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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 19 July 2017 at 5.00 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, Steve Ayris, David Barker, Lewis Dagnall, Tony Downing, Mike Drabble, Adam Hurst, Dianne Hurst, Talib Hussain, Douglas Johnson, Richard Shaw and Garry Weatherall

Healthwatch Sheffield
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
19 JULY 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 Meetings (Pages 5 - 20)
To approve the minutes of meetings of the Committee held on:-

a) 15th March, 2017
b) 12th April, 2017
c) 17th May, 2017

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

7. Oral and Dental Health in Sheffield (Pages 21 - 56)
Joint report of the Director of Public Health, Public Health England, University of Sheffield and NHS England

8. Draft Work Programme 2017/18 (Pages 57 - 66)
Report of the Policy and Improvement Officer

9. Date of Next Meeting
The next meeting of the Committee will be held on Wednesday, 20th September, 2017, at 5.00 pm, in the Town Hall

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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

Meeting held 15 March 2017

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

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe and Clive Skelton

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Zahira Naz and Garry Weatherall.

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 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The Committee approved the minutes of its last ordinary meeting held on 11th January 2017.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 Mike Simpkin questioned when the minutes of the Committee's special meeting held on 8th February 2017, to consider the Sheffield Place Based Plan/South Yorkshire and Bassetlaw Sustainability and Transformation Plan, together with the summary response of the Committee's Task and Finish Group, on this issue, would be publicly available so they could be shared at the two forthcoming public consultation meetings organised to consider the Plan.

5.2 The Chair stated that it was hoped that the minutes would be published as soon as possible.

6. ADULT SOCIAL CARE PERFORMANCE

6.1 The Committee considered a report of the Director of Adult Services, providing an update on Adult Social Care Performance in Sheffield. The report was supported by a presentation by Phil Holmes (Director of Adult Services) and attached, as appendices, Sheffield's Independent, Safe and Well report, which provided an overview on how the Council performed in terms of adult care and support in 2015/16 and a paper setting out detailed statistical information, as part of the Adult Social Care Outcomes Framework (ASCOF) in terms of performance outcomes.

6.2 As part of the presentation, Phil Holmes referred to the Independent, Safe and Well report, then provided a summary of performance, referring to the ASCOF, which provided a set of outcomes that helped the Council to know how it was performing. Mr Holmes stated that performance had generally been very poor, particularly in comparison with other authorities, and he referred to performance data in terms of four specific themes, which he considered would provide a general view in terms of overall performance. The four themes referred to ensuring quality of life for people with care and support needs; delaying and reducing the need for care and support; ensuring that people have a positive experience of care and support; and safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm. Mr Holmes stated that, whilst accepting that performance had been very poor, and that austerity should not be used as an excuse on the grounds that other authorities were facing similar budget difficulties, he hoped that the information, and format it was presented in, provided an open and fair picture of the current position.

6.3 Mr Holmes referred to statistics in terms of how the performance outcomes had affected different groups of people in the City, and reported on a series of actions which were required, together with target dates, with regard to performance improvement. He stated that there were a number of structural issues within Adult Services, which had not been addressed, together with historic issues regarding poor leadership and management, which had resulted in a lack of improvement.

6.4 Members of the Committee raised questions, and the following responses were provided:-

- It was accepted that the changes and improvements required would take some time to implement. It was also accepted that there had been issues in terms of systems and processes used, with some being deemed far too bureaucratic and which, ultimately, had been the responsibility of management. The general view of staff was that systems and processes were not working well, and required improvement. A number of smaller improvements had already been made, but some of the larger complex changes, such as the overhaul of all processes to bring in a new case management system, would take much longer. Management was very aware of the need, as part of the implementation of the new case management system, to ensure that the views of front-line staff and users were taken into account in terms of its design.

- It would take time to significantly improve performance from such a low base on the basis that it was imperative that all the fundamentals were in place, including the Council's relationships with its partners and the manner in how

front-line staff undertook their day-to-day duties. It was planned that the new case management system would be in operation with effect from April 2018.

- A number of other local authorities only had one Resource Allocation System, whereas Sheffield had three – Adults, Learning Disabilities and Mental Health. It was agreed that there was a need to review this, in the light of the need to find a consistent approach in terms of how the Council allocated its resources.

- It was agreed that there was a need to simplify the review process, mainly by reducing the number of questions service users were being asked to answer on the questionnaires, and making the questions more simple.

- It was accepted that there was a need to provide service users with more flexibility in terms of how they used their direct payments, and it was acknowledged that a low number of service users experienced sufficient control in terms of how they used such payments.

- Consideration would be given, as part of contract negotiations with home care providers, to ensure that the length of time carers allocated to visits commenced once they had entered the service user's property. In a lot of cases, carers would build in travel time, and time it took them to get into a property, which in turn, reduced the amount of time providing care for the user. Also, consideration would be given to looking at the time of home care visits, in the light of the fact that it was currently not possible, within the 20 minute time limit, for the carer to prepare a home cooked meal, resulting in a number of users not receiving adequate nourishment.

- Whilst the Council had no powers to instruct care providers in terms of pay rates for front-line staff, there was a statutory requirement on such providers to pay staff the minimum wage. As commissioners, the Council could negotiate with regard to travel time between calls in order to allow for more time with the service user. It had also been acknowledged that there was a need for improved training for care workers.

- In terms of the ASCOF Scores Summary, the three different colours, representing the 'traffic light' system, referred to the percentage rate of change in terms of the different measures, whereby red indicated worse, green better and amber the same.

- The reason for the percentage figure of the Theme 4 indicator (Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm) differing from the figure set out in the Independent, Safe and Well report was because in the Theme 4 indicator, the figure related to the proportion of people who use services who feel safe (63%) and in the report, it related to people who say the services they use make them feel safe (87%).

- In 2016/17, there had been a significant increase in the pay rates for care workers, and it was believed that such an increase had been linked to a reduction in the number of complaints received with regard to the quality of care provided. However, there were still a number of sustainability issues that

needed addressing. Details of pay rates of the different care providers used by the Council could be provided to Members.

- It was hoped that by working closely with the NHS to ensure the right supply of services, and to manage demand better, and by increasing pay rates for home care staff, increasing the number of care providers the Council worked with, and improved commissioning arrangements in terms of care providers, improvements would be seen in terms of the provision of adult social care in the City.

- Serious consideration was given to instances where care staff were rude to service users, and it was considered that, in such cases, it was not always simply due to the care worker's actions, but more down to the management regime. It was accepted that some fundamentals were still not right, and needed addressing.

- The best way to relieve pressure on the care home system was to improve all elements of homecare provision, including the provision of adequate nourishment in terms of meals. It was important that people were made aware of what help was available to them, and it was also important that younger people received adequate care, with the Council undertaking all its statutory obligations under the Children and Families Act, to ensure that the transition from under 18 to adult care went as smooth as possible.

- In terms of identifying those people who required care, it was accepted that there was a need for improved locality working, and provision of help and advice to ensure as many people as possible were aware of what care was available for them.

- In terms of the Council's commissioning model, a considerable amount of work had recently been undertaken in connection with assessing the actual cost of care provision, and efforts were now being made to learn from past errors.

- Every effort was made to ensure that care providers had all the necessary experience and knowledge in order to provide good quality training for their staff. Every effort was made to ensure that training was provided by people with the relevant experience.

- Details of those care providers who had had their contracts withdrawn following a failure in standards, could be forwarded to Members.

6.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, the Independent, Safe and Well report on Adult Care and Support in Sheffield 2016, the performance statistics in connection with the Adult Social Care Outcomes Framework, and the responses provided to the questions raised;

(b) whilst welcoming and appreciating the open and transparent format of the

information provided, together with the information now reported by the Director of Adult Services in terms of the performance of Adult Social Care in the City, expresses serious concerns in terms of the performance, which it considers totally unacceptable and reflects poorly on the City as a whole; and

(c) requests the Director of Adult Services to:-

(i) submit a report to the Committee, in six months' time, providing an update on the progress of the proposed improvements to the Service; and

(ii) provide more information for Members, in three months' time, on the new Case Management System.

7. QUALITY CARE PROVISION FOR ADULTS WITH A LEARNING DISABILITY IN SHEFFIELD - UPDATE ON IMPROVEMENTS

7.1 The Committee received a report of the Director of Adult Services providing an update on improvements with regard to quality care provision for adults with a learning disability in Sheffield.

7.2 In attendance for this item were Phil Holmes (Director of Adult Services) and Andrew Wheawall (Head of Mental Health/Learning Disabilities and Transition).

7.3 The report indicated that, in mid-2013, following changes in management arrangements, concerns had been raised about the quality of care within residential, short break and day services for adults with learning disabilities provided by Sheffield Health and Social Care NHS Foundation Trust (SHSC) and the City Council. Both organisations carried out extensive investigations that resulted in detailed improvement plans, and the Committee had asked for feedback on progress in January 2016, and further requested an update be provided in early 2017 in order to ensure that the Council was maintaining its focus in this area. The report contained a summary of outstanding actions reported to the Committee in January 2016, together with details of action taken, and details with regard to future areas for development in 2017.

7.4 Members of the Committee raised questions, and the following responses were provided:-

- There were adequate systems in place to ensure that the needs of younger people were properly assessed to ensure that their transition to Adult Social Care went as smoothly as possible. The Service would continue to look at what processes could be put in place to make such transition even smoother.

- Recent surveys in respect of the quality of respite care and short-term placements provided in the City had resulted in very positive feedback.

- Although it should not be the case, and it was not Council policy to do so, the Council was still using out of City placements for people with autism. There

was a need for transformational work to be undertaken in order to try and ensure such people were brought back to the City. More effort was required to ensure that such people were removed from institutionalised settings.

- It was acknowledged that a high number of people with learning disabilities were given work placements in charity shops. Such placements were supported by both the Council and the charity shops on the basis that they were viewed as suitable placements for them, and could help in the development of their social skills, prior to them moving on to other jobs.

7.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses provided to the questions raised; and

(b) welcomes the improvements made in terms of quality care provision for adults with a learning disability in Sheffield.

8. WORK PROGRAMME 2016/17

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

8.2 The Committee were asked to prioritise items for consideration at its last meeting of the Municipal Year 2016/17, on 12th April 2017, and agreed that the agenda for that meeting should comprise a report on Dental Access and Dental Health, the Public Health Strategy for Sheffield, a review of the Committee's Work Programme for 2016/17, and a briefing paper on Community Pharmacy in 2016/17 and Beyond – National Contract Changes.

8.3 RESOLVED: That with the suggestions now made, the Committee notes its Work Programme for 2016/17, now submitted.

9. NHS ENGLAND - NATIONAL CONSULTATION ON ITS PROPOSALS FOR THE FUTURE COMMISSIONING OF CONGENITAL HEART DISEASE SERVICES

9.1 The Committee received and noted a report of the Policy and Improvement Officer containing details of a national consultation, launched by NHS England, on 9th February 2017, on its proposals for the future commissioning of Congenital Heart Disease Services. The report contained a link at which details of the consultation could be accessed.

10. DATE OF NEXT MEETING

10.1 It was noted that the next meeting of the Committee would be held on Wednesday, 12th April 2017, at 4.00 pm, in the Town Hall.

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

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 12 April 2017

PRESENT: Councillors Pat Midgley (Chair), Sue Alston (Deputy Chair), Pauline Andrews, David Barker, Lewis Dagnall, Adam Hurst, Douglas Johnson, Zahira Naz, Bob Pullin, Peter Rippon and Garry Weatherall

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Mike Drabble, Moya O'Rourke and Gail Smith.

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 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the Special Meeting of the Committee held on 8th February 2017, were approved as a correct record and, arising from their consideration, it was noted that, in relation to paragraph 5.6(c)(iii) (Shaping Sheffield – The Plan), consideration would be given to inviting a group of grassroots practitioners to address a future meeting of the Committee in relation to their work and that this would be added to the Committee's Work Programme.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 In response to a question from Mike Simpkin (Sheffield Safe Our NHS) regarding the Urgent Primary Care Review, the Chair (Councillor Pat Midgley) indicated that the issues raised in the question would be covered in the forthcoming presentation on the Review.

6. URGENT CARE STRATEGY - SHEFFIELD CLINICAL COMMISSIONING GROUP

6.1 The Committee received a presentation, given by Kate Gleave (Sheffield Clinical Commissioning Group (SCCG)) on Reviewing Urgent Primary Care across Sheffield. Also present for this item were Dr Marion Sloane, Eleanor Nossiter and Alistair Mew (SCCG).

6.2 The presentation covered definitions, a current overview of Urgent Primary Care in Sheffield, details of the opening hours of the various facilities, key issues, adjusting investment to meet patient need, what it was desired to achieve, the process, development of options and plans for consultation.

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

- There was some flexibility in the approach to an Urgent Care Strategy, but the main feature was ensuring that it worked for Sheffield.

- All stakeholders would be included in the consultation process.

- Those involved in the development of the Urgent Care Strategy were very aware of issues such as the reduction in inequalities, the need to stop people who required Primary Care going to A&E and making the Strategy sustainable.

- With regard to the participation in consultation of those who didn't speak English, a consistent approach with set questions was to be used, together with face to face contact with members of the Roma and Asian communities. Interpreters would also be used in this regard.

- It was planned to consult over the period of June to September and, even though this was over the Summer holiday period, officers were confident that a targeted approach would reach the relevant people. It should be noted that there were timescales to work to in developing the revised options for Urgent Primary Care and also contract related issues. It was also preferable to consult during the proposed time as, in the period September to March, providers needed to focus on care delivery.

- The language and communication needs involved in the consultation were recognised.

- The decision as to what was urgent would be arrived at after discussion between the patient and the relevant professional. How this contact would be managed would come out in the options.

- The results of the consultation would be shared for comment.

- Consideration would be given to the further involvement of the Police and Fire and Rescue Service in the engagement process, to inform the development of options.

- There was a long list of options which were being worked through with providers, but it was necessary to await the outcome of the public engagement process. No decisions had been made yet, but it was likely that a model of care would be developed, with the options focusing on the types of service to be delivered.

- In relation to service entry points, consideration would have to be given as to whether services could be linked together or provided at one central facility.

- The options would be brought to this Committee when they had been developed, with one of the aims making it more simple as to where people should go to access Urgent Care services.

- It was hoped that health care records could be shared, so that patients would not have to continually repeat their health histories.

