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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 15 November 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
Margaret Kilner and Clive Skelton (Observers)

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Healthier Communities and Adult Social Care Scrutiny Committee exercises an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods area of Council activity and Adult Education services. It also scrutinises as appropriate the various local Health Services functions, with particular reference to those relating to the care of adults.

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Policy and Improvement Officer on 0114 27 35065 or email emily.standbrook-shaw@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
15 NOVEMBER 2017

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

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

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

5. Minutes of Previous Meeting (Pages 5 - 12)
To approve the minutes of the meeting of the Committee held on 20th September, 2017

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

7. Food and Wellbeing Strategy (Pages 13 - 32)
Report of the Director of Culture and Environment

8. The Sheffield Mental Health Transformation Programme (Pages 33 - 36)
Report of the Director of Commissioning, Inclusion and Learning

9. Sheffield Teaching Hospitals NHS Foundation Trust - Quality Account Objectives (Pages 37 - 40)
Report of the Sheffield Teaching Hospitals NHS Foundation Trust

10. Work Programme 2017/18 (Pages 41 - 46)
Report of the Policy and Improvement Officer

<u>For Information Only</u>

11. Urgent Care Consultation Update (Pages 47 - 54)
Report of the Director of Commissioning, Sheffield Clinical Commissioning Group

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

Wednesday, 17th January, 2018, at 5.00 pm, in the Town Hall

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's 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 20 September 2017

PRESENT: Councillors Pat Midgley (Chair), Pauline Andrews, Steve Ayris, David Barker, Lewis Dagnall, Tony Downing, Mike Drabble, Adam Hurst, Dianne Hurst, Talib Hussain, Douglas Johnson, Richard Shaw, Garry Weatherall and Sue Auckland (Substitute Member)

Non-Council Members (Healthwatch Sheffield):-

Margaret Kilner and Clive Skelton

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Sue Alston, with Councillor Sue Auckland attending as her substitute.

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 Responses were provided to two questions asked by Deborah Cobbett on behalf of Sheffield Save Our NHS, as follows:-

(a) The Policy and Improvement Officer stated that issues relating to the wider geographical footprint, such as the introduction of Accountable Care Systems and service reconfigurations, came under the remit of the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee. She confirmed that this issue was not currently included in this Committee’s Work Programme, but she would check with Leicester City Council, which it had been reported was threatening formal complaints about the process. A written response would then be provided to the questioner.

(b) In relation to the proposal for the introduction of charges for migrants and asylum seekers using health services other than emergency and GP care, the Chair, Councillor Pat Midgley, indicated that information would be sought to understand the present position in Sheffield and a written

response would be provided to the questioner by the Policy and Improvement Officer.

5. REDUCING DELAYED DISCHARGES FROM HOSPITAL

5.1 The Committee received a joint presentation of Michael Harper, (Chief Operating Officer, Sheffield Teaching Hospitals), Phil Holmes, (Director of Adult Services, Sheffield City Council) and Peter Moore (Director of Strategy and Integration, NHS Sheffield Clinical Commissioning Group (CCG)), on reducing delayed transfers of care in Sheffield.

5.2 The item was introduced by Phil Holmes, who suggested that the Committee should take the presentation as a background paper and indicated that last Winter, Sheffield was not in a good position with regard to delayed discharges from hospital. He added that plans were now being put in place for this Winter for people to have the right to treatment and leave hospital when appropriate. He also commented that there were issues both inside and outside the hospitals which had resulted in the poor performance last Winter.

5.3 Peter Moore reported that, last Summer the system in Sheffield had become full and, following meetings with the three relevant organisations, those being the Sheffield Teaching Hospitals Trust, the Sheffield City Council and the Sheffield CCG, a task team had been set up from last September and the delays had been reduced before Christmas, but the system had then filled up again.

5.4 Michael Harper indicated that there was now a changed focus on patients in hospital who didn't need to be there, together with the right level of care post-hospital. In relation to Sheffield being identified as one of three hotspots, alongside Cumbria and Fylde Coast, this was because, at the relevant time, Sheffield had a similar number of patients in hospital (90) who didn't need to be there, as those authorities. The present position was that Sheffield now had 52 such patients, with the emphasis being on moving to a 'why not home and why not today' attitude. He added that there were three main routes out of hospital, these being home, home with support and intermediate care to assess, and that success in keeping delayed discharges to a minimum relied on partnership working between the three aforementioned organisations.

5.5 In relation to the issues behind the problem, Phil Holmes stated that one-third was related to a lack of care in the community, one-third was about a route out of hospital not being clear and one-third was about assumptions on the care home requirement. He added that the issues were about human rights and interests and that the system would be severely tested this Winter.

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

- All reablement services were provided by the public sector, namely the Sheffield City Council and Sheffield Teaching Hospitals, and there were no plans to outsource these services.

- There were 154 intermediate care beds in Sheffield and access to these was arranged through the relevant hospital. There were also intermediate care services which provided additional support and all these services were covered by the Care Quality Commission. Consideration was being given to increasing the number of these beds for access by the Primary Care Service.

- The key was how organisations and staff worked together, so that capacity and skills were in the right place to provide an improved system of intermediate care.

- Work was being undertaken on getting assessments right to ensure that people were fit to leave hospital and go home or into residential care and it was important to strike the right balance. It was important to consider what was normal for any particular patient and there was a movement from assessing people in hospital to assessing people in their own home to facilitate this. Families could also be supported to provide a last chance for a patient to live at home and it was recognised that some patients may return to hospital. The Council would hear about any unsafe discharges, and experience of this was very rare in Sheffield, with more concerns being expressed about people getting infections in hospital.

- A written summary could be provided to any questions submitted by email by Councillor Douglas Johnson, for circulation to the Committee.

- The Accountable Care approach was based on people's experiences and this needed to be extended.

- The aim was to try to simplify a complex solution, but at least the problem could now be articulated. It was accepted that Winter would be a challenge, with the test being the number of patients in hospital. It was important to note that the organisations involved were regulated by different bodies, with no single point of regulation and different motivations and it would be necessary to step outside this framework to obtain solutions.

- There were two important elements in making progress on reducing delayed discharges from hospital. The first of these related to the role of the hospital in the process, putting into practice the 'why not home why not today' questions, as well as getting people fit and planning for what was to happen when they were fit. The second element related to the three routes out of hospital already mentioned at the point of fitness and these were managed outside the hospital. It was possible for change to be demonstrated, in that six months ago patients were waiting for long periods before discharge and now this was no longer than one week, with no significant issues being reported.

- The figures for re-admission were one of the metrics considered by the Delayed Transfer of Care Programme Board.

- Nationally, Accident & Emergency attendances were increasing but were down in Sheffield last year.

- The Programme Board was looking at external factors such as the use of step-up beds and links with urgent care.

- Work in the localities was presently at an early stage in terms of preventative work and ensuring that people weren't kept in hospital for social reasons.

- Early assessment and care was important in relation to decompensation, which was where patients became more frail as a result of being in hospital.

- Earlier that week there had been 52 people in hospital who didn't need to be there and now there were 46. This needed to be down to 40 during the Winter to be sustainable. In reducing delayed discharges, it was important to hear people's experiences.

5.7 RESOLVED: That the Committee:-

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

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

(c) requests that, in relation to reducing delayed discharges from hospital in Sheffield:-

(i) officers work with Sheffield Healthwatch in order to understand what was happening in the communities and ensure that the third sector be presented with all relevant information;

(ii) details of any complaints be shared with the Committee;

(iii) appropriate emphasis be placed on the quality of life issues in the community such as food and heating;

(iv) Phil Holmes (Director of Adult Services) meets with the Chair of the Committee, Councillor Pat Midgley, to assess the present situation; and

(v) a short update report be presented to the Committee in Spring 2018.

6. REVIEWING URGENT PRIMARY CARE ACROSS SHEFFIELD - PUBLIC CONSULTATION

6.1 The Committee received a report of the Director of Strategy and Integration, Sheffield Clinical Commissioning Group (CCG), which outlined the process undertaken to develop the Urgent Primary Care options, which were to be taken out to formal public consultation, and described the options for service reconfiguration which were to be included in the consultation. Attached to the report was the Urgent Care Strategy Review Engagement report, the draft Consultation Plan and a Neighbourhood map which provided details of the

locations of GP practices in the City.

6.2 In attendance for this item were Peter Moore (Director of Strategy and Integration, Sheffield CCG), Kate Gleave (Deputy Director of Strategy and Integration, Sheffield CCG) and Eleanor Nossiter (Sheffield CCG).

6.3 The report was supported by a presentation given by Kate Gleave, which covered the current system pathway, the revised system pathway, options within the consultation, what this meant for Sheffield patients and what the benefits were for Sheffield patients.

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

- The consultation would include a clear map of practices in the neighbourhoods, to give people an idea of how far they may need to travel and assessments had been made of travel times to get to these centres. There were also estate and workforce considerations to bear in mind when considering these locations.

