Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 28 February 2018 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
28 FEBRUARY 2018

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 17th January, 2018

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

7. Overview of Care Quality Commission Ratings for Sheffield General Practices (Pages 13 - 16)
Report of the Chief Nurse, NHS Sheffield Clinical Commissioning Group

8. Neighbourhood Model of Working (Pages 17 - 74)
Presentation from NHS Sheffield Clinical Commissioning Group

9. Age Better in Sheffield - Loneliness and Social Isolation in People Aged 50+ (Pages 75 - 80)
Report of the South Yorkshire Housing Association

10. Work Programme 2017/18 (Pages 81 - 84)
Report of the Policy and Improvement Officer

For Information Only

11. Update on the Activity of the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee (Pages 85 - 106)
Report of the Policy and Improvement Officer

12. Written Responses to Public Questions (Pages 107 - 110)

Report of the Policy and Improvement Officer

13. Date of Next Meeting

The next meeting of the Committee will be held on Wednesday, 21st March, 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 17 January 2018

PRESENT: Councillors Pat Midgley (Chair), Sue Alston (Deputy Chair), Steve Ayris, David Barker, Lewis Dagnall, Tony Downing, Mike Drabble, Adam Hurst, Dianne Hurst, Douglas Johnson and Richard Shaw

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Pauline Andrews and Talib Hussain and Margaret Kilner (Healthwatch Sheffield).

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 In relation to Agenda Item 7 (The Sheffield Mental Health Transformation Programme), the following declarations were made:-

- Councillor Lewis Dagnall declared a disclosable pecuniary interest as his partner was a Non-Executive Director of the Sheffield Health and Social Care Trust, but felt that his interest was not prejudicial in view of the nature of the report and chose to remain in the meeting during consideration of the item.

- Councillor Mike Drabble declared a personal interest by virtue of him providing mental health counselling services in non-urgent Primary Care and chose to remain in the meeting during consideration of the item, but take no part in any discussion.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 Three public questions were submitted by Dr Anne Hollows as follows:-

(1) What is the current availability of acute mental health beds and how many patients subject to compulsory admission have had to go out of the area last year, and where had they gone to? In particular regarding patients aged 15 to 25.

(2) Cuts in alcohol treatment services in the community mean that more patients are being admitted to acute wards with liver failure. Could the NHS be more effective with greater community support and what steps are being taken to ensure this?

(3) How many acute admissions of elderly people have resulted from underfunding of effective Adult Social Care and what cost savings could be achieved by acute hospital services if Social Care was effectively funded?

4.2 The Chair, Councillor Pat Midgley, indicated that Dr Hollows would be provided with a written response to these questions and Dr Mike Hunter (Medical Director, Sheffield Health and Social Care NHS Foundation Trust) added that no young adults had been placed outside the area in the last three years and that Sheffield was leading the way in this regard.

5. THE SHEFFIELD MENTAL HEALTH TRANSFORMATION PROGRAMME

5.1 The Committee received a report of the Director of Commissioning, Inclusion and Learning, which provided an outline and described key areas and objectives of the Sheffield Mental Health Transformation Programme, which was a collaborative programme of work that had been jointly developed and was being jointly delivered by Sheffield City Council (SCC), NHS Sheffield Clinical Commissioning Group (SCCG) and Sheffield Health and Social Care NHS Foundation Trust (SHSC).

5.2 Present for this item were Dawn Walton (Director of Commissioning, Inclusion and Learning), Jim Millns (Deputy Director of Mental Health Transformation and Integration, SCCG, SHSC and SCC), Dr Mike Hunter (Medical Director, SHSC) and Clive Clarke (Deputy Chief Executive, SHSC).

5.3 The report was supported by a presentation given by Jim Millns which provided some context, described the story so far including achievements, provided a Programme overview and set out a number of points for Members' consideration.

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

- Evidence suggested that investment in mental health could significantly improve physical health and that the Integrated Improving Access to Psychological Therapies Programme would assist in providing better support to those with both mental health and physical health problems and achieve better outcomes.

- There was a need to look at prevention in more detail in order to reduce attendances at A&E and this was not as developed as required. It was important to get mental health aspects into day to day situations and integrate into health access.

- The financial efficiency savings were about reducing unnecessary health and social care usage, whilst the Short Term Educational Programme looked to reduce the budget but with a negligible reduction in spend in quantum.