- Professionals would engage with patients in relation to care planning.

- Whilst active support and recovery was outside the scope of the review, there was an interdependency in that it impacted upon Urgent Care responses.

- Officers were working with independent people and organisations such as Healthwatch in relation to the conduct of the consultation process.

- A wide range of individuals would be included in the consultation, including those living on travellers sites.

- The way in which other areas dealt with Urgent Care had been looked at, but it was important that the review had a local focus.

- Officers had had their first meeting with a wide range of providers, including GPs and local representatives, on the previous day.

- It was important to get people to the right service and how this was managed needed to be addressed. It was recognised that people were accessing different services as they were unable to get appointments with their GP. There was a need to manage more appointments during the day and when the options had been shared, it would be possible to have a more constructive conversation on appointment waiting times.

- In relation to timescales, the SCCG needed to make a decision on the options for consultation on 25th May 2017, so that the consultation could take place between June and September 2017. There would then be a period of reflection, with the options being presented to the Governing Body in October 2017. Implementation of the options would then be considered and a period of 3 to 12 months' notice may be needed for this if providers needed to make any changes.

- In relation to GP access, it was recognised that a more urgent response was

required.

- Coverage of neighbourhood services was worked out between the local GP practices.

- It was not always necessary for someone to see a GP and it may be that someone such as a pharmacist may be a more appropriate point of contact. In some cases, practice care navigators were used and in these instances the patient would be directed to the appropriate service.

6.4 In summing up, the Chair (Councillor Pat Midgley) stated that the Committee wanted to work with the SCCG in the development of the review of Urgent Primary Care, adding that further areas for consideration could include the provision of some night duty service in the neighbourhoods, engagement with a wide range of people in the consultation process, the addressing of delays in obtaining GP appointments, inequalities, particularly in relation to those who did not speak English, and the inclusion of projects working alongside public health in the process.

6.5 RESOLVED: That the Committee:-

(a) thanks those attending for their contribution to the meeting;

(b) notes the contents of the presentation, Members' comments and the responses to questions; and

(c) requests that an update on progress on the development of the Urgent Primary Care Review be circulated to Committee Members following the end of the consultation period in September 2017.

7. PUBLIC HEALTH STRATEGY FOR SHEFFIELD

7.1 The Committee received a report of the Director of Public Health on the Public Health Strategy which had been agreed by Cabinet. The report was presented by Louise Brewins (Head of Public Health Intelligence) who made particular reference to the Strategy's public health focus, the adoption of the concept of Health in All Policies and the ten priorities outlined in the report. She also directed Members to the eight ideas to develop implementation.

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

- Building Health Impact Assessments into the decision making process was one of the first things it was desired to implement. Identifying conflicts in the process was also important.

- It was acknowledged that there was a gap with regard to children of school age in the Strategy.

- All Council services would be encouraged to consider the health benefits of

their actions.

- Improving air quality ticked a number of outcomes in improving health.
- School was an important setting for the promotion of public health, with documents being tailored to different age ranges.
- Black and minority ethnic groups were targeted in terms of vulnerability and need.
- Work had been undertaken in relation to sport and activity.
- Members' comments on smoking and drinking were noted, as were their comments on integrating public health impacts into the Scrutiny process.
- The inclusion on reports of a tick box referring to the health impacts of decisions, was worthy of consideration.
- Conversations were taking place as to the best way for the Senior Leadership Team to lead the Strategy.

7.3 RESOLVED: That the Committee:-

(a) thanks Louise Brewins for her contribution to the meeting;

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

(c) welcomes the Public Health Strategy in its promotion of public health in the City; and

(d) requests that Committee Members e-mail their preferences in relation to the ten priorities listed in the report to the Policy and Improvement Officer.

8. HOME CARE TASK GROUP - FORMAL RESPONSE

8.1 The Committee received a report of the Director of Adult Services which set out the responses to the recommendations made by the Committee's Home Care Task Group. The report was presented by Ian Ramshaw (Interim Head of Commissioning) who went through each of the recommendations in turn, together with the responses to each of them. In some cases this described work that had already taken place, was underway or planned. He concluded by indicating that good progress was being made and that there were robust plans to go forward.

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

- There was a move away from short call times and the home care workers undertook other tasks whilst the patient was occupied with such matters as eating or going to the toilet.

- It was recognised that the Social Workers and Care Managers in the localities had a better knowledge of what was locally needed.

- People were entitled to have gender specific carers and if this was not the case then it should be reported to the appropriate people.

8.3 RESOLVED: That the Committee:-

(a) thanks Ian Ramshaw for his contribution to the meeting;

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

(c) welcomes the progress being made with regard to the recommendations of the Committee's Home Care Task Group; and

(d) requests that:-

(i) any issues arising with regard to the implementation of the recommendations within the next six months be the subject of a short report to be submitted to the Committee; and

(ii) details of the geographical locations of Home Care service providers be sent to the Policy and Improvement Officer for circulation to Committee Members.

9. SHAPING SHEFFIELD SCRUTINY MEMBERS' WORKING GROUP

9.1 The Committee received a report of the Shaping Sheffield Scrutiny Members' Working Group which set out the Group's draft recommendations on the Shaping Sheffield Plan.

9.2 RESOLVED: That the Committee:-

(a) thanks the members of the Shaping Sheffield Scrutiny Members' Working Group for their work in producing the report and recommendations;

(b) approves the draft recommendations as set out in the report; and

(c) requests that these recommendations be forwarded to the Sheffield Place Based and Director Leads.

10. WORK PROGRAMME REVIEW 2016/17

10.1 The Committee received a report of the Policy and Improvement Officer which set out a summary of the Committee's activities over the Municipal Year for inclusion in the Scrutiny Annual Report 2016/17, together with a priority topic, which it was recommended for carry forward for consideration as part of the Committee's 2017/18 Work Programme.

10.2 RESOLVED: That the Committee:-

(a) thanks the Policy and Improvement Officer for the report and notes its contents; and

(b) notes that the Deputy Chair (Councillor Sue Alston) was prepared to act as the Chair's representative at the meeting of the Yorkshire and Humber Joint Health Overview and Scrutiny Committee to be held on 16th May 2017 if required, provided she was given reasonable notice.

11. DATE OF NEXT MEETING

11.1 As this was the last meeting of the Committee in this Municipal Year, the Chair (Councillor Pat Midgley) thanked everyone for their work during the year and particularly Helen Rowe (Healthwatch Sheffield), who had announced that this was to be her last Committee meeting, for her valued contribution to the work of the Committee over a number of years.

11.2 It was noted that the next meeting of the Committee would be held on a date to be arranged in the Municipal Year 2017/18.

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

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 17 May 2017

PRESENT: Councillors Sue Alston, Steve Ayris, David Barker, Lewis Dagnall, Mike Drabble, Adam Hurst, Dianne Hurst, Douglas Johnson, Pat Midgley, Richard Shaw and Garry Weatherall

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Pauline Andrews, Talib Hussain and Karen McGowan.

2. APPOINTMENT OF CHAIR AND DEPUTY CHAIR

2.1 RESOLVED: That Councillor Pat Midgley be appointed Chair of the Committee and Councillor Sue Alston be appointed Deputy Chair for the Municipal Year 2017/18.

3. DATES AND TIMES OF MEETINGS

3.1 RESOLVED: That meetings of the Committee be held on a bi-monthly basis, on dates and times to be determined by the Chair, and as and when required for called-in items.

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Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee
19th July 2017

Joint report of: Director of Public Health, Public Health England, University of Sheffield and NHS England

Subject: Oral and Dental Health in Sheffield

Authors of Report:
Sarah Robertson, Consultant in Dental Public Health, Public Health England Yorkshire and Humber
Kate Jones, Consultant in Dental Public Health, Public Health England, National Dental Team
Zoe Marshman, Reader/Honorary Consultant in Dental Public Health, School of Clinical Dentistry, University of Sheffield
Emma Wilson, Head of Co-commissioning (Yorkshire and Humber), NHS England

Summary:
Overall the oral health of people in Sheffield is improving but inequalities in oral health remain and there is still work to be done. Sheffield City Council is responsible for improving the oral health of the people of Sheffield and commissioning oral health improvement programmes and dental surveys. NHS England is responsible for commissioning dental services.

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 consider the paper and provide views and comments about the overall state of oral and dental health and dental services in Sheffield.

Background Papers: Draft Sheffield Oral Health Improvement Strategy 2017-2020 (Appendix 1)

Category of Report: OPEN

Joint report of the Director of Public Health, Public Health England, University of Sheffield and NHS England

Oral and Dental Health in Sheffield

1. Introduction/Context

This report has been requested by the Healthier Communities and Adult Social Care Scrutiny Committee, who wish to learn about the oral and dental health of children and adults in Sheffield from both a public health and NHS services angle.

It is a joint report of the Director of Public Health, Public Health England, the University of Sheffield and NHS England, reflecting the multi-sector partnership working around oral health. Sheffield's Oral Health Advisory Group includes representation from the Council, Public Health England, dental service providers, NHS commissioners and Healthwatch. The Oral Health Advisory Group meets quarterly to advise on matters relating to oral health. In addition, NHS England's South Yorkshire and Bassetlaw Local Dental Network (LDN) meets every two months to discuss oral health and dental services in Sheffield within the context of South Yorkshire and Bassetlaw and Yorkshire and Humber as a whole. Members of the LDN include NHS England dental commissioners, a dental practice advisor, dentists from primary and secondary care, a consultant in dental public health and a representative from Health Education England.

These groups recognise the importance of partnership working to improve oral health and reduce oral health inequalities. Oral health will not be improved by increasing access to dental care alone. It requires a multi-faceted approach involving evidence-based community oral health improvement supported by public engagement and addressing the wider determinants of oral health.

2. Oral and dental health in Sheffield

This section describes oral health in children and adults living in Sheffield.

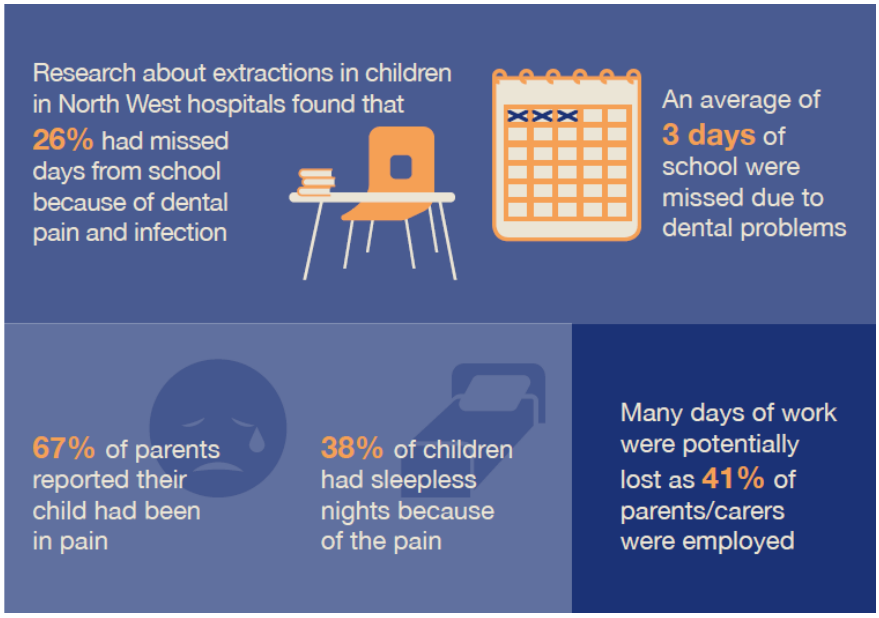
2.1 Current state of oral health and trends in oral health

Poor oral health remains a public health problem with social inequalities both in the prevalence and impact of dental diseases and in access to dental services. Poor oral health has a significant impact on both the

individual and wider society including pain, discomfort, time off work and school, self-consciousness and low self-esteem.

There are no local data for Sheffield regarding absence from school for dental reasons as this specific data is not included in the information returned by schools on pupil absence. However figure 1 provides an indication of the extent of the problem nationally.

Figure 1: Infographic showing the social impact of tooth decay in the North West



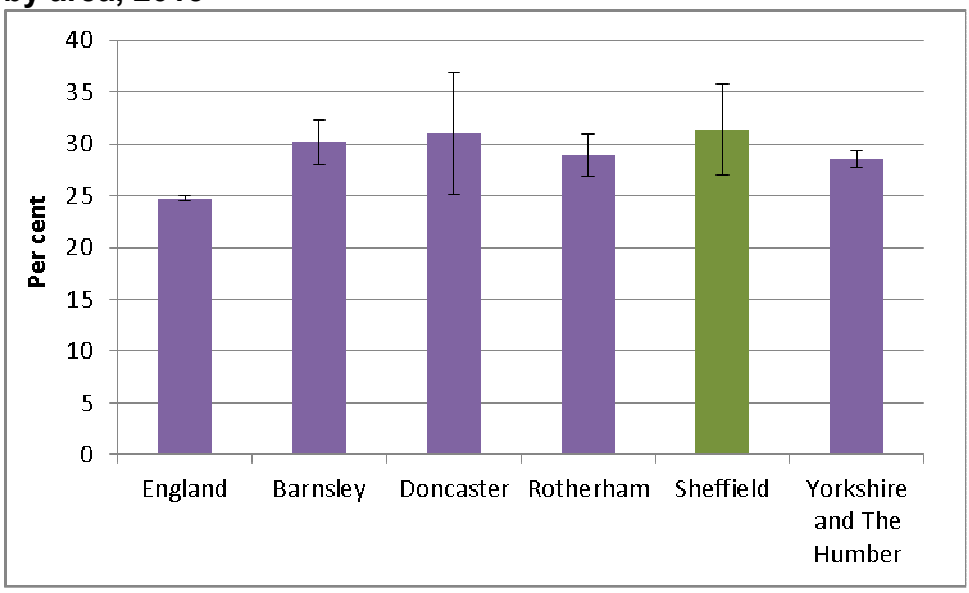
Source: PHE, 2017

The oral diseases of most public health significance are tooth decay, gum disease and mouth cancer. These diseases have the biggest impacts on individuals' lives, costs to society and are largely preventable.