- It was felt that GPs didn't need to see all patients and, in order to relieve the pressure on practices, practices would work together to see patients within their local area (neighbourhoods), rather than them necessarily being seen in their own practice. Patients with minor illness or injuries who attended Accident and Emergency Departments would be directed to the Urgent Treatment Centre (UTC). It was important to make primary care consistent and offer the right level of support.

- By improving local access, it was hoped that patients would choose to be seen in the neighbourhoods, ideally on the same day. The UTC at the Northern General Hospital was there as a national requirement and people seemed to like using it.

- The aim was to simplify the services available, ensure patients could access urgent care quickly, take out duplication from the system and invest in more effective primary care. An out of hours GP service would still be provided from the Northern General Hospital site.

- Whilst people with mental health needs had been covered in the engagement report, this would be revisited to ensure the significant representation of this group.

- The advantage of localisation was that those working locally would know the area and its people and could direct them appropriately.

- Whilst initial access to urgent care for the majority of people would be by telephone, access may be tailored for different neighbourhoods and groups of people, eg a drop in service may be needed for the homeless, and consideration was also being given to the use of skype and email.

- It would still be possible for people to consult their pharmacy or optician if they so wished. However, technological issues prevented these services from booking appointments for patients at their local GP service or UTC.

- Engagement with walk-in centre patients in the consultation process was progressing.

- A programme of work was being undertaken on improving mental health care to cut down on waiting times, but incidents relating to mental health tended to be more of an emergency situation rather than relating to urgent care.

- The implementation of neighbourhood solutions was designed to address situations where GPs could not manage their workloads.

- Full implementation was expected by 2020 and additional organisation may be required to provide services in the interim.

- The aim was for those patients requiring urgent care to be seen at a GP practice or in a neighbourhood setting. In the evenings and at weekends, four neighbourhood sites would be available across the City. Alternatively patients could attend the UTC. The process was designed to help patients get an early appointment and the appropriate care.

- Discussions were taking place with regard to communicating the new proposals to as many people as possible during the consultation and communications staff at the CCG would be undertaking work in the neighbourhoods.

- Whilst it was acknowledged that car parking at hospitals could be seen as a barrier, the aim was for people to be seen in the community.

- The report just outlined the proposals, as officers wanted to keep things simple, but it did include all the options. The draft document was to be considered by a Committee of the CCG the following week, with the consultation to start after that. Members of the Committee would be able to see the document at the same time at which it was released publicly.

- The reason why there was no option 3 in the presentation was that originally, six options were considered and three were identified from these. In the final consultation document, they would be designated as options 1, 2 and 3.

- The Royal Hallamshire Hospital had been considered as a location for the UTC, but this had not been progressed as it was not feasible.

- Patient care was a fundamental driver behind these proposals, with the intention being to avoid duplication and invest in those patients who had more complex conditions.

- It was important to get core standards in terms of telephone calls and

appointments, and it was hoped to get these arrangements in place quickly.

- The contracts with hospitals and the National GP Contract had a different performance management regime, but it was important to get a clear, consistent offer to the public.

- Officers would receive weekly and monthly reports on the responses to the consultation and it was hoped to have a good flavour of the outcome by the end of October 2017.

6.5 RESOLVED: That the Committee:-

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

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

(c) requests that:-

(i) Members' concerns regarding neighbourhood, inequality, mental health and language issues be taken into consideration in carrying out the consultation;

(ii) Members be kept informed of progress with the consultation process so that they could participate in events such as discussion groups; and

(iii) an update report on the consultation be presented to the Committee at its November 2017 meeting.

7. ORAL AND DENTAL HEALTH IN SHEFFIELD - FOLLOW UP

7.1 The Committee received a report of the Scrutiny Working Group on Oral and Dental Health which had met to consider areas for recommendations and where further information was required, following consideration of this issue at the Committee's previous meeting. The report set out the Group's findings and recommendations.

7.2 RESOLVED: That the Committee:-

(a) agrees the findings and recommendations of the Scrutiny Working Group on Oral and Dental Health as set out in the report, subject to the inclusion of an additional recommendation at paragraph 2.9 worded as follows:-

'The Group recognises that despite all the hard work that goes into oral health promotion, inequality persists in levels of child tooth decay across the City, with a fourfold difference between areas with the highest and lowest levels. There is also a clear link between deprivation and levels of child tooth decay. The report clearly indicates the importance of increasing children's exposure to fluoride in fighting decay, and the effectiveness of water fluoridation in ensuring all children benefit from fluoride. The Group notes the action in the draft Oral Health Strategy that a review of the

appropriateness of water fluoridation in Sheffield be conducted. It is 12 years since the Council last debated water fluoridation - the Group believes that it is time the issue be re-examined and asks the Cabinet Member and Director of Public Health to take this forward in the appropriate forum, reporting back to this Committee on how they plan to do this.'; and

(b) requests the Policy and Improvement Officer, in conjunction with the Chair, Councillor Pat Midgley, to progress the recommendations and report back to the Committee.

(**NOTE**: Councillor Douglas Johnson wished it to be recorded that he did not support the recommendation for the Council to debate water fluoridation.)

8. WORK PROGRAMME 2017/18

8.1 The Committee received a report of the Policy and Improvement Officer which set out the Committee's Work Programme for 2017/18.

8.2 RESOLVED: That the Committee:-

(a) approves the contents of the Work Programme 2017/18 report; and

(b) supports the suggestion now made for the Work Programme to be discussed at the Committee's pre-meeting held before each Committee meeting.

9. MINUTES OF PREVIOUS MEETING

9.1 The minutes of the meeting of the Committee held on 19th July 2017, were approved as a correct record.

10. DATE OF NEXT MEETING

10.1 It was noted that the next meeting of the Committee would be held on Wednesday, 15th November 2017, at 5.00 pm, in the Town Hall.

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
15 November 2017

Report of: Paul Billington

Subject: Food and Wellbeing Strategy

Author of Report: Jessica Wilson, Health Improvement Principal
Jessica.wilson2@sheffield.gov.uk
0114 2057467

Summary:
A new Food and Wellbeing Strategy is in development. Scrutiny has requested sight of the draft strategy for comment and to inform its development prior to cabinet decision making processes.

Poor diet is the second highest risk factor for ill health in the UK, coming second only to tobacco. Being overweight is the third highest risk factor for ill health and is closely related to our food intake. Poor diet is also a social justice issue - it is much more common in lower socio-economic groups and a major contributor to health inequalities in Sheffield.

The current Food Strategy was developed in 2013 and comes to an end in 2017. A new Public Health Strategy for Sheffield is now in place which calls for an increased focus improving health and wellbeing at population level and a move towards a health in all policies approach. The actions within the existing Food Strategy do not fully reflect this shift in emphasis and more could be done to employ the policy levers and influence that the council has to improve the food environment and improve diet at population level. There is currently no direct investment in prevention activity related to the Food Strategy but the council currently invests £800k in a range of weight management services that are loosely aligned to the existing food strategy. Current contracts expire in Oct 2018; there is also a planned 18% reduction to this budget over 2 years.

In light of the above a new Food and Wellbeing Strategy is being developed that better reflects current priorities, policy direction and manages the reduction in funding. As weight management contracts come to an end a new commissioning model will be developed that is more closely aligned to the new Food and Wellbeing Strategy and makes the most effective use of the reduced resource. This would involve a shift in resource to achieve a balance between services hat support people on an individual basis and initiatives that aim to improve food choices on a larger scale.

The new Food and Wellbeing strategy will have as its mission *"Making Good Food the Easy Choice for Everyone*". The aspiration being that everyone in Sheffield eats as well as possible, with healthy weight and diet the norm.

The strategy proposes a whole systems approach that will focus on making the healthier choice the easier choice in as many settings as possible alongside providing targeted information and support. There will be an explicit focus on reducing health inequalities; highlighting sugar consumption as an issue; and on early intervention by targeting the early years and children, young people and families.

The expected effect of these changes will be an increase in the proportion of people eating a well-balanced diet and a reduction in prevalence of conditions related to poor diet including obesity and tooth decay. The strategy will do this by:

- limiting exposure to cheap and appealing calorie-dense, nutrient-poor food in the wider environment and restricting opportunities for the marketing of this type of food (particularly in places where the council has some control or influence);
- improving access to good food so that it is physically and financially accessible to everyone;
- providing information and support to allow those in greatest need to gain the knowledge and skills to access a healthy diet.

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

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

The Scrutiny Committee is being asked to:

The Committee is asked to consider the proposals and provide views, comments and recommendations

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Background Papers:
Draft Food and Wellbeing Strategy

Category of Report: OPEN

Report of the Director of Culture, Environment & Leisure

Draft Food & Wellbeing Strategy

1. Introduction/Context

1.1 This report outlines a draft Food and Wellbeing Strategy for Sheffield and proposed changes in commissioning to support the strategy.