- The savings for this financial year were forecast at £1.94 million and it was felt that this would stand the programme in good stead to exceed projected

savings in Years 2, 3 and 4.

- Sheffield spent around £148 million on mental health services each year which would be an absolute minimum and could in fact increase. A big part of the programme was to invest in mental health, so that the benefits would be seen in other areas.

- It was important to consider what prevention looked like, particularly in terms of reducing isolation and building resilience in local communities.

- Whilst the projected savings in Year 1 had not been fully achieved, it was hoped to achieve what had been set out for Year 2.

- Whilst it was conceded that use of the expression 'unduly compromised' in paragraph 3.2 of the report might have been a poor use of language, it was emphasised that the clinical/professional leads for the five large scale transformational schemes were the guardians of quality. It should also be borne in mind that everything that had been done has had, or will have, a positive impact on patient care.

- Thirty-seven people had been returned from high cost placements and were now living closer to their families, and there had been no adverse reports arising from this. This also served to increase efficiencies, as less money was going into the private sector as a consequence.

- There needed to be conversations about long term care with regard to how services could work with older people, to ensure that they were in the right place at the right time.

- SHSC would not directly benefit financially from the programme and had its own different separate savings to make.

- The first £800,000 of efficiencies would be made available to the SCC, up to £1.6 million. Efficiencies generated after that point would be shared on a 50:50 basis with the SCCG.

- The A&E target for seeing people was four hours, but if the Mental Health Liaison Team were called they could usually be seen within two hours, although experiences had been reported of longer waits.

- The mobilisation of the Integrated Improving Access to Psychological Therapies Programme was now on schedule, with a Planning Officer now being employed.

- Outcomes of the Open Book session had not yet been scoped.

- Assumptions around early intervention were based on the fact that primary care was cheaper than secondary care, with those individuals with complex issues being dealt with at the primary care stage. This would mean a

transfer of resources in terms of improving GP time allocations.

- Employment was regarded as being very important for people with mental health issues and a £6million bid around employment from the Department of Work and Pensions had resulted in 20 people being supported in employment.

- It was felt that poor mental health could now be identified earlier and that there was now more opportunity to join up working.

- Where urgent care was provided, it was important to take into account mental health considerations.

5.5 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 the questions;

(c) requests that the Director of Commissioning, Inclusion and Learning submits a short written piece, setting out how Committee Members could contribute to the implementation of the Mental Health Transformation Programme, to the Policy and Improvement Officer for circulation to Committee Members; and

(d) requests that an update report on the Mental Health Transformation Programme be presented to the Committee in 12 months' time, such report to include details of achievements in relation to Liaison Mental Health, efficiency savings and investment.

6. ADULT SOCIAL CARE PERFORMANCE - UPDATE

6.1 The Committee received a report of the Director of Adult Services, to which was appended the draft final version of "Independent, Safe and Well": Sheffield's Local Account for 2017, together with the Adult Social Care Outcomes Framework Regional Benchmarking Overview (2016/17).

6.2 Phil Holmes (Director of Adult Services) took the Committee through the report, which set out how Adult Social Care was performing in Sheffield across a number of key measures, provided an update on improvement measures and queries covered with the Committee in March 2017, and described what would be done over the next year to improve performance. In conclusion, Phil Holmes indicated that he expected cautious improvement when the next survey of performance was undertaken, but a greater improvement onwards.

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

- Over the last year, significant improvements had been made with regard to

delayed transfers of care from hospital, with the NHS England target being met in October. It had been a difficult Winter, which had led to figures now being higher, but it was expected that they would get better in future.

- It was acknowledged that further work needed to be undertaken to find the reasons why a proportion of people using services did not feel safe, but it should be noted that the proportion of those using services which made them feel safe and secure was relatively high.

- A one stop shop for carers had been commissioned from a voluntary partner and it was acknowledged that further work was required to improve upfront expertise.

- Direct payments gave the individual a choice and control, but it was felt that better mechanisms were needed in this regard.

- Sheffield picked up on what others were doing better in relation to Adult Social Care performance and was learning all the time from comparators.

- Adult Social Work services in Sheffield were restructured in September 2017, and these new arrangements were still 'finding their feet'. The aim was to be more connected with communities and work more closely with the people in them.

- There was a need to be clear as to what Sheffield needed in relation to the Accountable Care Partnership and delayed transfers of care was one aspect where the Council had been involved.