Levels of tooth decay in five-year-olds are measured using the dmft index. This is the number of decayed, missing and filled primary (baby) teeth. The proportion of children with one or more decayed, missing or filled teeth is the prevalence of tooth decay experience. Local dental epidemiological surveys commissioned by Sheffield City Council provide the data for the dental indicator for the Public Health Outcomes Framework, 'the proportion of children aged five who are free from obvious tooth decay'. This indicator is used to monitor oral health improvement and the reduction of oral health inequalities at national and local levels.

Whilst children's oral health has improved over the last 40 years nationally, tooth decay continues to be a public health problem affecting 31% of five-year-old schoolchildren in Sheffield in 2015, which was higher than nationally (25%) (Figure 2). Each child with tooth decay had between three and four affected teeth.

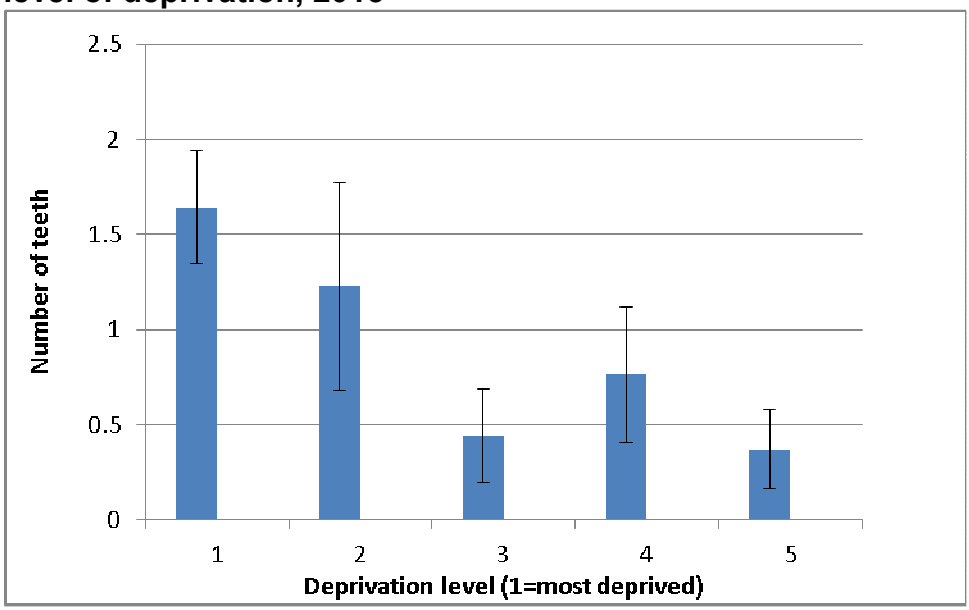
Figure 2: Prevalence of tooth decay in five-year-old schoolchildren by area, 2015



Source: PHE, 2015

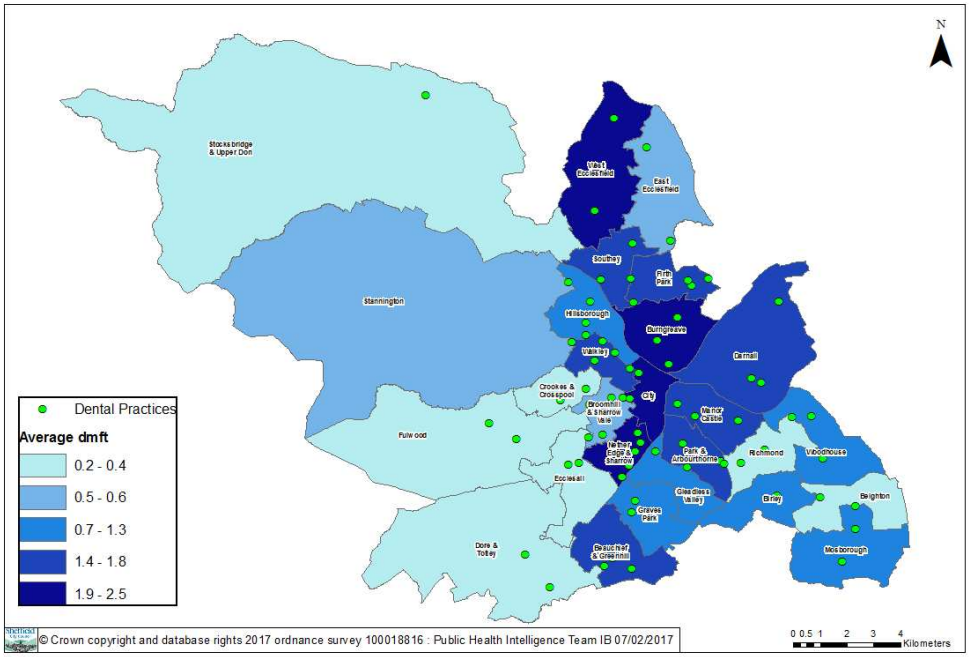
Children living in the most deprived areas of the city had average tooth decay levels that were four times higher than those living in the least deprived areas (Figures 3 and 4). Again, the proportion of children with tooth decay was higher in the more deprived areas (Figure 5).

Figure 3: Severity of tooth decay in five-year-old schoolchildren by level of deprivation, 2015



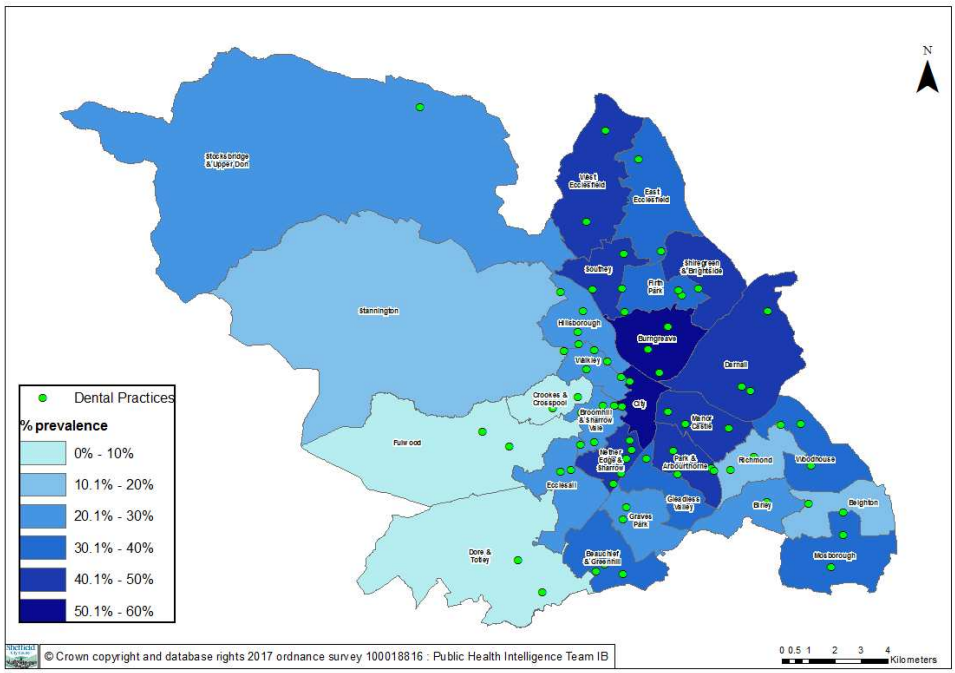
Source: PHE, 2015

Figure 4: Severity of tooth decay in five-year-old schoolchildren by ward, 2015



Source: PHE, 2015

Figure 5: Prevalence of tooth decay experience (percentage of children with tooth decay) in five-year-old schoolchildren by ward, 2015

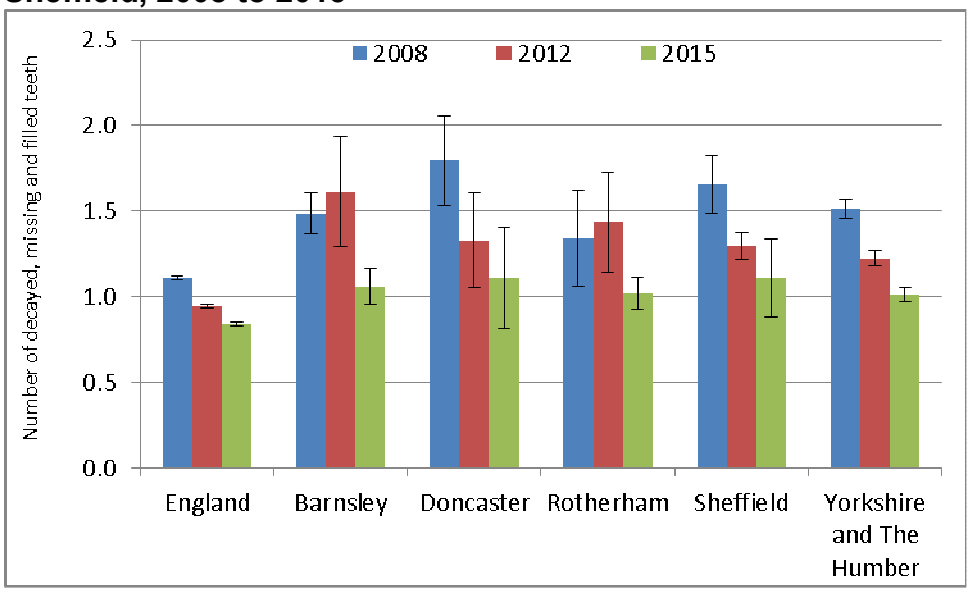


Source: PHE, 2015

Since 2008, the prevalence and severity of tooth decay in five-year-old school children has decreased (Figure 6). However there is still work to

be done to maintain these improvements and reduce the inequalities in children living in the most deprived areas of the city.

Figure 6: Tooth decay severity in five-year-old schoolchildren in Sheffield, 2008 to 2015



Source: PHE, 2015

Dental extractions are the most common reason for hospital admissions among 5-9 year olds nationally. Although recording mechanisms for the number of children undergoing tooth extraction in hospital are inconsistent, recent data from PHE (2017) suggests that in 2015/16, 995 0-19 year olds in Sheffield had a dental extraction due to tooth decay in hospital. Of these, 543 (1.6%) were aged 5 to 9-years-old and would have been likely to have had a general anaesthetic for the procedure. This was lower than figures for Rotherham (3.2%), Doncaster (3.3%), and Barnsley (2.2%) and higher than for Yorkshire and the Humber (1.3%) and England (0.7%) overall.

The oral health of adults has also improved significantly over the past 40 years as reported in the decennial UK adult oral health surveys. No local clinical dental surveys have been undertaken of adults so data on adult oral health is drawn from the 2009 national adult dental health survey, which is reported at Yorkshire and the Humber level.

In 2009 6% of adults in England were found to have no natural teeth with this figure rising to 7% in Yorkshire and the Humber. The proportion of adults with no natural teeth fell from 37% in 1968 to 6% in 2009. The fact that at least half of people aged 85 and over have retained some natural teeth has implications related to the ongoing care of a group of adults likely to be increasingly frail and with perhaps complex medical histories and difficulties accessing dental services.

Between 1998 and 2009 the prevalence of active tooth decay in adults in England fell from 46% to 28%. There were reductions across all age groups but the largest reduction was within the 25-34 year age band. The proportion with active tooth decay varied by age with the 25 to 34

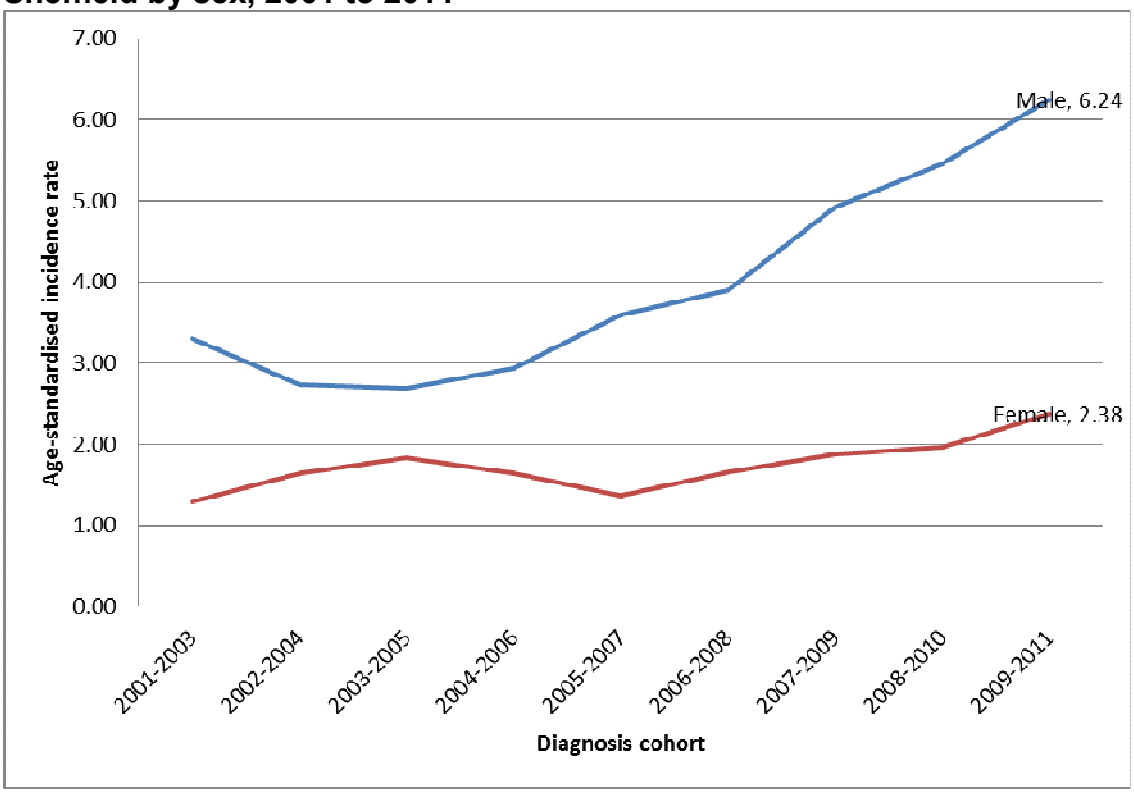
years group having the highest prevalence, 36%, and those aged 65-74 years the lowest, 22%.

In 2009, 45% of adults with some natural teeth in England had mild gum disease, 9% had moderate disease and 1% had severe disease. Between 1998 and 2009 there was an overall reduction in the prevalence of moderate disease from 55% to 45%. However for more severe forms of disease an overall increase from 6% to 9% was observed. In Yorkshire and the Humber there was a greater proportion of adults with moderate and severe forms of gum diseases relative to the national average: 42% of adults had mild disease, 10% had moderate and 2% had severe disease.