1.2 Poor diet is the second highest risk factor for ill health in the UK, coming second only to tobacco. Being overweight is the third highest risk factor for ill health and is closely related to our food intake. Poor diet is also a social justice issue. It is much more common in lower socio-economic groups and a major contributor to health inequalities in Sheffield. The ill health resulting from poor diet is also related to wider socioeconomic performance.

1.3 Much of the harm caused by poor diet is driven by overconsumption leading to people becoming overweight or obese. In Sheffield almost 1 in 4 children are overweight or obese when they start school. This increases to 1 in 3 by the time they leave primary school. Rates of childhood excess weight have been increasing, overweight and obesity prevalence in Y6 is now at its highest since measuring began in 2006/07. More than 2 in 3 adults are overweight or obese.

1.4 Less than 1 in 4 adults in Sheffield report eating 5 portions of fruit and vegetables per day. Sugar consumption nationally is well in excess of recommended levels and is a particular issue for children and young people. Eating a diet that is lacking in essential nutrients and high in sugar, salt and fat is also directly linked to poor health irrespective of a person's weight.

1.5 The current Food Strategy was developed in 2013 and comes to an end in 2017. The strategy was wide ranging and had three main outcomes – improving health and wellbeing, maximising the contribution of food to the local economy and minimising the environmental impact of the local food system. Actions were organised under 6 priority areas – tackling food poverty; making takeaway food healthier; supporting communities to eat well; encouraging more people get involved in food growing; boost the role of food in the local economy by promoting Sheffield's food assets; explore the value of an independent food trust.

1.6 Since the development of the 2013 Food Strategy a new Public Health Strategy for Sheffield has been developed which calls for an increased focus on population measures to improve health and a move towards a health in all policies approach. It was felt that the actions within the existing Food Strategy did not fully reflect this shift in emphasis and that more could be done to employ the policy levers and influence that the council has to improve the food environment and improve diet at population level. It was also felt that due to the scale of the problem regarding poor diet, obesity and rising health inequalities addressing this should be the primary outcome for the revised Food Strategy.

1.7 There is currently no direct investment in prevention activity related to the Food Strategy. The council currently invests £800k in weight management services which are loosely aligned to the existing food strategy. Current contracts expire in Oct 2018; there is also a planned 18% reduction to this budget over 2 years. It is proposed that as contracts come to an end a new commissioning model is developed aligned to the new Food and Wellbeing Strategy. This would involve a shift in resource to achieve a greater balance between services hat support people on an individual basis and initiatives that aim to improve food choices on a larger scale.

1.8 The proposed new Food and Wellbeing Strategy and accompanying commissioning model has been developed from a range of evidence sources including an assessment of local need and a review of national and international guidance, best practice and evidence (including that on addressing alcohol use and smoking where comparisons can be made).

2. Main body of report and matters for consideration

2.1 **Why Food?**
A good diet directly benefits our health by preventing serious health problems such as cardiovascular disease, diabetes, dementia and some cancers. It also means we are less likely to become overweight and experience the range of health problems associated with this. A good diet includes fresh fruit and vegetables; sugar, salt and fat intake that is in line with national guidance; and an overall calorie intake that is not in excess of our energy requirements.

2.2 Food is a social justice, fairness, and health inequalities issue for our city. In general healthier foods tend to be more expensive than less healthy, calorie dense processed foods and are therefore less accessible to those on the lowest incomes. Poor diet is the most harmful, in health terms, to the most vulnerable in our city and a major contributor to health inequalities in Sheffield. Factors such as child and adult obesity, proportion of children and adults consuming 5-A-Day and child tooth decay are far more prevalent in lower socio-economic groups and sustain inequalities throughout the life course by impacting on wider determinants of health including school attainment and employment.

2.3 Food also plays a part in our emotional wellbeing. The more often people eat with others the more likely they are to be satisfied with their life and feel engaged with their local community.

2.4 **What influences food choices?**
Evidence shows that our food choices are influenced by: the food we were given in early life (conception to start of school); all forms of marketing (this particularly affects children); widespread exposure to cheap and appealing calorie-dense, nutrient-poor food; affordability (including the impact of poverty); education and health promotion; social influences and social changes. In order to maximise effectiveness a food strategy will need to address all sources of influence.

2.5 The range of influences on our food choices highlights that whilst consumer education and personal responsibility are important, they will not be sufficient to produce the change we want to see in Sheffield. Interventions that rely less on individual choice and more on changes to the wider environment are essential in making healthier choices easier when we eat at home, eat out or eat on the go. Such changes will also have a greater impact on health inequalities as they are less reliant on individuals being motivated and capable of making sustained changes to their behaviour.

2.6 **Proposed strategy**

The proposed Food and Wellbeing Strategy will aim to improve food choices and reduce the prevalence of diet related ill health including obesity, cardiovascular disease and tooth decay at population level.

2.7 The strategy will do this by

- Transforming the food environment: limiting exposure to cheap and appealing calorie-dense, nutrient-poor food and restricting opportunities for the marketing of this type of food (particularly in places where the council has some influence)
- improving access to good food so that it is physically and financially accessible to everyone
- providing information and support to allow those in greatest need to gain the knowledge and skills to access a healthy diet

2.8 There is no single action that can improve food choices at population level. Therefore a whole systems approach will be taken that will focus on making the healthier choice the easier choice in as many settings as possible alongside providing targeted information and support.

2.9 There will also be an emphasis on reducing inequalities. This will be done by targeting interventions towards groups at highest risk and by putting greater emphasis on structural and policy level interventions as these have been shown to reduce inequalities.

2.10 It is proposed that sugar is highlighted as an issue and addressed through a range of interventions. Sugar is the biggest cause of excess calories in our diets and this contributes to obesity. Sugary food and drink often replaces more nutritious foods in our diet leading to diet related ill health including tooth decay, some cancers and diabetes. Consumption of sugary drinks is directly linked to development of type 2 diabetes. Diet is a complex issue with many components; highlighting sugar will provide a strong and simple message and a focal point on which to engage partners and the general public.

2.11 It is also proposed that there is a strong focus on interventions that target the early years and children, young people and families. Food choices have their foundations in early life, a quarter of children are already overweight by the time they start school and there has been shown to be greater return on investment for early years interventions.

2.12 The strategy proposes action in six areas:

2.13 **Area 1. Develop public policy around food.** Local authorities have an important role to play in improving the food environment and making the healthier choice the easier choice. We control planning, public and environmental health, leisure and recreation and have influence over food and drink in schools, nurseries, civic centres, leisure centres, sports facilities, parks, museums, theatres, our own workplaces and others. In order to help people to achieve healthier diets, we need to develop consistent policies regarding the food that is available, for sale and marketed in these settings. A first step in this area could be signing a Local Authority Declaration on Healthy Weight.

2.14 **Area 2. Create a better food environment by supporting businesses and organisations to improve their food offer.** Whilst we have less control and influence over the private sector, by developing our own food and drink policies we can lead the way and encourage others to follow suit, providing advice and support to them where necessary. We also have a number of business facing functions such as Environmental Regulations; Licencing; Events and City Centre Management; and Business Sheffield which could be used to disseminate information and guidance. High profile campaigns would be used to encourage retailers to participate.

2.15 **Area 3. Deliver mass media and marketing campaigns to change dietary behaviours with a specific focus on sugar reduction.** Health marketing is important as both a motivator and enabler for consumers to change their own and their families' diets and can help underpin structural and policy level interventions to improve food choices. There is a growing body of evidence on how marketing approaches can effectively change behaviours. Approaches can be targeted at particular population groups and issues. Actions would include the development of a "Low Sugar Sheffield" brand under which a range of actions and interventions would sit.

2.16 **Area 4. Increase access to healthy food for those on low incomes.** This may need to be tackled in a number of ways working alongside voluntary and community sector partners and may involve piloting initiatives in parts of the city to develop the evidence for what works. Schemes/initiatives might involve

- Voucher or subsidy schemes for individuals on low incomes or in deprived neighbourhoods to incentivise the purchasing of fruit and vegetables
- Support for community ventures that increase access to fresh food (social supermarkets and cafes, community meals, lunch clubs, veg box schemes etc.)
- Expanding the provision of School Holiday Hunger schemes (subject to evaluation)
- Use of subsidies or incentives to attract healthier food retailers to neighbourhoods where these are currently lacking
- Other small, community based pilots developed using asset based approaches

2.17 **Area 5. Support individuals to improve their diet and achieve/maintain a healthy weight**. We will look for ways to ensure that provision of information about the importance of healthy weight and diet and related brief interventions/advice is routinely given by front line practitioners. Training and tools to support this will be developed and implemented where appropriate. Some individuals may need more than brief advice in order to successfully change their behaviour for the long term. It is proposed that the council will continue to deliver the Start Well service to parents with pre-school children and commission lifestyle weight management support for children and adults; the latter may be commissioned at reduced scale and could be increasingly targeted towards groups and areas with the greatest level of need and this may mean that in some cases they are no longer universally accessible. We will also explore the use of online weight management tools for adults which can be widely accessed.