6.4 In conclusion, Phil Holmes considered that the Council was making modest improvements in Adult Social Care Performance after poor performance in the past and was looking to put a decent foundation in place, with investment in Home Care and Supported Living being successful. Furthermore, Social Workers were adopting a different approach to the public, with an emphasis on people's strengths as well as their problems. It was felt that the process was now at a stage of acceleration and a positive shift was expected by the end of the year.

6.5 RESOLVED: That the Committee:-

(a) thanks Phil Holmes, Director of Adult Services, for his contribution to the meeting;

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

(c) requests that Phil Holmes, Director of Adult Services:-

(i) liaises with Dawn Shaw, Head of Libraries and Community Services, to better understand the work previously undertaken on employment and skills for people with learning disabilities; and

(ii) provides the Policy and Improvement Officer with the annual Adult Social Care Complaints Report when next published, for circulation to Committee Members.

(NOTE: At this point, the Chair, Councillor Pat Midgley, left the meeting and the Chair was taken by the Deputy Chair, Councillor Sue Alston.)

7. MINUTES OF PREVIOUS MEETINGS

7.1 The minutes of the meeting of the Committee held on 15th November 2017, were approved as a correct record subject to:-

(a) the tenth bullet point in paragraph 6.3 (Food and Wellbeing Strategy) being amended to read, “In response to a comment that the new Strategy was too narrow, it was felt that the previous Strategy was too broad, which had limited its impact.”

(b) a further bullet point being added to paragraph 6.3 (Food and Wellbeing Strategy) to read “A request for the new Strategy to recognise the risks/opportunities around Brexit and the impact on food in Sheffield was noted.”

Arising from consideration of the minutes it was noted that:-

(i) in relation to paragraph 4.4(b)(ii) (Work Programme 2017/18), the Policy and Improvement Officer had not yet received a reply to enquiries made regarding the issue of unnecessary repeat prescriptions to people in residential care homes; and

(ii) in relation to paragraph 10.3(b)(ii) (Urgent Primary Care Consultation Update), the Policy and Improvement Officer would circulate to Committee Members the email response received with regard to her following up the Clinical Commissioning Group’s lack of contact with Committee Members.

7.2 The minutes of the meeting of the Committee held on 5th December 2017, were approved as a correct record and, arising from their consideration, it was noted that the Policy and Improvement Officer would follow up the recommendation in paragraph 5.13(e) (Call In of the Decision on the "Sheffield Accountable Care Partnership") that Accountable Care Partnership Board meetings take place in public and that reports and minutes are published in the public domain.

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; and

(b) notes that:-

(i) the Neighbourhood Working Approach would be included as part of the Care Quality Commission's visits to GPs report at the next Committee meeting;

(ii) the Adult Social Care Annual Complaints Report would be included in the Work Programme; and

(iii) the Home Care changes, together with a service users' perspective on those changes would be included in the Work Programme.

9. DATE OF NEXT MEETING

9.1 It was noted that the next meeting of the Committee would be held on Wednesday, 28th February 2018, at 5.00 pm, in the Town Hall.

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

Date of Meeting: 28th February 2018

Report of: Chief Nurse Sheffield CCG

Subject: Overview of CQC Ratings for Sheffield General Practices

Author of Report: Maggie Sherlock- Senior Quality Manager

Summary:
All Providers are required to register with the CQC and all partners must be included in the registration. The CQC will carry out inspections and will rate the provider against 5 key lines of enquiry. Ratings are graded as 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

This briefing paper was requested by the Committee

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

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

The Scrutiny Committee is being asked to:
The Committee is asked to note the contents of the briefing paper.

Category of Report: **Open**

Report from NHS Sheffield Clinical Commissioning Group
Overview of CQC Ratings for General Practices in Sheffield