In 2008, the results of a postal survey of adult oral health showed that in Sheffield 23% rated their oral health as fair, poor or very poor compared to a regional average of 25%. In terms of the impact of the mouth on people's everyday lives 31% of adults reported pain in the last year, 34% reported difficulty eating and 30% reported being self-conscious. These figures were comparable to the regional averages.

Mouth cancers make up 1-2% of all new cancers in the UK. Although mouth cancer is relatively uncommon it has a significant impact on the lives of those people affected. Historically, mouth cancer has been twice as common in men as in women, with increasing incidence with age. However, the incidence of mouth cancer is increasing in women and is also now being seen in a younger age group. The average five-year survival rate is 50% but this increases to 80% if the cancer is detected at an early stage. The incidence of mouth cancer in Sheffield increased over the period 2001 to 2011 in both males and females (Figure 7).

Figure 7: Mouth cancer incidence rate per 100,000 population in Sheffield by sex, 2001 to 2011



Source: PHE, 2017

2.2 Causes of poor oral and dental health

The main risk factors for tooth decay are diets high in sugars and lack of exposure to fluoride. The main risk factor for gum disease is poor oral hygiene. The main risk factors for mouth cancer are use of tobacco combined with alcohol consumption. These two factors act synergistically and this multiplies the risk of mouth cancer. Mouth cancer is also linked with poor diet and infection with the Human Papilloma Virus (HPV) transmitted through oral sex.

Given that poor diets, tobacco and alcohol are all significant risk factors for poor oral health and also the determinants for a number of other chronic diseases, activities to improve oral health will contribute to the general health and well-being of people living in Sheffield.

2.2.1 Preventing tooth decay

Fluoride remains the most effective means of preventing tooth decay. It strengthens teeth and makes them more resistant to decay. To continue to see improvements in tooth decay levels in children we need to provide more intensive exposure to fluoride as children grow up, both at home, at nursery, at school and in the dental practice. This could be through brushing with fluoride toothpaste, application of fluoride varnish to teeth and water fluoridation.

Reducing the amount and frequency of consumption of dietary sugars will also help prevent tooth decay along with reducing the risk of obesity which is associated with greater risks of developing type 2 diabetes, hypertension, coronary artery disease and cancer. Concerted action to reduce sugar consumption is recommended by the Scientific Advisory Committee on Nutrition (SACN), the World Health Organization (WHO), Public Health England (PHE) and the UK Public Health Forum. Actions to reduce dietary sugars include lowering the amount of free sugars in food and drinks, restricting the marketing and promotion of sugar-containing products, reducing the amount of sugar-containing food and drinks sold, advising, educating and helping people to consume less sugar and reducing the amount of sugar produced. In July 2015, SACN published a comprehensive review of the scientific evidence on carbohydrates and health which recommended that the average population intake of free sugars should not exceed 5% of total dietary energy for age groups from two years upwards. Importantly, the emphasis in the report was on the need to reduce total consumption of free sugars, which include not only monosaccharides and disaccharides added to foods and drinks by the manufacturer, cook or consumer but also sugars naturally present in honey, syrups, fruit juices and fruit concentrates.

In August 2016, government set out its approach to reduce the prevalence of childhood obesity in *Childhood obesity: a plan for action*. A key commitment in the plan was to launch a broad, structured sugar reduction programme to remove sugar from everyday products. All sectors of the food and drinks industry are challenged to reduce overall sugar across a range of products that contribute most to children's sugar intakes by at least 20% by 2020, including a 5% reduction in the first year of the programme. This can be achieved through reducing sugar

levels in products, reducing portion size, or shifting purchasing towards lower sugar alternatives. Another key commitment was the introduction of a soft drinks industry levy, which is being developed by HM Treasury. The levy, which is aimed at the producers and importers of added sugar soft drinks, is designed to encourage producers to reformulate their overall product ranges by reducing added sugar content, helping customers choose low/no added sugar products and by reducing portion size. PHE is also committed to helping consumers make healthier choices, which can increase the demand for lower sugar products. Public health social marketing campaigns, including Change4Life and the Be Food Smart campaign are helping to raise awareness of the sugar levels in foods and encourage people to swap to lower sugar alternatives.

2.2.2 Preventing mouth cancer

Mouth cancer may be prevented by not smoking or chewing tobacco, gutkha/paan, limiting alcohol consumption and eating a healthy diet. The risks from HPV may be reduced through the HPV immunisation programme, although this is currently only offered to girls between the age of 12 and 13 years primarily to tackle cervical cancer.

2.2.3 Universal and targeted approaches to prevention

Inequalities persist across socio-economic groups despite an overall improvement in oral health. A key priority is to reduce oral health inequalities while promoting oral health improvement for all.

Oral health inequalities, to a large extent, are avoidable. A reduction in inequalities will be seen when the oral health of those in more deprived areas improves at a faster rate than that of those in less deprived areas. Oral health initiatives which have a population-wide approach as well as a targeted approach will help improve oral health overall, while investing additional resources in more deprived areas will help reduce inequalities. This approach has been called 'universal proportionalism' in a report called *Fair Society, Healthy Lives* (Marmot, 2010). Focusing solely on the disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

Reviews of clinical effectiveness by National Institute for Health and Care Excellence (NICE) and Public Health England have found that the following oral health improvement programmes effectively reduce tooth decay in five-year-olds and provide a return on investment: targeted supervised tooth brushing programmes; targeted fluoride varnish programmes; water fluoridation; targeted provision of toothbrushes and toothpaste by post and by health visitors.

1. Responsibilities of Sheffield City Council for oral health improvement, dental surveys and water fluoridation

Prior to April 2013, oral health improvement, dental surveys and dental services were the responsibilities of Primary Care Trusts (*Functions of Primary Care Trusts (Dental Public Health) (England) Regulations 2006 SI 185).* From April 2013, local authorities became responsible for

improving the oral health of their communities and for commissioning oral health improvement services *(NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 SI 3094)* and are monitored on their progress as part of the public health outcomes framework through the rate of tooth decay in five-year-old children.

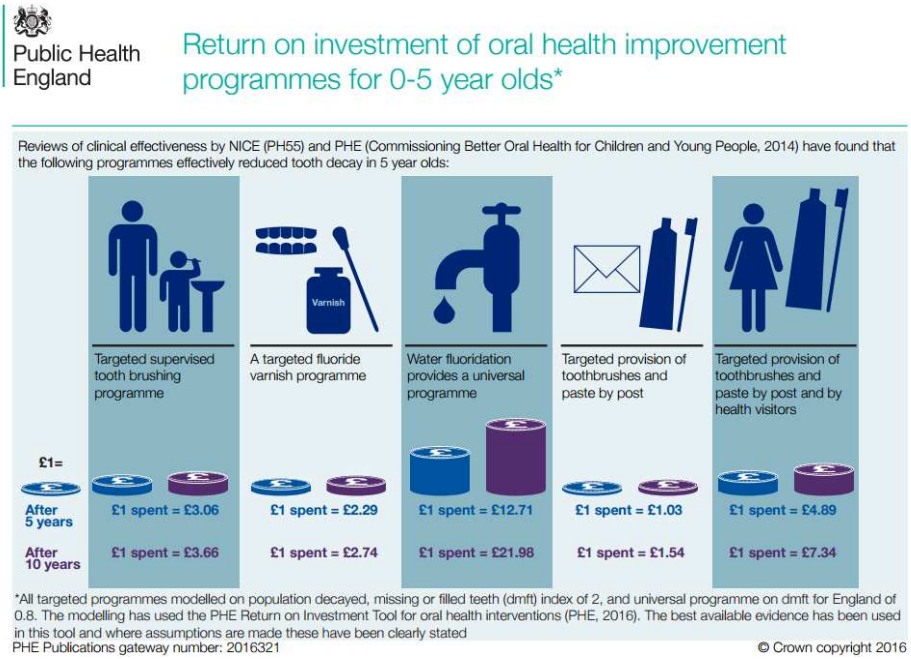
3.1 Sheffield City Council Oral Health Improvement Strategy

Oral health improvement activities have been implemented according to the Sheffield City Council Oral Health Improvement Strategy 2014 to 2017. The strategy was developed by the Council, Public Health England, the local NHS, dentists and Healthwatch. The strategy focused on improving exposure to fluoride, reducing exposure to sugars and tobacco and partnership working to improve oral health using a combination of universal and targeted population approaches.

There have been improvements in children's oral health in Sheffield during the period of this strategy and the ambitions for oral health improvement were achieved. Progress against the strategy was measured by the average number of decayed, missing and filled teeth in five-year-old children and maintaining this at or below the 2011 figure of 1.30 whilst reducing the levels of tooth decay in schoolchildren living in the 20% most deprived areas of Sheffield from 1.94 to 1.80. In addition there was a target for the oral health improvement service provider to achieve and this was for the proportion of five year old children with tooth decay to be less than 36%. All of the targets were met. The average number of decayed, missing and filled teeth in five-year-old children reduced to 1.1, the proportion of children with tooth decay reduced to 31% and the average number of decayed, missing and filled teeth in five-year-old children living in the 20% most deprived areas reduced to 1.60.

Whilst the strategy and monitoring focused primarily on improving the oral health of children and young people, this will have a positive impact throughout the life course (Fisher-Ownes, 2007) and this fits with the Council's Best Start Strategy. Return on investment of oral health improvement programmes for 0 to five-year-olds is shown below (Figure 8).

Figure 8: Return on investment of oral health improvement programmes infographic



Source: PHE, 2016

A refresh of the oral health improvement strategy has been drafted to build on this progress (appendix 1) and in summary includes:

- **Distribution of tooth brushing packs**

Currently 9,000 tooth brushing packs are distributed annually as part of the Baby's Teeth, Healthy Teeth scheme by members of the health visiting team at 12 months universally to all children in Sheffield and are also targeted to 2 year olds in the most deprived areas based on the 20% most deprived lower super output areas. In future, this scheme will be integrated into the Healthy Child Programme and a detailed plan has been developed. The return on investment of distributing tooth brushing packs has been estimated at £7.34 for every £1 spent over a 10 year period.

Over the past year 600 tooth brushing packs and oral health training have been provided to Children's Centre staff across Sheffield as an adjunct to the Baby's Teeth, Healthy Teeth scheme. Future work will include delivering oral health training as part of parent workshops, parenting programmes and training updates for Children's Centre staff.

Currently 6,200 tooth brushing packs are distributed to children starting all primary schools (mainstream and special schools) in Sheffield. This is enhanced by the delivery, on a rolling programme, of training to schools. The training will continue to be supported by dental hygiene and therapy students from the School of Clinical Dentistry, University of Sheffield supported by the oral health promotion team.

Children in local authority children's homes will continue to receive quarterly tooth brushing packs and annual oral health training provided to staff.

- **Tooth brushing clubs**

Early years providers have a responsibility to promote the health of children in their setting, as set out in the Early Years Foundation Stage Strategic Framework. Good oral health can form a part of this. Targeted childhood settings such as nurseries and schools can provide a suitable supportive environment for children to take part in a supervised tooth brushing programme, teaching them to brush their teeth with fluoride toothpaste from a young age and promote tooth brushing at home.

The return on investment of supervised tooth brushing clubs has been estimated at £3.66 for every £1 spent over a 10 year period. There has been a recent expansion of the daily tooth brushing clubs in nurseries, and mainstream schools in Sheffield. There are currently 72 tooth brushing clubs in nurseries and schools in Sheffield with 4,418 children involved. This expansion has been funded for one year only. In future, an evaluation of the tooth brushing clubs will be conducted by the School of Clinical Dentistry and sources of future funding will be explored. Early Years settings will continue to be supported to establish tooth brushing clubs and to work towards achieving the Healthy Early Years Award which now includes tooth brushing club as a criteria.

In Special Schools there are tooth brushing clubs in 8 schools with 534 children taking part and further expansion is planned.

- **Water fluoridation**

All water contains the mineral fluoride naturally. Mosborough, Halfway, Beighton, Westfield, Hackenthorpe, Birley, Stothall, Waterthorpe and Owlthorpe have naturally fluoridated water albeit at sub-optimal levels for prevention of tooth decay. This area covers approximately 10% of the city. An analysis undertaken in 2008 found that neighbourhoods with above average deprivation receiving fluoridated water had significantly lower levels of tooth decay than areas of similar deprivation in Sheffield not receiving fluoridated water. Hence, even though at a sub-optimal level, fluoridated water has had a positive effect on tooth decay experience in school children living in more deprived areas in Sheffield.

Water fluoridation involves topping up the fluoride level to an amount that whilst optimal for dental health is safe. In temperate climates this is 1ppm. It is a safe and effective public health measure to improve oral health. The adjustment of the levels of fluoride in drinking water is permitted through the Water Industry Act 1991 and subsequent legislation. Following a change to the Water Act 2003, water companies are required to fluoridate water supplies if requested to do so.

Local authorities are responsible for conducting public consultation on water fluoridation schemes and for the running costs of schemes. The process for public consultation is laid down in statutory instrument. The return on investment of water fluoridation has been estimated at £21.98 for every £1 spent over a 10 year period.

The feasibility of water fluoridation is dependent on water flows and water treatment works and their accessibility. Before any discussions can be held regarding water fluoridation in Sheffield factors such as feasibility would need to be explored.

- **Increase the usage of fluoride varnish**

There is a fluoride varnish programme in Special Schools which is provided by the Community Dental Services for patients attending Woolley Wood, Norfolk Park and Talbot special schools.

The increased use of fluoride varnish in Sheffield will continue to be supported and encouraged (see section 4.1.9). This will be achieved through continued engagement with NHS England dental service commissioners, Sheffield Local Dental Committee, the community dental service and dental hospital to increase the use of fluoride varnish through provision of training and audit.

- **Improving the oral health of vulnerable adults**

Oral health training will continue to nursing staff working within Sheffield's hospitals, staff in care homes for older adults and carers of people with learning disabilities. A plan will be developed to implement the NICE guidance on oral health for adults in care homes (2016). This includes ensuring care home policies set out plans and actions to promote and protect residents' oral health, ensuring residents have an oral health assessment and oral health care plan, ensuring daily mouth care takes place and ensuring staff have appropriate training in oral care.

