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.