPEN

All-party Scrutiny Members Working Group Response to *Shaping Sheffield: The Plan*

Purpose

1. This paper has been developed by an all-party Scrutiny Members Working Group from Sheffield City Council, a sub-group of the **Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee**, acting as a critical friend to recommend some improvements to *Shaping Sheffield: The Plan*. These recommendations focus particularly on seeking to make it more accessible to the public (who will need to support it) and to strengthen accountability within it so that achievements can be better monitored and met. The following provides the comments and recommendations from the Scrutiny Working Group.

Introduction

2. Achieving better co-ordination on the health and care challenges between the Council, the NHS and the wider community is necessary. Given the severity of these challenges it is very important to win public support for *Shaping Sheffield*. However, we need a clear understanding as to how this can be achieved and the *Shaping Sheffield* strategy as it currently exists has some significant issues with its ability to do this.
3. The plan lacks clarity, alternating between too much and too little detail, and offering too much commentary with too few measurable targets. Issues of language and structure are not just formal, but have a substantive impact given the recognised need for the plan to be accessible for the public and wider community. Making sure that commitments are measurable is particularly important in terms of scrutinising the plan's implementation in coming years[1].
4. It is recommended that the plan be revised to ensure that it is clear, concise, precise and measurable throughout.

Detailed recommendations

5. The purpose of *Shaping Sheffield* is to provide a clear expression of the strategy and what will happen to health and social care as a result. This purpose should be kept firmly in mind; other documents, such as the Memorandum of Understanding that will be produced, can contain the technical detail, but from this document the public want to be able to gain an understanding of the significant elements of the plan without confusing additions.

[1] A task that will be undertaken by the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

6. The plan and appendices should be significantly more concise. Much of the length results from repetition and issues of structure.
7. The use of graphics, illustrations and diagrams should be re-thought. Often these are decorative rather than aids to understanding.
8. The background context on the city of Sheffield is unnecessary for a Sheffield-based audience and contributes unnecessarily to the length and complexity of the document. Descriptions of Sheffield and its background should be kept to a minimum and greater explication instead provided of the impact of changing demographics, changing medical technology, and financial constraints. In particular funding issues for health and social care services need to be addressed more clearly.
9. The plan should include an executive summary and/or an introduction which clearly articulate in precise, clear language what *Shaping Sheffield* means for the city.
10. Many of the more concrete proposals and commitments are included in the appendices. These should be incorporated into the main body of the report.
11. Commitments in the plan should be restated with a clear actor, outcome, and timescale, avoiding the use of 'we' without definition. This will make it easier to measure the implementation.
12. The special commitments which *Shaping Sheffield* sets out should be picked out and explained clearly, using realistic and finite language, avoiding infinite terms ("radical upgrade") and statements with which nobody would disagree ("seek to be ambitious, learning from each other and our partners") but which are vague and difficult to measure.
13. The section on Governance is important, but not structured clearly. It needs to offer clear signposting to those decision-makers who are accountable for different decisions, so that individuals or groups know who they should approach.
14. The statements in the plan need to be meaningful. What new and different actions are involved in 'tackling inequalities head on'? What is a 'single risk stratification process', and what difference will it make to the public? What will the public see different as a result of 'neighbourhood working'? In addition, case studies of particular services, with a 'before and after' view, would be helpful.
15. The imprecise statements of the plan create contradictions that are hard to untangle: for example, it is stated that we will have midwives in every community, but also that disproportionate investments will be made in areas with most need. What will the result of these two principles look like concretely? (p.12)
16. We are concerned about the statement on Financial Strategy (p.13). The opening statement offers strong commitments which we were unsure could be guaranteed. We have significant issues with the wording of this and other paragraphs and will compromise our (the council's) credibility.
17. Acronyms (e.g. 'PBR' instead of Payment by Results) should be eliminated wherever possible.
18. Finally, the timetable contained in the document needs to be amended to be realistic.

Further comments and suggestions on specific parts of the document

19. Aims (p.8): need to be tightened as they are currently too general and therefore difficult to build plans on.
20. Vision (p.9): Sentences (plain English) need to be there to back up the graphics.
21. Overview and Impact (p.10): Mostly graphics which add little to the narrative; suggest they are deleted or moved to appendices.
22. Plan on a Page (p.11):
    a. Needs to be strengthened into a measurable plan, including a section for each of the comments outlining: the challenge; how this will be met; how success will be measured; how it will be reviewed.
    b. Remove reference to record on systems leadership
    c. All needs to be in plain English
23. Overview (p.12):
    a. Needs to be edited down to eliminate repetition
    b. What is a single risk stratification process?
    c. How are we to invest in neighbourhood working and what does it mean?
    d. What is being suggested reference to trying to tackle inequalities 'head on'?
    e. Reduce apparent contradictions with greater explanation e.g. reference to having midwives in every community and disproportionate investments in areas most in need (also see recommendation 15 above)