- **Oral health action teams**

While many of the activities described above are provided on a universal basis across the city, targeted oral health improvement work is carried out in areas of poor oral health including 'Lowedges, Batemoor and Jordanthorpe', 'Parson Cross, Longley, Foxhill, Southey Green and Shirecliffe', 'Manor, Park, Woodthorpe and Wybourn' 'Darnall, Tinsley and Acres Hill' and 'Burngreave'. Oral Health Action Teams in these areas work with existing public health, community and voluntary groups to focus activities on areas with the highest need for oral health improvement.

- **Integrating oral health into other policies and strategies**

Work is ongoing to integrate oral health improvement into existing policies and programmes such as the public health strategy, tobacco and alcohol strategies, the healthy child programme, food strategy (with a focus on reduction in sugar consumption), and care home policies through commissioning frameworks and the Maternal Health and Early Years' Delivery Plan.

4. NHS dental care

From April 2013, The Health and Social Care Act (2012) established NHS England as the single commissioner of all dental services which includes general and community dental services, urgent dental care and hospital dental services.

4.1 Primary dental care

Primary care is provided by general dental practices, community dental services and orthodontic practices.

4.1.1 General dental services

There are 70 general dental practices in Sheffield providing routine dental care. Dentists work under general dental service or personal dental service contracts and are contracted to provide an agreed annual number of Units of Dental Activity. They receive one UDA for every band 1 course of treatment, 1.2 UDAs for every band 1 urgent course of treatment, three UDAs for band 2 treatments and 12 UDAs for band 3 treatments. These reflect the time and material costs for the different complexities of treatment. The banding system will be described later.

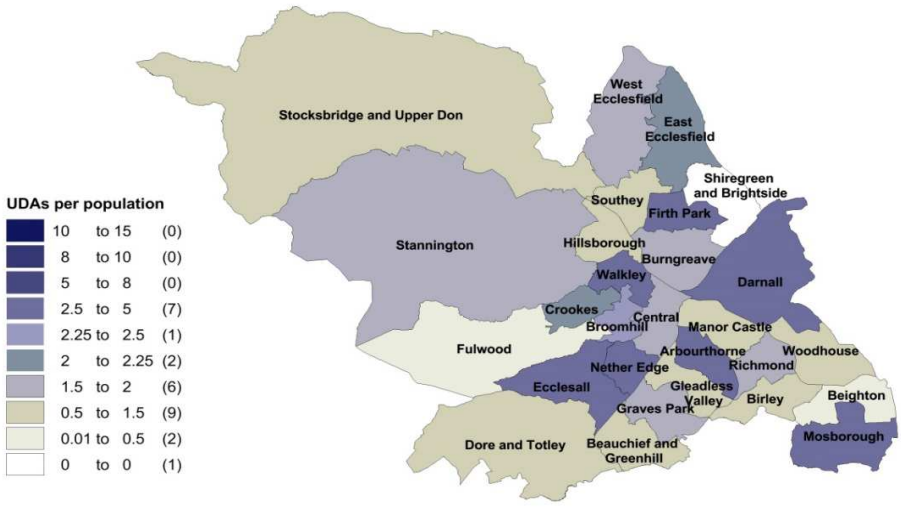
There is widespread availability of NHS dental care in Sheffield with practices distributed across all wards of the city (Figures 4 and 5). The average number of UDAs commissioned per person in Sheffield is similar to neighbouring local authorities in South Yorkshire (Table 1). More UDAs are commissioned on the east side of the city than the west, reflecting those wards which experience greater social deprivation and also poorer oral health (Figure 9).

Table 1: Average number of UDAs commissioned per person 2015/16

Area	Average no. of UDAs commissioned per person
Bassetlaw	1.5
Barnsley	2.2
Doncaster	2.1
Rotherham	1.7
Sheffield	1.9

Source: NHS England, 2016

Figure 9: UDAs commissioned per population in Sheffield by ward 2012/13



Source: PHE, 2014

General dental practices accepting new patients
Patients are no longer officially 'registered' with a dental practice, but patients tend to be associated with particular dental practices for their routine dental care.

General dental practices provide information to the NHS Choices website regarding whether they are able to take on new patients and the facilities they offer including access for disabled patients. It is the responsibility of the practice to keep this information up to date, but many practices have not done this recently. Following a recent request from NHS England to update NHS Choices, information was acquired concerning which practices are taking on new patients in Sheffield (Table 2). There are currently 26 practices taking on adults and children and three taking on children only. This situation has improved compared to previous years.

Table 2: Number of practices taking on new patients

Is the practice taking on new patients?	Number of practices
Yes taking on new patients - adults and children	26
Yes taking on new patients – children only	3
No not taking on new patients	30
No data	11

Source: NHS England, 2017

Cost of NHS dental treatment provided in general dental practice
There are three NHS charge bands and patients only have to pay one of these charges per course of dental treatment depending on the extent of their treatment requirements.

Band 1: £20.60. Includes an examination, diagnosis and advice. If necessary, it also includes x-rays, scale and polish, application of fluoride varnish or fissure sealants and preventive advice and planning for future treatment.

Band 1 urgent: £20.60. Most urgent treatments can be done in one appointment. However, if more than one visit is required and the patient returns to the same dentist to complete their urgent treatment, the Band 1 urgent charge is all that they should pay.

Band 2: £56.30 covers all treatment covered by Band 1, plus additional treatment, such as fillings, root canal treatment, gum treatment and removing teeth (extractions).

Band 3: £244.30 covers all treatment covered by Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges.

If, within two months of completing a course of treatment, the patient needs more treatment from the same charge band or a lower one such as another filling, they do not have to pay anything extra. However, after two months of completing a course of treatment, they will have to pay the NHS charge band for any dental treatment received.

Although cost may be perceived as a barrier to dental care, NHS dental care is free for people: aged under 18, or under 19 and in qualifying full-time education; pregnant or who have had a baby in the previous 12 months; staying in an NHS hospital with treatment carried out by a hospital dentist; attending an NHS hospital dental service outpatient department (however, people may have to pay for dentures or bridges). It is also free if the person or their partner (including civil partner) receive, or the person is under the age of 20 and the dependent of someone receiving: income support; income-related employment and support allowance; income-based jobseeker's allowance; pension credit guarantee credit; or universal credit and meet the criteria. It is also free for those with a valid NHS tax credit exemption or HC2 certificate and some costs may be met for those with an HC3 certificate.

4.1.2 Community Dental Services

The community dental services (CDS) in Sheffield are provided by Sheffield NHS Teaching Hospitals NHS Trust from 6 clinics across the city in Jordanthorpe, Heeley, Manor, Hillsborough, Firth Park and Wheata Place, and 3 clinics in special schools. In 2016/7 the CDS provided care for 7,356 patients for special care dentistry and primary care for groups of people who cannot be treated in the general dental services. They include children with physical or learning disabilities or medical conditions, children who are looked after or on the at risk register, children with extensive untreated tooth decay who are particularly anxious or uncooperative, adults with complex needs who have a proven difficulty in accessing or accepting care in the general dental services, including adults with moderate and severe learning and physical difficulties or mental health problems and severe dental anxiety, adults with medical conditions who need additional dental care and housebound and homeless people. Monthly clinical sessions are provided at Sheffield Cathedral at the Archer Project for homeless people. Outpatient care is provided for people with medical special needs at Charles Clifford Dental Hospital and comprehensive dental treatment under consultant-led general anaesthesia is provided for adults with special care needs at the Royal Hallamshire Hospital. Jordanthorpe clinic also provides some general dental services, and there is a cognitive behavioural therapy service for anxious/phobic adult dental patients, a sedation service and a service to Aldine House, a secure centre for children.

In 2016, the Care Quality Commission inspection rated the Community Dental Service as exceptional, particularly in terms of responding to patients' need and leadership. Family and Friends Test analysis for October 2015 showed patients were extremely likely or likely to recommend the service to family or friends.

Although most patients are exempt from paying NHS dental charges in the Community Dental Service, some patients will pay in the same way as for general dental services.

Community Dental Services across Yorkshire and Humber are currently under procurement. It is planned that by October 2018, there will be a new CDS service covering the whole of South Yorkshire.

4.1.3 Dental care in patients' homes and care homes

Fifteen of the 70 general dental practices provide domiciliary care to housebound patients within patients' own homes, residential units, nursing homes, hospitals and day centres. Sheffield is the largest provider of domiciliary care within South Yorkshire and Bassetlaw and provided 63% of all domiciliary visits in 2013/14.

In addition, 10 general dental practices and the Community Dental Service are part of the nationally renowned Residential Oral Care Sheffield (ROCS) scheme which is a comprehensive service that provides two yearly oral health screening and follow-up care and oral health promotion for people in almost all residential care homes in Sheffield. Of the 84 care homes, the Community Dental Service provides a service to five care homes and ROCS provide a service to 77 care homes. In 2013/14, 2,359 people were screened, of whom 844 required oral hygiene advice, 254 had tooth decay and 196 had other conditions. Older people in Sheffield are fortunate to benefit from the ROCs scheme, as there is no consistent care for residential homes in other local authorities.

4.1.4 Urgent care

The urgent care dental service in South Yorkshire and Bassetlaw consists of three elements: a call answering service, an appointment booking service and a clinical service. Calls are triaged through NHS 111 provided by Yorkshire Ambulance Service using national protocols. The personal details of people needing an urgent dental appointment are then emailed to the Doncaster Dental Access Centre, which is provided by The Rotherham NHS Foundation Trust. A dental care professional from the dental access centre then telephones the patient to offer an appointment at their nearest provider. The clinical service is provided in hours and out of hours by the Doncaster Dental Access Centre, Taptonville House Dental Practice in Sheffield and Wright Dental Care in Worksop on occasional weekends. There are also access appointments commissioned from dental practices in Barnsley, Rotherham, Doncaster and Bassetlaw. There are approximately 8,000 appointments per year provided at Taptonville House.

Patients pay for treatment in the same way as for general dental services.

The urgent dental care service for Yorkshire and Humber is currently under review and redesign by NHS England.

4.1.5 Orthodontic practices

There are four specialist orthodontic practices within primary care, which only provide orthodontics which is concerned with the development,

prevention and correction of irregularities of the teeth, bite and jaw. They are contracted under a personal dental services agreement and provide an agreed number of units of dental activity (UOAs). One UOA may be claimed for every assessment and 20 for starting active treatment. Free NHS orthodontic treatment is only available for children with severe enough orthodontic needs as determined by level 3.6 on the Index of Orthodontic Treatment Need.

Orthodontic services are currently under procurement by NHS England.

4.1.6 Access to NHS general, urgent and community dental services

Access to primary care dental services has been a key issue both nationally and locally. Substantial investment has been made since March 2006 to increase access to dental care. The indicator used to assess dental access in terms of utilisation of general and community dental services is the number of unique people accessing (using) dental services over the previous 24 months for adults and over the last 12 months for children. This metric is based upon NICE recall guidance, which recommends the longest interval between dental examinations for adults should be 24 months and 12 months for children.

Table 3: Percentage of children and adults accessing NHS dental care

Area	Children seen in the previous 12 months as a percentage of the population				Adults seen in the last 24 months as a percentage of the population			
	30 Jun 2016	30 Sep 2016	31 Dec 2016	31 Mar 2017	30 Jun 2016	30 Sep 2016	31 Dec 2016	31 Mar 2017
Barnsley	65.8	65.6	65.4	65.2	63.6	63.3	63.4	63.4
Doncaster	65.7	66.0	64.9	64.3	69.4	69.4	69.3	69.0
Rotherham	61.2	61.6	61.5	61.2	60.5	60.4	60.3	60.2
Sheffield	64.9	64.9	64.7	**65.7**	58.7	58.7	58.8	**59.3**
NHS England North (Yorkshire and Humber)	62.7	62.8	62.7	63.2	56.9	56.9	56.8	56.9
England	**57.6**	**57.6**	**57.8**	**58.2**	**51.4**	**51.3**	**51.4**	**51.5**

Source: NHS Digital, 2017

Access to NHS dental care in Sheffield has increased slightly over the past year, with around 66% of children having accessed dental care over a 12 month period and 59% of adults accessing care over a two-year period (Table 3). The child access rates are higher than neighbouring local authorities, yet the adult rates are slightly lower. However, the access rates for children and adults in Sheffield have been consistently higher than the averages for Yorkshire and Humber and England. The access rates reflect the widespread availability of NHS dental care in Sheffield. In addition, many people will also be accessing private dental care for which there are no access data collected. Therefore, the true

percentage of Sheffield's child and adult population accessing dental care (both NHS and private) will be higher than those shown in table 3.

It is important to note that there will never be 100% of the population accessing NHS dental care as some people prefer to opt for private dental care, especially for cosmetic procedures which are not offered on the NHS. Furthermore, many do not wish to access regular routine dental care, opting to attend urgent dental care services only when in pain. This may be due to anxiety, phobia, lifestyle and cultural issues and cost.

Despite the availability and utilisation of NHS dental services in Sheffield, five-year-olds have a care index (percentage of teeth with tooth decay which have been treated with fillings) of only 8% which is lower than that for Yorkshire and Humber (10%) and England (12%). This suggests that primary (baby) teeth are often not being filled. However this may be influenced by the lack of definitive evidence-based guidance on the benefit of filling primary teeth and is the subject of current research. The School of Clinical Dentistry is involved in a multi-centre trial of the clinical and cost-effectiveness of different approaches to the management of tooth decay in primary (baby) teeth. The results will be published in 2018. In addition, many children are not being taken to the dentist from an early age. A national campaign led by NHS England and the British Society of Paediatric Dentistry called Dental Check by One is promoting the need to take children for their first dental visit as soon as their first tooth starts to come through around 6 months and certainly before their first birthday. The campaign is being promoted by the Chief Dental Office for England.

NHS England is currently looking at access to NHS dental care and urgent dental care across Yorkshire and Humber. More detailed ward level access data is being analysed and used to inform future general dental service provision. This work will also be taking into consideration issues raised through Healthwatch Sheffield. In December 2016 they published the summary report of *Disabled Access to Dental Services in South Yorkshire and Bassetlaw.* The objective of the project was to explore access to dental services in South Yorkshire and Bassetlaw from the perspective of service users with a disability and dental healthcare professionals. Through this project dental services users said they wanted more accessible dental surgeries, improved communication with their dental healthcare professionals and to have an increased understanding of their disability reflected in their treatment and care. The South Yorkshire and Bassetlaw Local Dental Network received the report and will have a key role in ensuring that the recommendations of the report are taken forward through key stakeholders. In the past there has been NHS investment to improve access for people with disabilities in Sheffield, such as funding hearing loops for surgeries. However dental practices now have to self-fund any additional modifications. It is a requirement of any new dental contract in Sheffield that the premises will meet equality and diversity requirements.