2.18 **Area 6. Influence national policy where this support us in meeting our targets.** In order for our local strategy to have the greatest impact we need it to be underpinned by robust national policy. The national Childhood Obesity Plan has taken some positive steps such as the introduction a sugar levy and work with industry to reduce the amount of sugar in certain foods. However, our progress could be further supported by national policy for example restricting junk food advertising to children through family TV programmes such as Britain's Got Talent or reconsidering changes to the welfare system where these are placing people in food poverty

2.19 **Proposed Commissioning Model**
Current expenditure on obesity prevention and treatment is £800k per year. This will be reduced to £658k by 19/20 as part of required savings to public health budgets (18% reduction).

2.20 Current expenditure is outlined below. Where contracts with external providers are in place they are due to expire in October 2018.

Service description	Contract value	Current provider
Start Well service – support to Early Years settings to adopt healthy early years standards, deliver obesity brief intervention training to early years staff and deliver HENRY family programmes	£75k	SCC
Children and Young People Weight Management	£200k	Everyone Health
Adult Weight Management	£260k	
Specialist Adult Weight Management	£265k (reducing to £194k in 18/19)	

2.21 It is proposed that as current contracts come to an end a new commissioning model is implemented aligned to the new Food and Wellbeing Strategy. The new commissioning model would maintain investment (minus the planned 18% reduction) for a further 3-5 years,

but this investment would be shifted so that there is greater expenditure on initiatives that address the factors that influence people's food choices.

2.22 Areas of investment will need further consultation but may include:

2.23 *Support for Schools* to implement a whole school approach to healthy eating. Evidence has shown this can lead to an increased uptake of school meals, an increase in healthy eating behaviours, increased cooking and growing skills in children and families and more knowledge about nutrition. Targeting schools in particular aligns with evidence that there is a greater return on investment from interventions targeting children and young people. There will also be a continuation of the Healthy Early Years award scheme delivered by the council which mirrors this approach within early years settings.

2.24 *Delivery of mass media and marketing campaigns.* Mass media and social marketing campaigns using evidence based techniques have the potential to change behaviour on a large scale thus making them cost effective. There are examples of successful campaigns that have been used to reduce sugary drinks consumption such as Howard County Unsweetened and Give Up Loving Pop. It is proposed that an overarching Low Sugar Sheffield brand is developed to raise the profile of actions that are being taken citywide and to engage wider stakeholders including businesses and local residents in the campaign. There could also be campaigns targeting specific priority groups and issues including pregnant women; early years sugar reduction/sugary drinks; sugar reduction for young people; front line staff to encourage delivery of brief interventions on diet and healthy weight; engaging food businesses and workplaces in sugar reduction.

2.25 *Developing tools and support for businesses and organisations* to improve their food offer in order to reduce exposure to cheap and appealing calorie-dense, nutrient-poor food in the wider environment. There are a range of ways in which voluntary pledges and healthy catering guidance could be developed and implemented dependant on the level of investment. Businesses and workplaces in deprived areas and/or on school fringes and near to children's visitor attractions would be prioritised. Council services such as environmental regulations, licensing & city centre management could be utilised as a way to reach businesses.

2.26 *Increasing access to unhealthy food for those on low incomes.* This could be implemented through a range of initiatives and pilots in areas of high need by community organisations. The VCF sector would be engaged in shaping this approach which might include as examples:

- Voucher or subsidy schemes for individuals on low incomes or in deprived neighbourhoods to incentivise the purchasing of fruit and vegetables
- Use of subsidies or incentives to attract healthier food retailers to neighbourhoods where these are currently lacking

- Support for community ventures that increase access to fresh food (social supermarkets and cafes, community meals, lunch clubs, veg box schemes etc.)
- Extending the provision of School Holiday Hunger schemes

2.27 *Support individuals to improve their diet and achieve/maintain a healthy weight.* Weight management is currently the main area of spend related to the existing food strategy. It is proposed that the council continues to fund weight loss support but at a reduced level and increasingly targeting high need groups and focusing on early intervention and prevention. Consideration will also need to be given about how to deliver such interventions at sufficient scale to reduce population prevalence of poor diet and obesity. This might include online weight management interventions and an increased focus on brief interventions by front line staff by offering training and simple screening and referral tools.

2.28 The above represents an outline of the areas of activity that would be funded in the new commissioning model. There will need to be a period of stakeholder consultation and market testing to a) determine the optimum spread of investment across the interventions b) agree the scope of each intervention and c) develop a procurement strategy

2.29 In addition to the commissioned work outlined above policy change will be a major focus of the strategy. Policy change has a greater impact on population prevalence of diet related illness due to its widespread impact. It can also reduce health inequalities as changes affect the whole population and tend to particularly benefit those who currently find it most difficult to make better food choices. Officer time will be dedicated to the development of council policy around food for example in planning, procurement, sponsorship and advertising, catering etc. and to influence national policy. Public sector partners such as hospitals, schools, leisure and tourism will also be engaged to develop their contribution to this agenda.

2.30 **Summary of changes to approach from existing Food Strategy**
The proposed new strategy differs from the current approach in the following ways:

2.31 An increased focus on reducing diet related ill health at population rather than individual level by addressing the factors that influence our food choices. The need for change comes from recognition that there is a diminishing resource for public health and for Local Authorities as a whole and this must be used effectively if we are to improve health and population level and reduce health inequalities. In practice this would mean reducing the spend on interventions such as weight management and redirecting this to interventions that target larger groups of the population such as marketing and communications or settings based approaches such as working with schools and early years providers. If funds were less restricted the city would maintain its investment in services *as well as* investing more in wider work but this is not the reality.

2.32 A shift in emphasis so that the strategy's primary outcome is to improve health and wellbeing by making it easier for people to make better food choices wherever they are. This shift is due to the scale and impact of the health consequences of poor diet and the urgent need to address these. The previous food strategy had two additional outcomes – supporting a strong and vibrant food sector in the city and reducing the environmental impact of the local food system. Both of these outcomes will have a positive impact on the wider determinants of health and remain of importance to the broader public health agenda. However, they align with existing areas of council policy (economic strategy and sustainability). The role of public health will be to support policy makers in these areas to ensure that the contribution of food is recognised and represented.

2.33 A more systematic approach to developing public policy around food. A recent example of this has been the inclusion of restrictions in contracts on the types of food and drink that can be sold in our leisure centres. Policy change like this has a greater impact on population prevalence of diet related illness. It can also reduce health inequalities as changes affect the whole population and tend to particularly benefit those who currently find it most difficult to make better food choices. For this reason policy and structural interventions play an essential role in reducing health inequalities and there will need to be broad organisational sign up and cooperation.

2.34 **Financial implications**
The proposed commissioning model will allow Place Public Health to manage the 18% reduction in funding. Due to the scale and health impact of poor diet it is recommended that investment in this area does not see any further reductions.

2.35 It should be noted that there may be financial implications arising from changes to policy. For example if we were to place restrictions on food vendors at public events or on the types of sponsors we would accept for these events there might be a risk to revenue. There would be a need for discussion on this kind of issue on a case by case basis and an examination of the public health gains vs other impacts.

2.36 **Equalities implications**
Due to the vast inequalities in diet and related health outcomes that exist in Sheffield a primary driver for the Food and Wellbeing Strategy is increasing fairness and reducing health inequalities. The changes in approach outlined above should have a positive impact on health inequalities and targets will be set to ensure that improvements are not only seen in those groups and parts of the city that already experience better health outcomes.

2.37 The proposed commissioning model may involve ending or reducing expenditure on existing services. There may also be increased targeting of new services. Equality impact assessments have not yet been undertaken but will need to be completed as part of this process.

2.38 **Relationship to other strategies**

An effective Food and Wellbeing strategy will support the Sheffield City Council Corporate Plan priorities Thriving Neighbourhoods and Communities, Better Health & Wellbeing and Tackling Inequalities

2.39 The strategy is in line with the direction of travel set out by Sheffield's Public Health Strategy in particular due to the emphasis on policy change and shifting to population level interventions.

2.40 Obesity is a consequence of poor diet and physical inactivity and so together the Food and Move More strategies will contribute to reduction in obesity, neither will be effective in isolation. However, it should be noted that a well-balanced diet and being physically active are both important contributors to wellbeing in their own rights and are not solely about reducing obesity hence the need for two strategies rather than a single obesity strategy. There may be some overlap in objectives between the two strategies. Where this occurs we will seek to work in partnership to maximise opportunities and avoid duplication.

2.41 The recent Sheffield Oral Health Strategy calls for reduction of sugar to be considered a priority in food and other council strategies. Consultation and joint working has and will continue to take place during strategy development and implementation.

2.42 Affordability is an important factor influencing our food choices. The Food and Wellbeing Strategy will need to continue work closely with the Tackling Poverty Strategy. The Food and Wellbeing Strategy will support the outcomes of the Tackling Poverty Strategy in particular by undertaking activities that mitigate some of the worst effects of poverty (hunger and poor diet) and that contribute to breaking the cycle of poverty.