1. Introduction

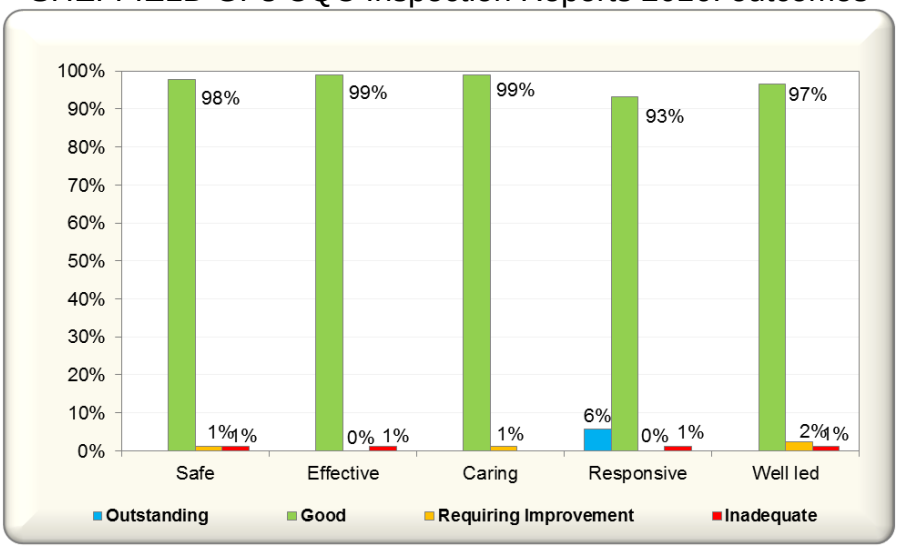
1.1. All Providers are required to register with the CQC and all partners must be included in the registration. The CQC will carry out inspections and will rate the provider against 5 key lines of enquiry. Ratings are graded as 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

1.2. The CQC have now completed all their inspections of Sheffield General Practice. A dashboard providing an overview of the CQC ratings, incorporating trends and themes of non-compliance has been developed by Sheffield CCG. The dashboard also shows the support offered to practices by Sheffield CCG Quality team.

1.3. This paper is being submitted to the Committee following a request from a previous Committee meeting.

2. Overview of CQC rating in Sheffield General Practices.

SHEFFIELD GPs CQC Inspection Reports 2016: outcomes



Accessed 11/01/2018

2.1 To date the CQC, 85 (100%) of practices (including the GP HUBS) have been inspected; 83 (97.7%) have been rated as 'Good'; 1 (1.1%) has been rated as 'Requiring Improvement' and 1 (1.1%) has been rated as 'Inadequate'.

2.2 For practices that have either been rated as 'Requiring Improvement' or 'Inadequate' the CCG Quality team have supported practices to ensure the practice CQC action plans meet the requirements identified in the CQC report and identify resources where available.

2.3 The Quality team have worked alongside practices and NHSE to gain assurance the action plan has been implemented. This has been achieved by ongoing review of the evidence and by verbal assurance from the practices.

3. Trends and Themes

3.1. The CQC rate the inspection against 5 key lines of enquiry (KLOE) these form the categories of: Are services safe?; Are services effective?; Are services caring?; Are services responsive?; Are services well led?. There are 4 practices that have been rated as 'Outstanding' against the standard 'Are services responsive?'

3.2 Table 1 below represents 3 practices which have been rated as 'requiring improvement' or 'inadequate' against the 5 KLOE. Please note that a practice may be represented against more than 1 KLOE.

Are services safe?	2
Are services effective?	1
Are services caring?	1
Are services responsive?	1
Are services well led?	3

Table 1: The 5 KLOE - Requiring improvement or inadequate

4 Areas of outstanding practice

4.1 The CCG would like to acknowledge the good work that is undertaken within general practice which has also been recognised by the CQC. For example:

- To improve communication a practice offers those with learning disabilities pictorial information and easy to read letters.

- A practice holds a drop in clinic at an outreach centre one day a week providing easy access to chronic disease management and opportunistic screening to homeless patients.

- A practice responded to the needs of the practice population when they identified that 23% of the had caring responsibilities. The lead GP is the carer's champion; the practice has a carer's notice board and works closely with the community support workers to improve the holistic package of care received by patients with mental health needs and those living with dementia, offering advocacy and carer support. The practice also undertakes opportunistically housebound visits to check the health and wellbeing of the patients and carers.

- One practice has linked with schools and organisations to encourage young carer to register as carers with the practice. This will alert practice staff, who can then offer flexible appointments and signposting to appropriate support services as well as an annual invitation for a health check.

- A practice provided a listening service for patients facing difficult life choices, ill health, loneliness or bereavement and offered signposting to resources and local support groups if appropriate.

5 CQC Trends and Themes

5.1 Since the Scrutiny Report 2016, 21 practices have been re-inspected. Table 2 provides a summary of the main themes for areas for improvement during the CQC inspections.