Improving access to dental care does not necessarily equate with improvements in oral health as dental services tend to be more treatment-focussed. Improving oral health and reducing oral health

inequalities requires a more prevention-focused primary dental care service following the guidance in *Delivering Better Oral Health* (PHE, 2017) and local authority-led oral health improvement programmes within the community.

4.1.7 National Dental Contract Reform

New NHS dental contract prototypes for general dental services are being tested which aim to change the focus of dental service provision from the delivery of treatment to a more preventive approach. The idea is to promote a shared responsibility to improve and maintain patients' oral health. Although initially planned to be introduced in 2018, the new contract is now likely to be delayed. There are currently three dental practices testing the prototype dental contract in Sheffield.

4.1.8 Prevention in general and community dental practice

Evidence-based prevention is described in *Delivering Better Oral Health* and includes providing key oral health messages around diet, brushing with fluoride toothpaste and common risk factors such as smoking and alcohol intake. There are also interventions such as placing fissure sealants, prescription of high fluoride toothpastes and mouthrinses, and application of fluoride varnish. Fluoride varnish can reduce tooth decay by 33% in primary teeth and 46% in adult teeth. It should be applied in general dental practices twice a year to all children aged 3-16, or two or more times to those aged 0-16 at higher risk of tooth decay. It may also be applied to adults giving concern. Dentists are monitored on the level of fluoride varnish applications they do as part of a course of treatment.

The most recent data for Sheffield shows that in 2015/16, 56% of child courses of treatment in Sheffield contained fluoride varnish application (NHS Digital), which was lower than in Barnsley (64%), Doncaster (58%) and Rotherham (57%). The percentage of children having fluoride varnish has increased considerably over the last three years (table 4). This may be attributed both to raised awareness of fluoride varnish amongst dental professionals and the public but also improved recording of fluoride varnish application by dentists on FP17 forms which they complete for each patient. Barnsley Local Dental Committee has audited fluoride varnish application among practitioners in 2014 and again in 2017 and this has helped to raise awareness and increase fluoride varnish rates in Barnsley. A similar audit may help to improve fluoride varnish rates in Sheffield.

Table 4: The trend in percentage of child courses of treatment that contain fluoride varnish in Sheffield

Year	2013/14	2014/15	2015/16
Percentage of child courses of treatment that included fluoride varnish	43%	49%	56%

Source: NHS Digital, 2017

4.1.9 Quality assurance of general dental services

The dental workforce includes dentists and dental care professionals such as dental nurses, hygienists, therapists, (clinical) dental technicians

and orthodontic therapists. They must all be registered with the General Dental Council in order to practice, and undergo regulation through providing evidence of continuing professional development. In order to practice in an NHS dental practice in Sheffield, the dentist must be on the dental performers list.

NHS England uses a dental assurance framework (NHS England, 2014) to ensure and improve quality, which looks at: contract delivery; patient safety, based upon discussions with the Care Quality Commission (CQC), which all dental providers have to be registered with; patient experience; and quality/clinical effectiveness. Quarterly dental assurance framework reports are available for every dentist who carries out treatment and an assessment of outliers is made which may lead to a dental advisor visiting any practices of concern. Dental practices must also comply with any conditions of registration applied by the CQC.

4.1.10 Patient experience

NHS dental practices implement the Friends and Family Test (FFT) through providing patients with a card to anonymously respond to the question:
"We would like you to think about your recent experiences of our service. How likely are you to recommend our dental practice to friends and family if they needed similar care or treatment?"
Patients place their response cards into a box in the waiting room, and the dental practices then submit response data monthly to NHS England.

Table 5 below presents results from May 2016 to April 2017 and demonstrates that responses in South Yorkshire and Bassetlaw compare well against the overall figure for England.

Table 5: Responses to the Friends and Family Test (May 2016-April 2017)

Area	Recommended (%)	Breakdown of Responses (n)					
		Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't know
England	97%	59,909	14,651	1,039	218	241	565
Sheffield	99%	589	167	2	0	0	4
Rotherham	99%	119	38	1	0	0	0
Barnsley	99%	270	135	1	1	0	2
Doncaster	97%	214	30	3	0	2	2
Bassetlaw	100%	56	10	0	0	0	0

Source: NHS England, 2017

4.2 Secondary and tertiary care

4.2.1 Charles Clifford Dental Hospital

Charles Clifford Dental Hospital provides secondary and tertiary care to the population of Sheffield, South Yorkshire and nationally. Over 95,000 patients attend Charles Clifford Dental Hospital annually with inpatient and day case sessions in the Royal Hallamshire Hospital and Sheffield Children's Hospital. There are approximately 1,000 children admitted annually to Sheffield Children's hospital children for general anaesthetics for the management of dental disease. Specialist care is provided in oral and maxillofacial surgery, orthodontics, restorative dentistry (covering crowns, bridges, dentures, root canal treatment, treatment of gum

conditions), paediatric dentistry, oral surgery, oral pathology, oral medicine, oral microbiology, special care dentistry and oral radiology. Tertiary referrals are received for cleft lip/palate, implantology, facial pain, hypodontia and nerve injury.

A recent CQC inspection of Charles Clifford Dental Hospital in 2015 rated it as good overall with responsive rated as outstanding. Inspectors commended the sensitivity of staff "to the needs of vulnerable patients, making reasonable adjustments to ensure that effective two-way communication was achievable to allow patients to be fully empowered to make decisions about their treatment options".

NHS Choices rated the Charles Clifford Dental Hospital 4.5/5 having reviewed 60 patient feedback responses for the month of December 2015. Charles Clifford Dental Hospital has regular patient satisfaction surveys and a Patient and Public Involvement Panel for research.

4.2.2 Minor oral surgery

Depending on the complexity of minor oral surgery, some patients may be treated in primary care whereas for others it is more appropriate to be seen in secondary care.

There is a strong national approach for the establishment of managed clinical networks (MCN) to support a new way of working when developing new pathways of care. A pilot MCN for minor oral surgery comprising representation from general practice, specialist oral surgeons, secondary care based consultants and other key stake holders has been in place in West Yorkshire since October 2016. The benefits of this approach, which has a primary aim to better deliver high quality oral surgery services in a suitable environment which are safe, effective and patient centred, are currently being assessed. Following this consideration will be given to developing such networks in South Yorkshire.

4.3 School of Clinical Dentistry

The School of Clinical Dentistry is currently training 443 dental students and 48 dental hygiene and therapy students. Dental students provide urgent care for around 4,000 patients annually at Charles Clifford Dental Hospital. All of the senior students also spend around 20 weeks in outreach placements. There are 10 primary care practices in South Yorkshire and East Midlands that host students. Our research shows these placements increase students' confidence with the demands of working in primary dental care. In 2016/17 23 of the 68 dental students who graduated from the School of Clinical Dentistry undertook their first jobs in South Yorkshire. All dental hygiene and therapy students undertake oral health promotion projects which involve early years, schools and residential care homes. In 2016/17, 19 of these projects were conducted in Sheffield, including establishing tooth brushing clubs in nurseries and providing oral health training to care home staff. The School of Clinical Dentistry also has a team of student volunteers, the Smile Squad who work with Sheffield's Oral Health Promotion team to deliver talks to schools. In 2016/17 they have responded to four requests from schools and talked to nearly 300 children.

The School of Clinical Dentistry also has a vibrant research programme with 93% of the research graded world-leading or internationally excellent. The research includes fundamental, translational and clinical research to improve the diagnosis of oral cancer and the management of diseases such as dental caries (tooth decay) and gum disease, develop advanced biomaterials and improve patients' treatment experiences, evaluate care pathways and improve oral health at a community level.

The University of Sheffield is seeking to develop its civic mission within the wider city region. In keeping with this mission the School of Clinical Dentistry are exploring ways to further contribute to improving oral health through learning, teaching and research. The School has already led local evaluations of care pathways and is planning to evaluate the tooth brushing club scheme. Future directions being considered are strengthening the partnership between the School of Clinical Dentistry and the wider region by re-evaluating the relationship with outreach dental practices and exploring how research could be more directly engaged within the city and region. Further suggestions on how this relationship might be developed would be welcomed.

5. What does this mean for the people of Sheffield?

Although Sheffield has seen an overall improvement in oral health, many people still experience unacceptable levels of disease. Poor oral health will only be addressed if it is approached in the context of good oral health being vital for general health and wellbeing.

It is important to ensure people understand how they can keep their teeth and mouths healthy through optimal exposure to fluoride, healthy eating and reducing the proportion of sugars in the diet in line with national guidelines, avoiding using tobacco and keeping alcohol consumption to national guidelines and through accessing timely and appropriate dental care. However, given that it is difficult to change behaviour, people need to be helped to make healthier choices by tackling the wider social determinants of health at a higher level to create environments which support better oral health. This requires working at a community level. While community oral health improvement programmes will be an essential component of this, there may also be opportunities to: influence policies such as those relating to food and drink in educational and public establishments and infant feeding; influence planning decisions, for example the location of new food outlets in relation to schools; and incorporate oral health into specifications for health and social care services and early years services.

Tackling poor oral health will only succeed if there is continued partnership working between Sheffield City Council, NHS England, Public Health England and Sheffield University.

6. Priority issues

The main issues the council may consider regarding oral health are:

- Oral health should be part of Sheffield's Joint Strategic Needs Assessment, Health and Wellbeing Strategy and any STP plans
- The budget for oral health improvement should be maintained or increased
- The refresh of the oral health improvement strategy should now be consulted on and signed off by the council, including the need for and feasibility of water fluoridation.
- Reduction of sugar should be considered a priority in food and other council strategies
- There should be promotion of dental check by one by all partners in oral health to ensure consistency of message
- Oral health should be considered in all health and social care and education policies and services for children and older people

Appendix I

Sheffield Oral Health Improvement Strategy 2017-2020 - draft

Introduction

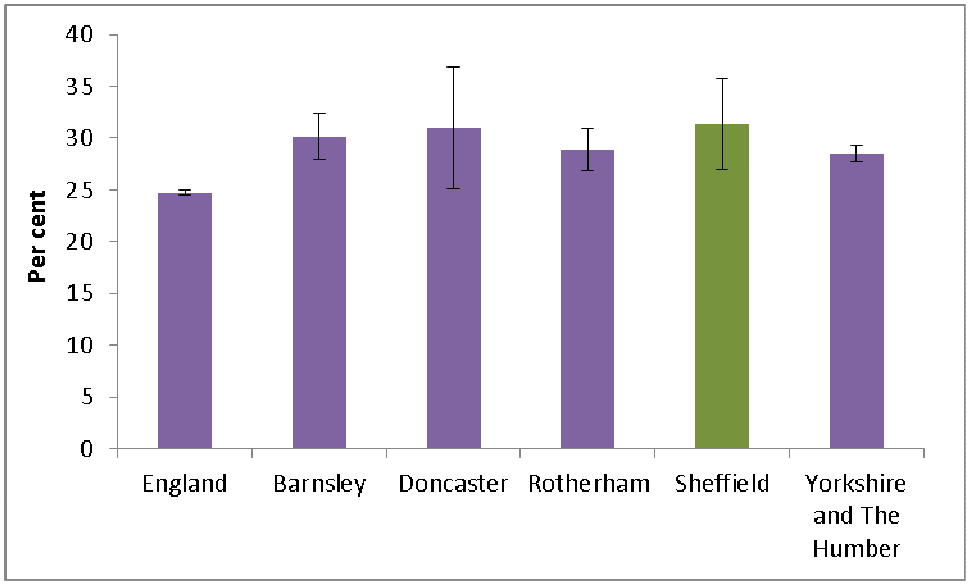
Oral health improvement is a statutory responsibility of Sheffield City Council. This responsibility has been discharged through its 2014-17 oral health improvement strategy. There have been improvements in children's oral health in Sheffield since 2014 and the ambitions for oral health improvement were achieved. However, while there has been progress there is still work to be done to improve oral health in the city.

This strategy lays down the proposed activities for 2017 to 2020 and refreshes the targets for oral health improvement in children, which will also contribute to the public health outcomes framework indicator of reducing tooth decay in five year old children.

Oral health in Sheffield

Targets for oral health improvement in the last strategy were achieved. The proportion of five year old children with tooth decay reduced from 36% to 31% and the average number of decayed, missing and filled teeth of five-year-old children living in the 20% most deprived areas of the city reduced from 1.94 to 1.6.