2.43 Economic Strategy and Sustainably Strategy. Food makes a contribution to our local economy and has an environmental impact. Public Health will work alongside policy makers to ensure related strategies continue to represent the contribution of food.

3 What does this mean for the people of Sheffield?

3.1 Food is a social justice, fairness, and health inequalities issue for our city. Poor diet is the most harmful, in health terms, to the most vulnerable in our city and a major contributor to health inequalities in Sheffield. Factors such as child and adult obesity, proportion of children and adults consuming 5-A-Day and child tooth decay are far more prevalent in lower socio-economic groups and sustain inequalities throughout the life course by impacting on school attainment and employment.

3.2 In Sheffield fewer than 1 in 4 adults are eating the recommended 5 portions of fruit and vegetables a day on overage. This varies across the city and is closely related to deprivation.

3.3 National surveys show that children are eating three times the recommended amount of sugar each day. Tooth decay is a

predominantly preventable disease linked to high levels of sugar consumption. On average Sheffield 5 year olds have 1.2 decayed, missing or filled teeth. This ranges from 0 in some areas, to in excess of four decayed, missing or filled teeth in others and is related to deprivation. Teeth extractions are the most common reason for child hospital admissions. Over the last five years, on average, children in Sheffield are more than twice as likely to be admitted to hospital to have teeth extracted than England. Research has shown that over a quarter (26%) of children have missed school because of dental pain with an average of 3 school days missed. Children also miss, on average, two additional school days when attending hospital for extractions, with some children being absent from school for up to 15 days. Due to inequalities in dental health the educational impact of missed school is likely to affect those from lower socioeconomic groups most thus reinforcing inequalities.

3.4 Much or the harm caused by poor diet is driven by overconsumption leading to people becoming overweight and obese. In Sheffield in 2016 11.2% of 2-18 year olds were estimated to be clinically obese - this equates to 12,377 children (the number of children estimated to be overweight or obese combined is likely to be closer to 25,000). The percentage of adults classified as overweight or obese was 64.7% this equates to around 304,953 people. The percentage of adults classified as obese was 23.7% this equates to 103,240 people.

3.5 22.3% of 4/5yr olds in Sheffield were classified as overweight or obese in 2015/16. This was an increase from the previous year and the largest year-on-year increase since 2008/09. Sheffield has comparable combined overweight and obesity with England and the Yorkshire and Humber region. However, historically Sheffield has been below these national rates and the increase between 2014/15 and 2015/16 is marked. By age 10/11 the prevalence of overweight & obesity combined was 34.3% in 2015/16. Although the trend is stable prevalence is at its highest rate since 2010/11

3.6 An effective Food and Wellbeing strategy will lead to an increase in the proportion of people eating a well-balanced diet and a reduction in population prevalence of conditions related to poor diet including obesity, cardiovascular disease and tooth decay. A set of indicators will be developed to measure success. When setting targets and measuring progress will we will also need to ensure that in each case the greatest improvements are experienced by the groups that are currently experiencing the worst health outcomes.

3.7 In short we want everyone in Sheffield to eat as well as possible with healthy weight and diet across the population

4. Recommendation

4.1 The Committee is asked to consider the draft strategy and commissioning model and provide views and comments.

Appendix 1 – Draft Food and Wellbeing Strategy

Our vision

Everyone in Sheffield will have the opportunity, environment and social capital to consume food in a way that benefits their well being

Our mission

Make good food the easy choice for everyone

Why Food?

A well-balanced diet is directly beneficial to our health and wellbeing, helping us to maintain a healthy weight and prevent serious health problems such as cardiovascular disease, diabetes, dementia and some cancers. In the UK the highest risk factors for ill health, after tobacco, are a poor diet and being overweight[i]. Overconsumption of foods high in sugar, fat and salt is a major contributor to diet related ill health including obesity and tooth decay.

A wider culture of healthy eating benefits society through improved school attainment, increased employment and work productivity, reduced health and social care costs and reduced environmental impact[ii iii iv].

Unhealthy weight is a consequence of poor diet (excess calorie consumption) and inactivity and is a serious and worsening public health problem. It increases disability, disease and premature death and has substantial long term economic, wellbeing and social costs. The total societal cost of obesity, including lost productivity, is second only to smoking[v].

Poor diet and unhealthy weight are affected by health inequalities and are more common in lower socio-economic groups. This leads to poorer health outcomes for these groups.

Food also makes a broader contribution to our health and wellbeing, beyond the nutritional value of what we eat. Food gives us pleasure; often plays a central role in how we socialise, share and celebrate; and connects us to our culture and to our friends and family. The more often people eat with others the more likely they are to be satisfied with their life and feel engaged with their local community[vi].

What influences our food choices?

Evidence shows that there are multiple factors that affect our food choices. In order to change behaviour we must seek to address these aspects by taking a whole systems approach.

- **Early life** - the food eaten between conception and weaning influences how we respond to the food environment through a range of biological and psychological mechanisms. For example, maternal diet and early infant diet can alter the way in which genes are switched

on or off or children can grow accustomed to a diet high in sugars[vii]. Poor diet during this period can carry adverse health consequences in later life.

- **Marketing** is disproportionately used to promote unhealthy products. Evidence shows that all forms of marketing influences food purchasing and consumption, especially amongst children[viii].
- **Exposure** to healthy vs unhealthy food and drink in the wider environment. Evidence shows that our buying and eating behaviour is automatic and unthinking, prompted by what has been marketed to us and what food is around us[ix]. In our current environment the default food and drink options are too often the unhealthy ones. Foods that are high in sugar, fat and salt are widely available and affordable and are strategically located near schools, on our high streets and in areas of higher deprivation where often few healthy alternatives are available.
- **Poverty** – Low income households are more likely to consume highly processed, high sugar and high saturated fat foods[x]. Healthier diets are becoming more expensive[xi]. Food is often the flexible item in household budgets and therefore households on low incomes often respond by trading down on the food they buy, increasingly purchasing cheaper, energy dense, less nutritious food. Some areas may also suffer from a lack of access to good food at the right price[xii].
- **Education and health promotion** can help individuals to make healthy, informed food and drink choices. Health marketing is important as both a motivator and enabler for consumers to change their own and their families' diets. However, in order to be effective in tackling obesity, and particularly to help the poorest in society, activity needs to go beyond just health messages and information to consumers[xiii].
- **Social influences** – parents and carers can directly and indirectly influence their children's dietary preferences. For adults and older children the food eaten by friends, families and colleagues influences food choices.
- **Social changes** – for example the growing convenience culture has led to increased consumption of processed foods which are often higher in sugar, salt and fat. These ingredients are often "hidden" leading to people unknowingly consuming high levels of sugar, salt and fat. People are also increasingly less likely to sit down and eat meals together.

Our approach

This strategy will seek to change dietary behaviours across three domains which will address the known sources of influence on people's food choices.

1. Exposure – make the healthier choice the easier choice by limiting people's exposure to cheap and appealing calorie-dense, nutrient-poor food in the wider environment and by restricting opportunities for direct and indirect marketing of this type of food. Use marketing and behaviour change techniques to influence healthier food choices

2. Improve access - ensure good food is physically and financially accessible to everyone

3. Provide services and support – ensure people have the knowledge and skills that are needed to access a healthy diet and that support is available to those in greatest need

In addition to this the actions and investment resulting from this strategy will be guided by a number of key themes:

This strategy will advocate for a **whole systems approach** to improving dietary behaviours. The environmental drivers of poor diets are too big to be tackled by any single action alone. A broad programme of approaches at population, settings and individual level are required to promote healthier food environments and make healthier choices easier[xiv]. The strategy will seek to strike a balance between policy and population level interventions and interventions that support individuals to make healthier choices. In doing so we will aim to improve health and wellbeing at population level whilst also providing support to those with greatest need.

There will be emphasis on interventions that reduce **health inequalities.** This will be done in two ways – by targeting services and interventions towards groups at highest risk; and by putting greater emphasis on structural and policy change as this type of intervention is likely to have a greater impact on reducing health inequalities.

Due to strong evidence on the impact of diet in the **Early Years** (from conception to starting school) on future dietary behaviours and health outcomes there will be a focus on intervention during this time period. **Children, Young People and Families** will also be a focus of intervention because obesity begins in childhood - overweight and obese children and teens are much more likely to become obese adults. Also prevention of childhood obesity is easier relative to supporting adults to lose weight once they have already become obese.

There will be an initial focus on **sugar reduction.** The widespread consumption of sugar is causing concern as it can lead to an overall unhealthy diet through increased calorie consumption with a concurrent reduction in nutritionally adequate foods. This can lead to weight gain, obesity, diabetes and an increased risk of tooth decay. Tooth decay particularly affects children's health and school attainment. There has been recent national attention on sugar including a number of high profile national campaigns and there is evidence that ANY significant progress to reduce sugar intakes would yield benefits[xv]. There has also already been pioneering local action which can be capitalised on. For example SIV are the first leisure centre in the country to introduce a tax on sugary drinks and our Hospital Trusts have taken action to reduce the number of sugary drinks and snacks on sale.