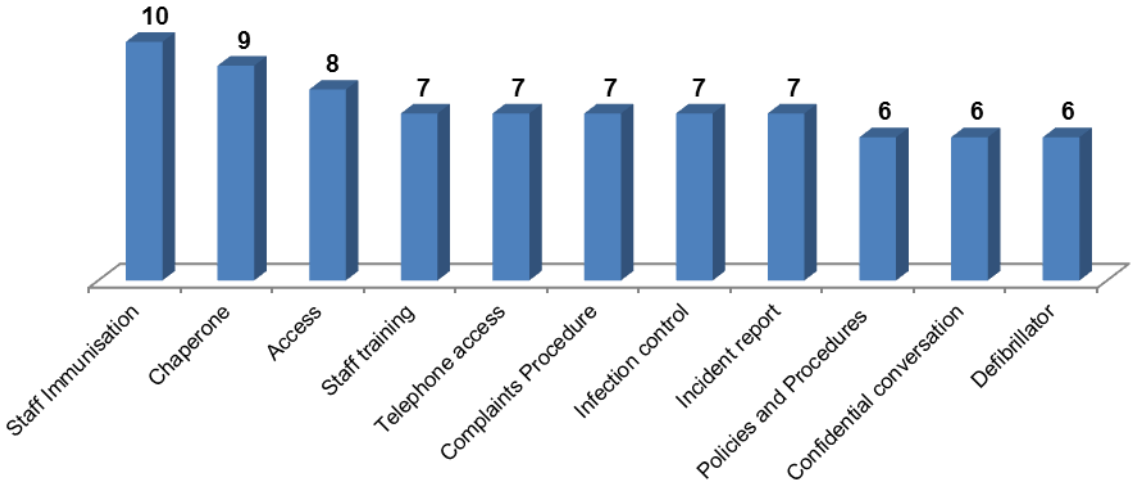


Table 2: Areas for Improvement: trends and themes (No. of occurrences)

5.2 Since the previous scrutiny report there has been an improvement across all areas. The areas for improvement that have been identified above will remain until the CQC have re-inspected the service.

6.0 Areas Improved

6.1 Where areas for improvement have been identified by the CQC, Sheffield CCG Quality team have contacted each GP practices to gain assurance that these areas have been actioned. Practices have confirmed that:

- DBS checks have been undertaken
- Chaperone training has been completed and included in the practice policy
- Immunity status is recorded within staff files
- Access problems are being addressed, for example; Employing nurse practitioners and pharmacists; Triaging patients and utilising the HUBs; Opening on Thursday afternoon; Increasing receptionists during busy times to answer calls and care navigation to direct patients to other points of care; Monitoring and reviewing appointment systems

7.0 What does this mean for the people of Sheffield?

7.1 This report outlines the quality of current provision of general practice within the city of Sheffield as measured by the Care Quality Commission inspection teams.

8. Recommendation

8.1 The Committee is asked to note the report

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Neighbourhoods Update

Nicki Doherty Director of Delivery Care Outside of Hospital
+ Dr Anthony Gore Clinical Director Care Outside of Hospital

NHS Sheffield CCG

24/7
RESPONSE
12:00
CARE
PLAN
SINGLE SHARED
CARE PLAN
ASSESSMENT
FAMILY AND COMMUNITY SUPPORT
SINGLE POINT
OF ACCESS
CRISIS
PLANNING
Welcome to
Sheffield
CARE CO-ORDINATION
PROACTIVE
SERVICES
PLANNING FOR
RESILIENCE
PERSON
CENTRED
ACCESS TO
TIMELY SUPPORT
MULTI -
SKILLED,
MULTI-PROFESSIONAL

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

What is a Neighbourhood..

a geographical population of around 30-50,000 people supported by joined up health, social, voluntary sector and wider services to support people to remain independent , safe and well in their community.