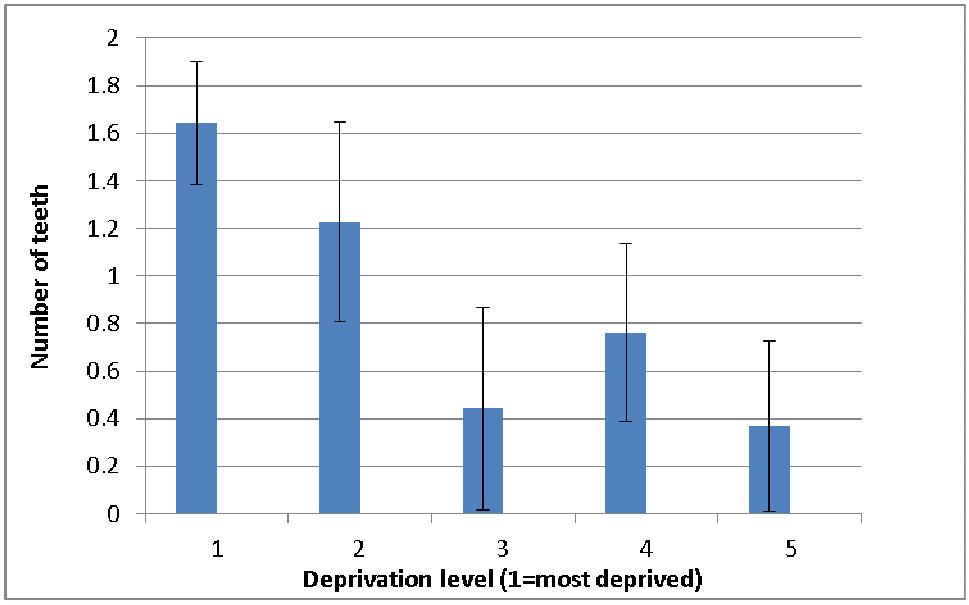
Figure 1 Prevalence of tooth decay in five-year-old schoolchildren by area, 2015



Source: PHE, 2015

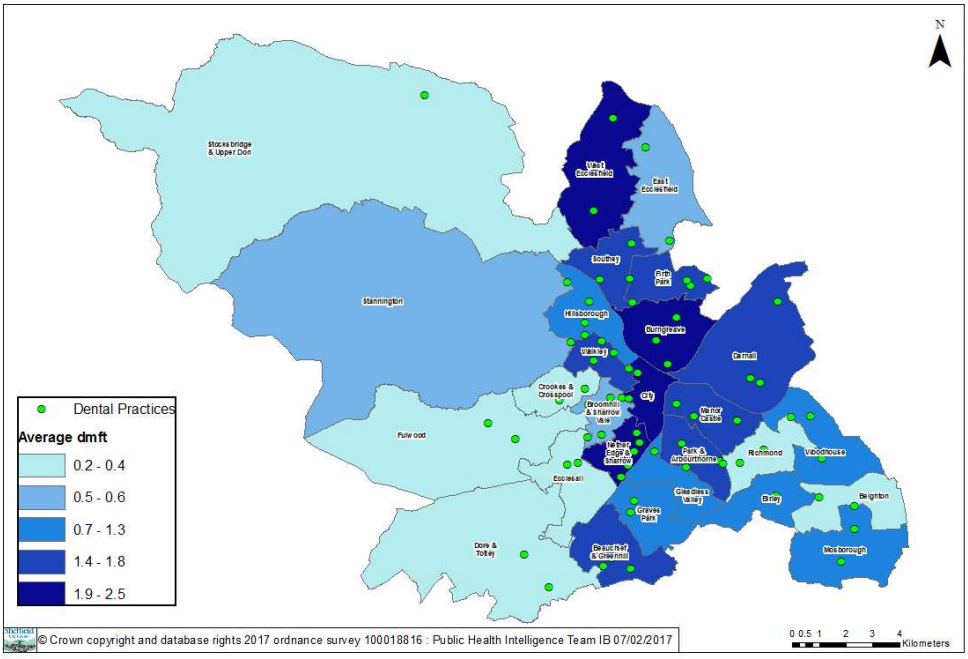
Children living in the most deprived areas of the city had average tooth decay levels that were four times higher than those living in the least deprived areas (Figures 2 and 3).

Figure 2 Severity of tooth decay in five-year-old schoolchildren by level of deprivation, 2015



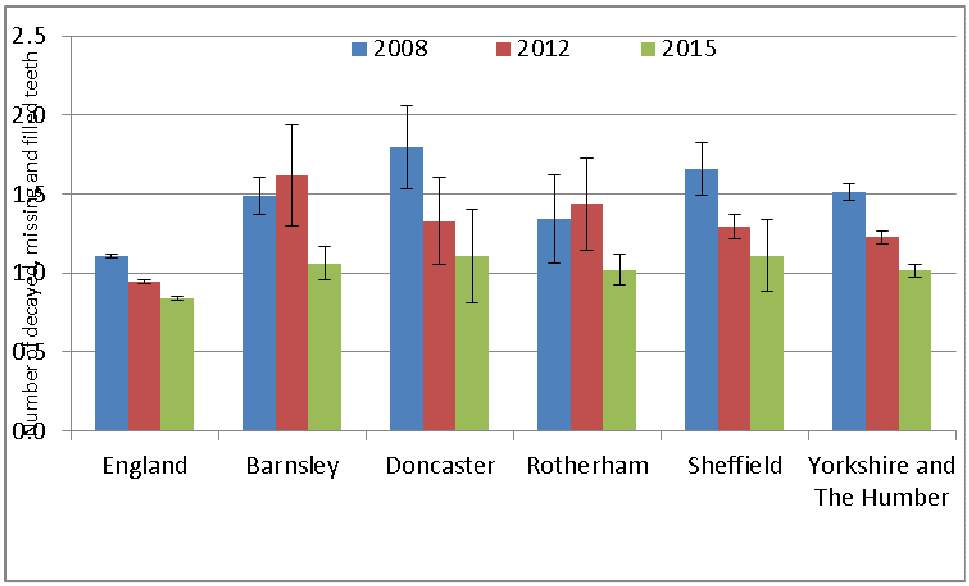
Source: PHE, 2015

Figure 3 Severity of tooth decay in five-year-old schoolchildren by ward, 2015



Since 2008, the prevalence and severity of tooth decay in five-year-old schoolchildren has decreased (Figure 4). However there is still work to be done to maintain these improvements and reduce the inequalities in children living in the most deprived areas of the city.

Figure 4 Tooth decay severity in five-year-old schoolchildren in Sheffield 2008 to 2015



Oral health vision

The vision is for all Sheffield residents to be able to speak, smile and eat with confidence and without pain or discomfort from their teeth or mouths. This will be achieved through improving overall oral health and reducing oral health inequalities with a particular focus on those children and young people who experience the worst oral health.

The objective of the strategy is to maintain levels of tooth decay at or below the current figure of 1.1 while reducing oral health inequalities in schoolchildren living in the 20% most deprived areas of Sheffield.

Whilst monitoring data are not available for other age groups, improving the oral health of children and young people will have a positive impact throughout the life course (Fisher-Owens, 2007). This is in keeping with the council's Best Start Strategy.

What can we do in future to meet the vision for oral health in Sheffield?

The oral health promotion activities in this strategy have been selected with reference to the evidence base for oral health improvement and policy both nationally and locally. This includes Commissioning Better Oral Health, NICE guidance, LGA report and the PHE rapid review and return on investment tool. The costs of the activities can be met within current resources to ensure continued improvements in oral health are achieved over the next three years.

As well as prioritising interventions based on their level of evidence, the range of activities cross the five Ottawa Charter areas for health improvement action (WHO, 1986) and are described under these five areas. Recommendations are also made for new oral health improvement programmes that could be implemented if additional resources were available.

Creating Supportive Environments

Fluoride remains the most effective means of preventing tooth decay. To continue to see improvements in tooth decay levels in children we need to provide more intensive exposure to fluoride as children grow up, both at home, at nursery, at school and in the

dental practice. Use of fluoride toothpaste is responsible for the vast improvements in oral health in developed countries over the past 40 years since its introduction. Fluoride toothpaste has been reported to result in a 24-26% reduction of new tooth decay over a three-year period (Petersen and Lennon, 2004).

Baby's Teeth, Healthy Teeth scheme

Currently 9000 tooth brushing packs are distributed annually as part of the Baby's Teeth, Healthy Teeth scheme. This is made up of 6800 packs to all children at 12 months of age and 2200 for 2 year olds in the most deprived areas.

These tooth brushing packs will continue to be distributed by members of the health visiting team. In future, this scheme will be integrated into the Healthy Child Programme and evaluation of the scheme will be conducted.

ACTION:

- Ensure the Baby's Teeth, Healthy Teeth scheme is integrated into the Healthy Child Programme
- Conduct an evaluation of the implementation of the Baby's Teeth, Healthy Teeth scheme within the Healthy Child Programme

New school starters tooth brushing pack scheme

Currently 6200 tooth brushing packs are distributed to children starting all primary schools (mainstream and special schools) in Sheffield. This is enhanced by the delivery, on a rolling programme, of training to schools. The training will continue to be supported by dental hygiene and therapy students from the School of Clinical Dentistry, University of Sheffield supported by the oral health promotion team.

ACTION:

- Maintain the new school starters tooth brushing pack scheme and evaluate to ensure packs are distributed appropriately by schools

Expansion of tooth brushing clubs

Tooth brushing clubs have been established in 26 nurseries and schools with 1748 children participating. In 2017 an oral health campaign will see an additional 40 tooth brushing clubs established for one year. This campaign will be evaluated from the perspectives of commissioners, providers, parents and children by the School of Clinical Dentistry. If additional funds are made available on a recurrent basis it will be possible to continue these tooth brushing clubs beyond the duration of this campaign.

ACTION:

- Conduct an evaluation of the tooth brushing clubs from the perspectives of commissioners, providers, parents and children
- Seek additional funding to continue the extended scheme subject to the results of the evaluation.

Water fluoridation

A review of the appropriateness of water fluoridation for Sheffield will be conducted based on further detailed examination of tooth decay trends and feasibility.

The costs of a water fluoridation scheme in Sheffield have been estimated to be in the region of £1,000,000 for capital costs and from £190,000 to £220,000 in revenue costs per year.

ACTION:

- Explore the need for and feasibility of water fluoridation in Sheffield

Reorienting health services to prevention

Increase the usage of fluoride varnish by dental practices

The use of fluoride varnish has increased in dental practices in Sheffield over the past 3 years. This increase will continue to be supported and encouraged. This will be achieved through continued engagement with NHS England dental service commissioners, Sheffield Local Dental Committee, Public Health England, the community dental service and dental hospital to increase the use of fluoride varnish through provision of training, audit and referral management systems.

The costs of this scheme are borne by NHS England.

ACTION:

- Work with the local dental community, NHS England and Public Health England to increase the use of fluoride varnish

Tobacco and alcohol control

Dental service providers in Sheffield will be encouraged to undertake training in Making Every Contact Count including providing brief interventions aimed at alcohol and tobacco use. Public Health England and the oral health promotion team will disseminate national guidance and online training to local dentists and dental teams.

ACTION:

- Ensure oral health is included in the tobacco control strategy
- Contribute to the council's making every contact count initiative by providing training to dental service providers about tobacco and alcohol control
- Encourage dental providers to work more closely with other health professionals (including general medical practitioners and pharmacists) around tobacco and alcohol control.

Developing personal skills

The health, education, early years and voluntary sectors provide opportunities to promote oral health of children and adults through training and collaboration.

Children and young people

Healthy Child Programme

Oral health is now incorporated into the service specification for the Healthy Child Programme. The Healthy Child Programme objectives about oral health include:

- The Healthy Child Programme team will proactively reduce levels of tooth decay in children at each contact by providing tailored support on sugar consumption, dental attendance and brushing with fluoride toothpaste.
- Support parents to begin to brush children's teeth twice daily with fluoride toothpaste as soon as teeth come through and continue active involvement in tooth brushing until 7 years of age.
- Encourage parents to take their children to the dentist before one year of age and then regularly for check-ups and fluoride varnish application. Pregnant mothers to be encouraged to visit the dentist themselves.
- Provide tailored advice to reduce sugar consumption in food and drinks integrated into advice on breastfeeding and weaning.
- Attend annual training based on the Sheffield health visiting flowchart
- Work collaboratively with other practitioners to provide integrated support and signposting for parents.

Implementation of the Healthy Child Programme will commence in 2017.

ACTION:

Implementation of the Healthy Child Programme to be supported by the oral health promotion team and Public Health England with specific actions to:

- Develop a flow chart to guide the oral health contribution of the health visiting teams, identify resources to support the use of this flowchart and develop a programme of annual oral health training for health visiting teams.
- Develop a generic flow chart to guide the oral health contribution of other members of the Healthy Child Programme workforce, identify resources to support the use of this flowchart and develop a programme of oral health training for this workforce.
- Support the Healthy Child Programme when they are reviewing their other activities, for example weaning clubs, to offer practical help to improve oral health through these activities.
- Contribute to updates of the Red Book to ensure oral health advice is comprehensive, evidence-based and appropriately written for parents.
- Integrate with antenatal care to ensure expectant mothers know dental services are free and encourage new mums to seek dental care for their babies before one year of age.

Early Years

Current oral health activities in Early Years settings mainly involve tooth brushing clubs. Tooth brushing clubs have been established in 21 nurseries with 1598 children participating. As previously stated, the number of tooth brushing clubs in nurseries will be increased in 2017 as part of a year-long campaign.

In future, Early Years settings will continue to be supported to establish tooth brushing clubs and to work towards achieving the Healthy Early Years Award which now includes tooth brushing club as a criteria. Oral health training will also be offered to nurseries and childminders. The involvement of quality improvement officers in oral health initiatives in early years settings should also be explored.

A further action will include national and local work to ensure an oral health component of the Health Exercise and Nutrition for the Really Young (HENRY) parenting programme is developed.

Over the past year 600 tooth brushing packs and oral health training have been provided to Children's Centre staff across Sheffield as an adjunct to the Baby's Teeth, Healthy Teeth scheme.

Future work will include delivering oral health training as part of parent workshops and training updates for Children's Centre staff.

ACTION:

- Continue to establish tooth brushing clubs in early years settings
- Continue to distribute tooth brushing packs from Children's Centres
- Work with early years setting to support them to achieve the oral health aspects of the Healthy Early Years Award
- Provide oral health training to nurseries, childminders and Children's Centre staff
- Explore involving quality improvement officers in oral health initiatives in early years settings
- Contribute to national and local work to integrate oral health into parenting programmes

Multi Agency Support Team (MAST)

The MAST workforce including intervention prevention, infant feeding peer support and community early years practitioners have received oral health training over the past year. Further work is needed with MAST to optimise their ability to deliver oral health messages and signpost parents to dental services.

ACTION:

- Develop a programme of oral health training and support for MAST

Work with schools, special schools and children's homes

Forty primary schools with the highest levels of tooth decay have resource boxes for their use throughout the year. Five additional boxes will be available for loan from the Oral Health Promotion Unit. A recent evaluation of these resources has been positive.

Currently, 5 schools and 150 children in reception classes are participating in tooth brushing clubs. As previously stated, the number of tooth brushing clubs in reception classes will be increased in 2017.

The oral health promotion team with the School of Clinical Dentistry, University of Sheffield co-ordinate the activities of a team of dental student volunteers who provide ongoing support for schools in deprived areas who have chosen to prioritise oral health within their schools.

The oral health improvement activities provided in special schools and children's homes were reviewed in 2014 and an action plan for special schools implemented. This action plan has resulted in:

Tooth brushing clubs have been set up in the following schools:

School	Number of children in school	Number of children brushing daily	Number of classes brushing daily
Woolley Wood	92	92	9/9
Norfolk Park	82	75	9/9
Mossbrook	84	83	9/9
The Rowan	81	81	11/11
Talbot	168	64	8/19
Bents Green	163	42	5/17
Sevenhills	155	67	7/16

Fifty dental packs are distributed annually to children starting in the foundation year at Woolley Wood, Norfolk Park, Mossbrook and The Rowan.