Our actions

Actions will be grouped into six areas:

1. **Develop healthy food and drink policy for the council and wider public sector**

   Local authorities have an important role to play in improving the food environment and making the healthier choice the easier choice. We control planning, public and environmental health, leisure and recreation and have influence over food and drink in schools, nurseries, civic centres, leisure centres, sports facilities, parks, museums, theatres, our own workplaces and others. In order to help people to achieve healthier

diets, we need to develop consistent policies regarding the food that is available, for sale and marketed in these settings.

2. **Create a better food environment by supporting businesses and organisations to improve their food offer**
   Whilst we have less control and influence over the private sector by developing our own food and drink policies we can lead the way and encourage others to follow suit, providing advice and support to them where necessary. We also have a number of business facing functions such as Environmental Regulations; Licencing; Events and City Centre Management; and Business Sheffield which could be used to disseminate information and guidance.

3. **Deliver mass media and marketing campaigns to change dietary behaviours with a specific focus on sugar reduction**

   Health marketing is important as both a motivator and enabler for consumers to change their own and their families' diets and can help underpin structural and policy level interventions to improve food choices. There is a growing body of evidence on how marketing approaches can effectively change behaviours by applying behavioural insights techniques. Approaches can be targeted at particular population groups and issues. The following are suggested as priority campaigns: development of a "Low Sugar Sheffield" brand, healthy diet during pregnancy; early years sugar reduction/introducing solid foods; young people and sugary drinks; front line staff and brief interventions; engaging food businesses

4. **Increase access to healthy food for those on low incomes**

   This may need to be tackled in a number of ways and may involve piloting initiatives in parts of the city to develop the evidence for what works. Schemes/initiatives might involve

   - Use of subsidies or incentives to attract healthier food retailers to neighbourhoods where these are currently lacking
   - Voucher or subsidy schemes for individuals on low incomes or in deprived neighbourhoods to incentivise the purchasing of fruit and vegetables
   - Support for community ventures that increase access to fresh food (social supermarkets and cafes, community meals, lunch clubs, veg box schemes etc.)
   - Expanding the provision of School Holiday Hunger schemes

5. **Support individuals to improve their diet and achieve/maintain a healthy weight**

   We will look for ways to ensure that provision of information about the importance of healthy weight and diet and related brief interventions/advice is routinely given by front line practitioners. Training and tools to support this will be developed and implemented where appropriate.

   Some individuals may need more than brief advice in order to successfully change their behaviour for the long term. The council will continue to deliver the Start Well service to parents with pre-school children and commission lifestyle weight management support for children and adults; these will be targeted towards groups and areas with the greatest

level of need. We will also explore the use of online weight management tools for adults which can be widely accessed.

6. **Lobby for changes to national policy that would support us in meeting our targets**

   In order for our local strategy to have the greatest impact we need it to be underpinned by national policy. The national Childhood Obesity Plan has taken some positive steps such as the introduction a sugar levy and work with industry to reduce the amount of sugar in certain foods. However, our progress could be further supported by national policy in the following areas:

   - Banning price-cutting promotions of junk food in supermarkets, such as multipacks and buy one get one free
   - Restricting junk food advertising to children through family TV programmes such as Britain's Got Talent and The X Factor, as well as on social media and websites.
   - Ending junk food sponsorship of family and sporting events

Outline Action Plan

1. Develop healthy food and drink policy for the council and wider public sector

Action	Owner(s)
Reduce opportunities to market sugary drinks through advertising and sponsorship	City Centre Management and Major Events Finance and Commercial Services Public Sector partners including hospitals and schools
Support settings that are controlled or under the influence of the council and wider public sector to improve their food offer where necessary. Settings may include: • Public events • Parks, leisure, sports and recreation facilities • Childcare settings & schools (development of whole setting/school approaches to food) • Hospitals • Pharmacies • Universities and FE colleges • Other contractors	City Centre and Major Events Partnerships and Special Projects, Culture and Environment Finance and Commercial Services Parks and Countryside Prevention & Early Intervention, CYPF Public Sector partners

2. Improve the food environment by supporting businesses and organisations to improve their food offer

Action	Owner(s)
Develop sugar reduction pledges and/or healthy catering guidance/award targeting a range of organisations as outlined below. • Workplaces with on-site food provision	Place Public Health

• Fast food and street traders • Cafes and restaurants • Grocery stores • Non-food retailers such as department stores who may sell high sugar food and drink at points of sale	
Utilise council services such as environmental regulations, licensing & city centre management to engage businesses in the above with a focus on those in deprived areas and on school fringes.	Environmental regulation Licensing City Centre Management and Major Events Business Sheffield

3. Deliver mass media and marketing campaigns to change dietary behaviours with a specific focus on sugar reduction

Action	**Owner(s)**
Commission marketing and communications campaigns. Specific campaign areas/target groups would include: • Developing a "Low Sugar Sheffield" brand • Pregnancy • Early years sugar reduction/sugary drinks • Young people and sugary drinks • Front line staff (encouraging delivery of brief interventions) • Food businesses (encouraging adoption of healthier catering pledges)	Place Public Health

4. Increase access to healthy food for those on low incomes

Action	**Owner(s)**
Pilot and/or support a range of initiatives in high need areas. This might include: • Use of incentives/ subsidies/ differential business rates to attract healthier food retailers into areas where they are lacking • Pilot the use of voucher schemes to incentivise purchasing of fruit and vegetables. • Support for community ventures that increase access to fresh food (social supermarkets and cafes, community meals, lunch clubs etc) • School Holiday Hunger programmes • Pilot Universal Free School Breakfast in the most deprived schools • Pilot extension of School Fruit and Vegetable scheme in the most deprived schools	Place Public Health Public Health, Children's Commissioning Services Social Justice and Inclusion Lead People Commissioning Service Finance and Commercial Services

5. Support individuals to improve their diet and achieve/maintain a healthy weight

Action	Owner(s)
Continue to deliver the Start Well programme which aims to improve diet and increase physical activity in the early years including supporting individuals, developing staff capability and supporting early years settings to improve the food environment	Public Health, Children's Commissioning Services
Commission support for schools to implement a whole school approach to healthy eating e.g. food and drink policy development; development of school curriculum/campaigns to include information on diet/sugary drinks & snacks; social mobilisation of governors, parents and pupils to influence the food offer on the school fringe	Place Public Health
Commission diet and obesity brief intervention training for front line staff and development of brief intervention tools	Place Public Health
Ensure that diet and healthy weight are covered within Standard Operating Guidelines for key universal services (particularly 0-19, maternity and Primary Care)	Public Health, Children's Commissioning Services
Commission weight management support for Children, Young People and Families	Place Public Health
Commission weight management support for adults who require additional support to reach a healthy weight	Place Public Health

6. Influence national policy that would support us in meeting our targets

Action	Owner(s)
Policy areas to influence could include: • Banning price-cutting promotions of junk food in supermarkets, such as multipacks and buy one get one free • Restricting junk food advertising to children through family TV programmes such as Britain's Got Talent and The X Factor, as well as on social media and websites. • Ending junk food sponsorship of family and sporting events	Place Public Health

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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
15th November 2017

Report of: Dawn Walton, Director – Commissioning, Inclusion & Learning

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Subject: The Sheffield Mental Health Transformation Programme

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Author of Report: Jim Millns
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Summary:
The Sheffield Mental Health Transformation Programme was born from a collective need to improve quality, secure better joined up services and deliver better value for money.

Rather than take the traditional 'organisational specific' approach to transformation, Sheffield City Council, Sheffield Health and Social Care NHS Foundation Trust and NHS Sheffield CCG have designed, developed and are currently implementing a joint transformation programme. This has removed the barriers caused by having to manage individual financial risks and has enabled us to look at opportunities to reduce duplication and deliver economies of scale; as well as take a more innovative and creative approach to service delivery.

This report is being presented to the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee by way of seeking views, comments and/or recommendations for future delivery.

Type of item:

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:
Consider the Sheffield Mental Health Transformation Programme and provide views, comments and/or recommendations for future delivery.

Background Papers:
The Sheffield Mental Health Transformation Programme is underpinned by the Five Year Forward View for Mental Health: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Category of Report:
OPEN

The Sheffield Mental Health Transformation Programme

1. Introduction/Context

1.1 The Sheffield Mental Health Transformation Programme is an ambitious programme that was born ostensibly from a collective need to secure better joined up services and better value for money through economies of scale, reducing overlaps, eliminating wastage and through innovation and creativity.

1.2 Rather than take the traditional 'organisational specific' approach to transformation, which has historically been defined by an underlying perception that financial risks will undoubtedly be 'shunted' which inevitably leads to confrontational behaviour; Sheffield City Council (SCC), Sheffield Health and Social Care NHS Foundation Trust (SHSC) and NHS Sheffield CCG (SCCG) have designed, developed and are currently implementing a joint transformation programme consisting of 17 project areas, including 5 large scale transformational schemes focussing on:

a. Residential care;
b. Dementia care (from diagnosis to end of life care)
c. Liaison mental health (i.e. providing mental health support to those patients who may be experiencing distress whilst receiving physical healthcare services);
d. Primary care mental health; and
e. Integrated psychological therapies (i.e. ensuring psychological interventions are available as part of physical healthcare pathways).

Primary Care Sheffield are also helping to deliver the programme.

2. Programme Objectives

2.1 The overarching aim of the Transformation Programme is to address what are predominantly long-standing issues in Sheffield, whilst remaining focused on QIPP principles, i.e. quality, innovation, productivity and prevention. The latter 'P' of QIPP is particularly important and is a key component of the programme; tackling ill health at the earliest opportunity. If we get this right, this will not only improve the outcomes for individual service users but will ultimately deliver better value for money as we will rely far less on secondary health care services. This aspiration therefore underpins the entire transformation programme.

2.2 There is a genuine cross-organisational commitment to ensuring this work is undertaken jointly, collaboratively and safely. All parties are clear that whilst one of the (key) drivers for this work is the delivery of better value, the desired outcomes are very much quality focused; changing the way that mental health and learning disability services are delivered in Sheffield so that the quality of services are not undermined and that the offer of care and treatment is far more localised, individualised and

focused (where possible) on prevention, early intervention and recovery.

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

3.1 Taking a more holistic approach to the delivery of mental health care will genuinely promote parity of esteem by strengthening support across the wider health system for people with mental health problems who tend to (a) have more negative experiences and outcomes when they receive health care, and (b) place a disproportionate level of demand on general health services. It will, as noted above, also help us to focus on the wider determinants of mental ill health and develop more preventative services.

3.2 Improving the quality of care for patients is therefore very much the motivation for this collegiate approach. We are therefore committed to ensuring that service users, carers, staff and the general public are actively involved and supported to contribute to individual projects. We are currently developing an engagement plan which will include learning from good practice used in other areas of our work.

4. Recommendation

4.1 Whilst there are no specific recommendations as such, the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee are very much asked for their views, comments and/or recommendations for the future delivery of the Sheffield Mental Health Transformation Programme.

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 15th November 2017

Report of: Dr David Throssell
Medical Director
Sheffield Teaching Hospitals NHS Foundation Trust

Subject: Quality Objectives Themes for 2018/19

Author of Report: Sue Butler
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Summary:
Foundation trusts are required to produce an Annual Quality Report, which forms part of the Annual Report, and specific reporting requirements are currently detailed in NHS Improvements NHS Foundation Trust Annual Reporting Manual 2016/17.

The Quality Report has two key aims; to report on the quality of services delivered by Sheffield Teaching Hospitals during the previous year and to identify the quality objectives for the following year.

Presented here are proposed themes for quality objectives for Sheffield Teaching Hospitals during 2018/19. These are key themes which have been drawn up following discussion involving key Trust staff, Governors and Healthwatch Sheffield.

We welcome your views and comments on these and ask if you could please indicate your six top themes. Following wider consultation we aim to select nine to twelve objectives which will then be worked up, ensuring they are specific and measurable.

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:
The Committee is asked to review and comment on the themes presented, indicating the top six themes they would like to be taken forward as quality objectives for 2018/19.

Background Papers:
NHS foundation trust annual reporting manual 2016/17
Detailed requirements for quality reports for foundation trusts 2016/17
Detailed guidance for external assurance on quality reports for foundation trusts 2016/17
Quality Accounts: a guide for Local Involvement Networks

Category of Report: OPEN

Possible Quality Objectives Themes for 2018/19

Safety

- Reduction in Sepsis and Acute Kidney Injury- Improve recognition and management of patients presenting with or developing Red Flag Sepsis and Acute Kidney Injury (5 year)
- Improvement in the safety culture within STHFT- develop a Human Factors Strategy and a shift of focus from the absence of harm to the presence of safety (2 year)
- Reduction in falls/pressure sores/catheter acquired UTI/VTE (2 year)
- Improved recognition and timely management of deteriorating patients leading to improved care- Implement an electronic system for tracking patients observations (1 year)

Experience

- Significantly increase the scale of patient engagement with those who may be harder to reach or seldom heard. This includes older people, young people including young carers, people who are homeless and people from black and minority ethnic groups. These people are often those who need our services most but with whom we engage the least. We will undertake specific programmes of work to engage with harder to reach groups and, in doing so we will work with relevant voluntary sector organisations which have a wealth of experience and expertise to draw upon (2 year)
- Build on our experience of co-production, working in partnership with our patients, their families and carers towards shared goals. Implement and evaluate at least one major co-production project during the lifetime of this strategy and will develop a plan for embedding this approach more widely (2 year)
- Further improve End of Life Care (2nd Year)
- Improve patients' experience by addressing two priority areas identified through patient surveys: -
    - i) Improve refreshment facilities through introducing coffee carts in outpatient areas to improve access to refreshments);
    - ii) implement processes for keeping patients updated when they are on a waiting list for a procedure (1 year)
- Put in place a process for contacting bereaved families following the death of a patient, to check whether they have any questions or concerns they would like to discuss in relation to the patient's care and treatment within the Trust. This will provide an opportunity to address any worries or outstanding questions and provide an opportunity to address any points of concern, which may in turn prevent complaints.

Effectiveness

- Once implemented, demonstrate significant learning from NHS England Learning from Deaths Guidance, and where necessary implement changes to practice Learning from deaths (2 year)
- Deliver a reduction in the cardiac arrest rate (In for 2017/18)
- Improve the process and quality of consenting within STHFT; with a focus on ensuring patients are provided with individualised information (2 year)

- Ensure that the WHO Safer Surgery Checklist is embedded into practice across STHFT; aiming to decrease errors and adverse events, and increase teamwork and communication in surgery (2 year)

Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee Wednesday 15th November 2017

Report of: Policy and Improvement Officer

Subject: Work Programme 2017/18

Author of Report: Emily Standbrook-Shaw, Policy and Improvement Officer
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The Committee's work programme is attached at appendix 1 for consideration and discussion.

The work programme remains a live document throughout the year and can be added to and altered as issues arise. The work programme is presented at every meeting of the Committee for discussion.

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 the committee's work programme for 2017/18

Category of Report: OPEN

Appendix 1

Healthier Communities & Adult Social Care Scrutiny Committee Draft Work Programme			
Topic	**Reasons for selecting topic**	**Lead Officer/s**	**Format**
Wednesday 15th November 5-8pm			
Food Strategy	To consider the draft food strategy.	Jess Wilson, Health Improvement Principal	Agenda Item
Mental Health Transformation	Gain an understanding of the mental health transformation programme and the impact it will have on Sheffield people.	Jim Milns, NHS Sheffield CCG	Agenda Item
Quality Accounts - Sheffield Teaching Hospitals	To consider the draft priorites that STH have selected for their Quality Account 2017/18	Hannah Constantine	Agenda item (no attendees)
Wednesday 17th January 5-8pm			
Dementia Friendly City	What progress is being made on becoming a Dementia Friendly City - what more can we do? Including a range of witnesses.	Greg Fell, Lorraine Jubb	Agenda Item
Care and Support Performance	Request for 6 month update following 2016/17 consideration.	Phil Holmes, Director of Adult Services	Agenda Item

Wednesday 28th February 5-8pm			
Health in All Policies	To consider how well the Public Health Strategy is being embedded across all areas of Council activity	Greg Fell, Director of Public Health	Agenda Item
Wednesday 21st March 5-8pm			
Oral Heath - progress update	To receive an update on progress in developing the oral health strategy and reviewing water fluoridation.	Greg Fell, Director of Public Health	Briefing Note
Reducing Delayed Transfers of Care	Update on how the new system coped over the winter period.	Phil Holmes, SCC; Michael Harper, STH, Peter Moore, CCG.	Briefing Note
Future items to be scheduled - scope to be determined			
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?	TBD	

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.	NHS Sheffield CCG, Sheffield City Council	
Emergency Preparedness	To seek assurances that Sheffield's health system is prepared for major incidents.	STH/CCG	
Joint Strategic Hospital Services Review	To consider the outcome of the review and the potential impact on Sheffield	NHS Sheffield CCG	
Adult Safeguarding	Scope to be determined	Jane Heywood, Simon Richards	
Health & Wellbeing Board	To understand the role of the Health and Wellbeing Board and its relationship with Scrutiny	Policy and Improvement Officer	
Joint Overview and Scrutiny Committees			
South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Scrutiny Committee	This Committee meets in relation to Health Service Change across the geographical footprint. Focussing on two NHS service reconfigurations - Hyper Acute Stroke Services; and Children’s Surgery and Anaesthesia. (Note different footprint than South Yorkshire and Bassetlaw STP)		
Yorkshire and the Humber Joint Health Overview and Scrutiny Committee	This Committee is currently considering changes to congenital cardiac surgery services.	Leeds City Council are lead body	

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
15th November 2017

Report of: **Brian Hughes, Director of Commissioning, SCCG**

Subject: **Reviewing Urgent Primary Care across Sheffield – Public Consultation**

Author of Report: **Kate Gleave, Deputy Director of Strategy and Integration, SCCG**

Summary:
The purpose of this paper is to outline the progress of the public consultation against the plan that was presented to the last meeting of the Scrutiny Committee. As set out in the previous meeting, the formal public consultation commenced on 26th September and will conclude on December 31st.