The oral health promotion team provided oral health training to 37 staff in 2015/6 and 10 staff working within special schools in 2016/17. Classroom-based lessons were provided to 13 classes in 2015/6 and 10 in 2016/7.

Fluoride varnish is prescribed by a dentist for children that are patients of Community and Special Care Dentistry and who are attending Talbot, Woolley Wood and Norfolk Park School. The Oral Health Promotion Team works alongside dental staff to provide integrated assessments and clinical prevention.

ACTIONS:

- Increase the numbers involved in tooth brushing clubs in special schools

- Address remaining actions in the action plan including:
    - Conduct an audit of the oral health resources provided to special schools
    - Improve signposting of parents to appropriate dental services
    - Explore feasibility of extending fluoride varnish programme

There are currently five local authority children's homes in Sheffield. In total 25 children in these children's homes receive a tooth brushing pack quarterly and staff are given annual training. In future, if resources allow, oral health input should be developed into the other privately run children's homes in Sheffield.

ACTION:

- Provide quarterly tooth brushing packs and annual training to local authority children's homes
- Provide oral health training to staff in other children's homes.

Children's workforce partners including GPs, pharmacists, weight management service and voluntary organisations

The wider child workforce will be engaged with and trained in basic oral health messages including general medical practitioners, pharmacists, weight management services and voluntary organisations.

ACTION:

- Engage with the Maternal and Child Health Planning and Partnership group and other local authority networks to provide oral health training to the wider children's workforce.

Adults

Oral health for people in hospital

Training of nursing staff working within Sheffield's hospitals will continue to ensure oral health is included in patients routine care plans during their stay in hospital. It is proposed to develop this work by producing a protocol for mouth care for use in hospital wards and to provide training to ward staff on the implementation of the protocol.

ACTION:

- Develop a protocol for mouth care for use in hospital wards
- Provide training to ward staff on the use of the protocol

Oral health for older adults in care homes

Currently the oral health promotion team works with the School of Clinical Dentistry, University of Sheffield dental hygiene and therapy students to provide oral health training to carers working in residential homes for older people every three years. This training is provided as part of the Residential Oral Care Sheffield (ROCS) scheme which provides dental services and promotes oral health in care homes for older adults.

The National Institute for Health and Care Excellence produced guidance in 2016 on the oral health for adults in care homes. The ROCS scheme was used as an example of shared learning. In future, further work is needed in Sheffield to fully implement this NICE guidance.

ACTION:

- Implement NICE guidance on oral health for adults in care homes

People with learning disabilities

Training for carers of people with learning disabilities in oral health is provided every two years.

ACTION:

- Continue to provide oral health training for carers of people with learning disabilities

Strengthening community action

Continuation of the Oral Health Action Teams

Oral health action teams are currently working in ‘Lowedges, Batemoor and Jordanthorpe’, ‘Parson Cross, Longley, Foxhill, Southey Green and Shirecliffe’, ‘Manor, Park, Woodthorpe and Wybourn’ ‘Darnall, Tinsley and Acres Hill’ and ‘Burngreave’. While there are differences between the team’s activities some core activities include the distribution of free fluoride toothpaste packs, introduction of tooth brushing schemes, training of dental teams in the management of high caries risk children and training and support for health, social and education professionals working in these neighbourhoods. Action plans are developed annually to guide their activities. In future these action plans will be developed through wider involvement of Sheffield City Council.

ACTION:

- Develop annual action plans for the Oral Health Action Teams with wider involvement of Sheffield City Council

Healthy public policy

Work is ongoing to integrate oral health improvement into existing policies and programmes such as the public health strategy, healthy child programme, food strategy, and care home policies through commissioning frameworks and the Maternal Health and Early Years' Delivery Plan.

It is proposed that additional action is undertaken in the following areas:

- Development of a policy to support the prescribing of sugar free medicines or reduce the impact of sugar-containing medicines where no alternatives exist in partnership with NHS England and Sheffield Clinical Commissioning Group
- Development of a policy restricting advertising of high sugar products within the City

- Prioritising sugar reduction within the city's food strategy
- Sugar tax on drinks sold in all leisure centres in Sheffield Review of healthy food and drink policies in childhood settings
- Lobbying for tax free fluoride toothpaste
- Ensuring the availability of cheap fluoride toothpaste in local shops and supermarkets
- Implementation of the work of the national Child Oral Health Improvement Board
- Research to develop the evidence-based for oral health improvement

ACTION:

- Implement these actions through partnership with Public Health England and Sheffield City Council.

Implementation of the strategy

The responsibility for implementing the strategy lies with primarily with the provider of oral health improvement services in Sheffield in partnership with the council, Public Health England, NHS England and the School of Clinical Dentistry. Oversight of delivery will rest with Sheffield City Council as the commissioner and the organisation with statutory responsibility for oral health improvement.

This draft strategy will be consulted on and amended accordingly.

Contributors

- Kate Jones, Public Health England
- Zoe Marshman, School of Clinical Dentistry
- Joanne Charlesworth, Sheffield Teaching Hospital NHS Foundation Trust
- Greg Fell, Sheffield City Council
- Debbie Hanson, Sheffield City Council
- Jess Wilson, Sheffield City Council
- Bethan Plant, Sheffield City Council
- Sheffield Oral Health Advisory Group members

Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Wednesday 19th July 2017

Report of: Policy and Improvement Officer

Subject: Draft Work Programme 2017/18

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At the start of the municipal year each scrutiny and policy development committee develops a work programme. A list of issues the Committee may wish to consider including in the work programme this year is attached at appendix 1 for discussion. Appendix 2 provides a log of the issues looked at in 2014/16, 2015/16 and 2017/18. Appendix 3 is Sheffield's selecting scrutiny topic tool.

Following the discussion at this meeting, a draft work programme will be drawn up. It will remain a live document throughout the year to be shared and discussed at each meeting of the Committee.

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

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

The Scrutiny Committee is being asked to:

- Consider and discuss issues for inclusion in the committee's work programme for 2017/18

Background Papers:
Sheffield Council Constitution

Category of Report: OPEN

Draft Work Programme 2017/18

1.0 Developing the work programme

1.1 The list at Appendix 1 sets out areas the Committee may wish to look at this year, to be agreed, added to, prioritised and scheduled.

1.2 The work programme remains a live document throughout the year to be shared and discussed at each meeting of the Committee.

1.3 For information a log of topics considered by the Committee in previous years is attached at Appendix 2.

1.4 The Committee may wish to reflect on the principles attached at Appendix 3 and referred to in section 2 below to ensure that scrutiny activity is focussed where it can add most value.

2.0 Resources for scrutiny

2.1 We have set up a scrutiny intranet page which contains some useful documents and links, including the following documents:

- **Selecting topics -** PAPER criteria - **P**ublic Interest, **A**bility to Change, **P**erformance, **E**xtent, **R**eplication - our tool for selecting the most appropriate topics for scrutiny (Appendix 3)
- **Approaches to scrutiny** – an overview of the four broad ways in which a committee can choose to scrutinise topics
- **Developing KLOEs** –questions to ask when developing Key Lines of Enquiry (KLOEs)
- **Questioning styles** - a Centre for Public Scrutiny (CfPS) guidance document

3.0 Recommendations

3.1 The Scrutiny Committee is being asked to:

- Consider and discuss issues for inclusion in the Committee's work programme for 2017/18

Healthier Communities & Adult Social Care Scrutiny Committee Draft Work Programme 2017/18	
Proposed Topic	**Reasons for selecting topic**
Transfers of Care	To understand how we are currently performing? What are key issues? How are they being resolved? How can we improve?
Clinical Commissioning Group Financial Position	To understand decisions the CCG is taking to manage its financial position
Urgent Care and Primary Care Reviews	Update on progress, what does this mean for the City?
Mental Health Transformation	Gain an understanding of the mental health transformation programme and the impact it will have on Sheffield people.
Accountable Care Partnership and Shaping Sheffield	To consider how the Accountable Care Partnership is developing, and how it is driving forward Shaping Sheffield, with a focus on how the plan is translating into action.
Care and Support Performance	Request for 12 month update following 2016/17 consideration.
Dementia Friendly City	What progress is being made on becoming a Dementia Friendly City - what more can we do?
Mental Health - role of voluntary sector	Focus on Community Services, and programmes delivered by voluntary sector. How can we spread best practice across the city?
Social Prescribing	What is Sheffield's approach? Is it working? How do the costs and savings work? Is social prescribing being implemented in an equal way across the City?
Health in All Policies	To consider how well the public health strategy is being embedded across all areas of Council activity.
CQC visits to GPs	Follow up from issues considered in 2016/17 - how do we ensure high quality GP services across the city - report on progress.
Joint Strategic Hospital Services Review	To consider the outcome of the review and the potential impact on Sheffield
Children, food and health	To consider impact of food on children's health - obesity and malnutrition - with a focus on the wider determinants of health, particularly poverty and the role of food banks

Health & Wellbeing Board	To understand the role of the Health and Wellbeing Board and its relationship with Scrutiny
Joint Health Overview and Scrutiny Committees	**Commissioners Working Together Programme Joint Scrutiny Committee** - this Committee meets in relation to the Commissioners Working Together Collaborative looking at Health Service Change in South and Mid Yorkshire, Bassetlaw and North Derbyshire. Focussing on two NHS service reconfigurations - Hyper Acute Stroke Services; and Children's Surgery and Anaesthesia. **Yorkshire and Humber Joint Health Overview and Scrutiny Committee –** this Committee is currently considering changes to Congenital Heart Disease services.

Healthier Communities & Adult Social Care		
Log of Topics 2014-17	**Year**	**Month**
Sheffield Health and Wellbeing Board - Plans for 2014/15	2014/15	July
Sheffield NHS Clinical Commissioning Group - Commissioning Intentions 2014/15	2014/15	July
How Did We Do? - Sheffield's Local Account of Adult Social Services 2014	2014/15	July
Nutrition and Hydration Working Group	2014/15	July
Draft Work Programme 2014/15	2014/15	July
Sheffield Adult Safeguarding Partnership - 2014/15 Business Plan	2014/15	July
Right First Time Programme - Update	2014/15	September
Care Act 2014 - Progress on Implementation	2014/15	September
End of Life Care in Sheffield	2014/15	October
Sheffield Dementia Strategy and Commissioning Plan	2014/15	October
Minor Oral Surgery Procurement	2014/15	October
Adult Safeguarding Business Plan - Update	2014/15	October
Petition - Opposing the Potential Privatisation of the Learning Disability Service	2014/15	December
Better Care Fund - Update	2014/15	December
Input to Care Quality Commission 2015 Inspection Programme	2014/15	December
Call-in of Leader's Decision Regarding the tender for the Reprovision of Day Services and Residential Short-Term Care Beds for People with Dementia	2014/15	February
Sheffield Teaching Hospitals Annual Quality Report 2014/15	2014/15	February
Commissioners Working Together Programme Update	2014/15	February
Adult Social Care Performance Update	2014/15	February

Sheffield Health Inequalities Plan	2014/15	February
Care Act 2014 - Update	2014/15	February
Update on Developing a Social Model of Health - briefing note	2014/15	February
Sheffield Adult Safeguarding Partnership - Business Plan Update - briefing note	2014/15	February
Quality Accounts - Yorkshire Ambulance Service	2014/15	April
Quality Accounts - Sheffield Teaching Hospitals NHS Foundation Trust	2014/15	April
Quality Accounts - Sheffield Children's Hospital NHS Foundation Trust	2014/15	April
Sheffield Health and Social Care NHS Foundation Trust 2014-15 - Quality Report	2014/15	April
Update on the De-registration of Learning Disability Care Homes	2015/16	July
Transforming Care - Update on Winterbourne Actions	2015/16	July
Child & Adolescent Mental Health Services - written briefing	2015/16	July
Urgent Care Review - written briefing	2015/16	July
Carers' Strategy	2015/16	September
Better Care Fund with a focus on Active Support and Recovery	2015/16	November
Quality Care Provision for Adults with a Learning Disability in Sheffield	2015/16	January
Adult Social Care Performance	2015/16	January
Improving Access to Psychological Therapies	2015/16	February
Deregistration of Learning Disability Care - follow up	2015/16	February
Access to GP (General Practice)	2015/16	March
Scrutiny and the Adult Safeguarding Board - information item	2015/16	March
Summary of Committee activity 2015-2016	2015/16	March

Home Care Task Group Report	2015/16	February
CQC Inspection Reports - Sheffield Teaching Hospitals NHS Foundation Trust	2016/17	July
Task Group 2016/17 - scope	2016/17	July
Quality Accounts –membership of sub group 2016/17; QA submissions 2015/16 - FOR INFORMATION	2016/17	July
JHOSC - The Commissioners Working Together Programme - UPDATE	2016/17	July
Primary Care Strategy - CCG (Katrina Cleary) - FOR INFORMATION	2016/17	July
Sustainability & Transformation Plan (STP)	2016/17	September
Public Health Strategy SCC	2016/17	September
JHOSC - The Commissioners Working Together Programme - UPDATE	2016/17	September
Shaping Sheffield: The Plan	2016/17	November
Better Care Fund	2016/17	November
Community Pharmacy - national contract changes	2016/17	November
CQC Visits to GP Reports - Sheffield CCG	2016/17	January
Adult Safeguarding priority setting and future plans	2016/17	January
JHOSC - The Commissioners Working Together Programme - UPDATE	2016/17	January
Shaping Sheffield: The Plan - SPECIAL MEETING	2016/17	February
Adult Social Care Performance	2016/17	March
Quality Care Provision for Adults with a Learning Disability in Sheffield	2016/17	March
NHS England Congenital Heart Disease services (CHD) Consultation - FOR INFORMATION	2016/17	March
Urgent Care Strategy - Sheffield CCG	2016/17	April

Public Health Strategy for Sheffield	2016/17	April
Home Care Task Group: Formal response to scrutiny	2016/17	April
Shaping Sheffield: Scrutiny Members Working Group	2016/17	April
Work Programme Review 2016/17	2016/17	April

Sheffield Council Scrutiny
Selecting Scrutiny topics

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

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

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

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

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

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

Other influencing factors

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

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

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