The paper has been submitted as per the request by the last meeting that an update on the progress of the public consultation surrounding the Urgent Primary Care Review was brought to the November meeting.

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

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	**Yes**
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:
- Note the update on progress with the public consultation
- Comment on the progress of the public consultation and the feedback received thus far

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Background Papers:
Report presented to the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee on 20th September 2017

Category of Report: CLOSED until 13th November

1. Introduction

1.1. The purpose of this paper is to update the Committee on the progress of the public consultation on the review of Urgent Primary Care services within Sheffield, and to provide an overview of the key themes emerging from feedback received so far.

1.2. As set out in the consultation plan previously presented to the Committee, we are carrying out a wide variety of activities to :

- Raise awareness of, and provide information on the changes being proposed
- Involve all stakeholders in discussions around the proposed options and draw out any issue or concerns and preferences
- Work with stakeholders to consider potential solutions to any issues raised

1.3. Specifically, the objectives of the consultation are:

- To facilitate genuine and meaningful engagement with patients, the public and health professionals to determine the most effective approach for delivering urgent primary care.
- To reach as many people as possible across Sheffield
- To ensure engagement with all sectors of our communities, including groups traditionally classed as 'hard to reach' or 'seldom heard'.
- To generate discussion and feedback from stakeholders to help inform decision-making and identify solutions to issues raised.
- To build on learning from pre-consultation engagement to ensure that tactics are robust and meet statutory requirements and best practice.

1.4 The consultation is aimed at all stakeholders, including patients, members of the public and those working in primary care. It includes a focus on reaching people with protected characteristics, those from vulnerable groups or those living in deprivation, to help to ensure that the views of all communities in Sheffield are represented.

2. Consultation Activities

2.1. Awareness raising

The main focus of the first month has been to get information on the consultation out as widely as possible. As well as a dedicated section on the CCG's website and online promotion, we have printed and distributed 11,000 summary consultation documents and 750 full documents to locations across the city including GP practices, pharmacies, optometrists, community centres, leisure centres, libraries, lunch clubs, hospitals and university students unions. 30,000 postcards and 1,500 posters advertising the consultation and public meetings have also been distributed. This month we will also be handing out information to publicise the consultation at the markets, bus and train stations and local universities, and we are looking into whether we can also do this at local supermarkets. We have also worked with local media to publicise the consultation, with features in the Sheffield Star and a radio interview on BBC Sheffield, which also publicised the public meeting dates.

2.2. Public meetings

The first public meeting was held on 24th October in Broomhill – we had expected a large audience but only 8 members of the public attended. There was some very useful discussion and feedback from people there but we are obviously keen to try to get more people at the next events. We are focusing media relations work on publicising the meetings and the meeting dates will be given out with the information drops at the market and stations etc. These dates are:

- Thursday 23rd November - 6-8pm - The Circle, 33 Rockingham Lane, Sheffield S1 4FW
- Wednesday 6th December - 1.30-3.30pm - Carers Centre, Concept House, 5 Young Street, Sheffield S1 4UP

2.3. Public drop in sessions

We are also holding drop-in sessions at public libraries. Two have already taken place – at Stockbridge and Manor libraries - where we have discussed the proposals with people and captured their comments to feed into the consultation analysis. The next two events are:

- Monday 6 November - 10am - 5:30pm - Crystal Peaks Library,1-3 Peak Square, Sheffield S20 7PH
- Tuesday 14 November - 9:30am - 5:30pm - Firth Park Library, 443 Firth Park Road, Sheffield S5 6QQ

2.4. Other meetings

In addition to the public meetings, we also presented the proposals at the Patient Participation Group Network meeting on 12th October. This meeting was attended by 29 representatives of GP practice patient participation groups in the city. As well as generating good discussion at the event, members also took away the information to discuss more widely with their practice groups.

2.5 Digital media

As per the plan presented at the last meeting, we have also sought to engage with the public via digital media. We are using social media to raise awareness of the consultation and engage with online community groups. There have been over 300 tweets from 73 different users, mainly retweeting the CCG's announcement of the public consultation.

2.6 Facebook has also generated considerable feedback, largely linked to the coverage in The Sheffield Star. Most comments have focused on the proposal to relocate the minor injuries unit and walk in centre services.

2.7 Other stakeholders

We have also met – or are due to meet - with providers , including walk-in centre staff, Sheffield Teaching Hospitals, GPs, optometrists and pharmacists.

3. Feedback Received

3.1 All feedback is being analysed by an external company, which provides a weekly update on response rates and key themes. The latest overview

(6 November) is attached as appendix 1 but key findings to note so far include:

- 199 survey responses have been received to date.
- The main concerns raised so far are around ease of access to the Northern General (most notably parking).
- Other common themes include concern around the possible impact on emergency services (A&E/Ambulances); the perceived lack of availability for those living in the South, West or East of the city; and the need for more public education about services and how to use them appropriately.
- Access to GPs is another common theme, with some concerns around placing more demand on GPs and others expressing a preference for more investment in general practice.
- In terms of the options for the urgent treatment centres, the majority of respondents (65.8%) preferred option 1, with two separate urgent treatment centres at the Northern General and Children's Hospital
- 71.91% of participants would rather be seen at a GP practice in their local area if they need an urgent GP appointment and its not relating to a long standing health issue – rather than be seen at the Urgent Treatment Centre or either

4. Next steps

4.1 The current focus is on hard to reach and vulnerable groups to ensure their views are well-represented. We are also targeting BME communities as there has been very little feedback from them to date. We are hoping to work with community and voluntary sector groups to help us achieve this, based on the success of this approach during the engagement phase.

4.2 We are also trying to work with the student unions and universities to encourage responses from students. While we have been made aware indirectly that there are concerns about the proposals amongst students, there have been very few responses from the 16-21 age group so it would seem these concerns are not being captured.

4.3We are continuing to monitor responses to determine if additional activities are required to increase the response rate and will determine other actions required once the information drops have been completed this month.

5. Recommendations

The Scrutiny Committee is asked to:

- Note the update on progress with the public consultation
- Feedback any comments or concerns regarding the consultation activity carried out to date and the feedback received.

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Feedback from Urgent Care consultation up to 6th November 2017

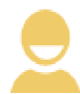
NHS Sheffield Clinical Commissioning Group

57 new responses

For this week, taking the total number of responses to 199

53.48% (100)

Of participants feel that these changes will NOT make it simpler to know where to go if they need urgent care (treatment for minor injuries or illnesses within 24 hours).



50.00% (93)

Of participants felt that providing more urgent care in local communities will make it easier to get urgent care when they need it

51.87% (97)

Of participants will be happy to have their appointment at another practice in their local area if this meant they would be seen more quickly

71.91% (128)

Of participants would rather be seen at a GP practice in their local area if they need an urgent GP appointment and it's not relating to a long standing health issue

80.77% (147)

Of participants would find it convenient in the daytime or evening if they needed an urgent appointment

65.83% (79)

Of participants preferred Option 1

Category	Demographic	Responses
Are you?	A member of public	73.37% (124)
	Someone working in Primary Care	20.35% (23)
Postcodes[1]	S6	14.04% (25)
	S11	16.85% (30)
	S10	15.17% (27)
Gender	Female	69.71% (122)
	Male	26.29%(46)
	Prefer not to say	4.00% (7)
Gender identity different to birth?	Yes	16.36% (27)
	No	77.58% (128)
	Prefer not to say	6.06%(10)
Age[1]	32-41	20.63% (33)
	42.51	21.25% (34)
	62-71	18.136% (29)
Sexual orientation	Heterosexual/Straight (opposite sex)	78.61% (136)
	Prefer not to say	14.45% (25)
Ethnic background[1]	White-British	88.57% (155)
	Prefer not to say	6.29% (11)
Religion[1]	Christianity	45.93% (79)
	No religion	40.70% (70)
Disability	Yes	16.00% (28)
	No	76.57% (134)
	Prefer not to say	7.43% (13)
Type of disability[1]	Long-standing illness or health condition	38.30% (18)
	Physical or mobility	27.66% (13)
Carers?[1]	Yes	20.00% (36)
	No	74.44% (134)
How did you find out about the consultation?[1]	Twitter/Facebook	30.39% (55)
	Email	27.07% (49)

[1] Only the top 2-3 most reported are listed here.

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