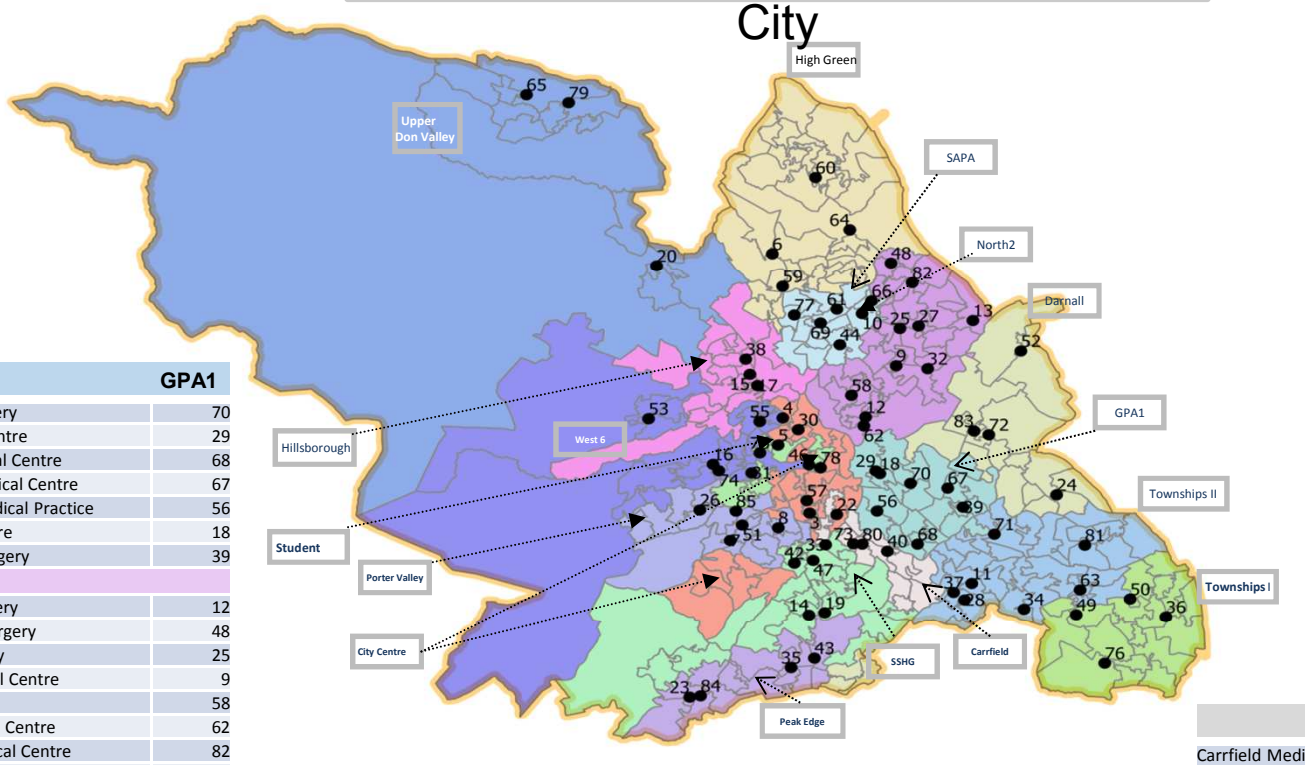
Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Why Neighbourhoods?

- General Practice at Scale
- Wider integrated working across the health and social care system
- Targeting Care to priority patient groups
- Managing Resources
- Empowering Neighbourhoods

16 Neighbourhoods Across Sheffield City



4 in Central
4 in Hallam & South
3 in North
5 in West

- GP Association 1
- North2
- Townships (I)
- West4
- Darnall
- Carrfield
- Peak Edge
- City Centre Practices
- SSHG
- SAPA
- High Green
- Hillsborough
- Upper Don Valley
- Universities
- Porter Valley
- Townships (II)

Sheffield LA Boundary

	GPA1
Dovercourt Surgery	70
Duke Medical Centre	29
East Bank Medical Centre	68
Manor Park Medical Centre	67
Norfolk Park Medical Practice	56
Park Health Centre	18
White House Surgery	39
North 2	
Burngreave Surgery	12
Dunninc Road Surgery	48
Firth Park Surgery	25
Page Hall Medical Centre	9
Pitsmoor Surgery	58
Sheffield Medical Centre	62
Shiregreen Medical Centre	82
The Flowers Health Centre	27
Upwell Street Surgery	32
Wincobank Medical Centre	13
Townships I	
Crystal Peaks Medical Centre	50
Mosborough Health Centre	76
Owlthorpe Medical Centre	49
Sothall and Beighton Health Centres	36
Hackenthorpe Medical Centre	63
West 6	
Broomhill Surgery	31
Manchester Road Surgery	16
Selborne Road Medical Centre	74
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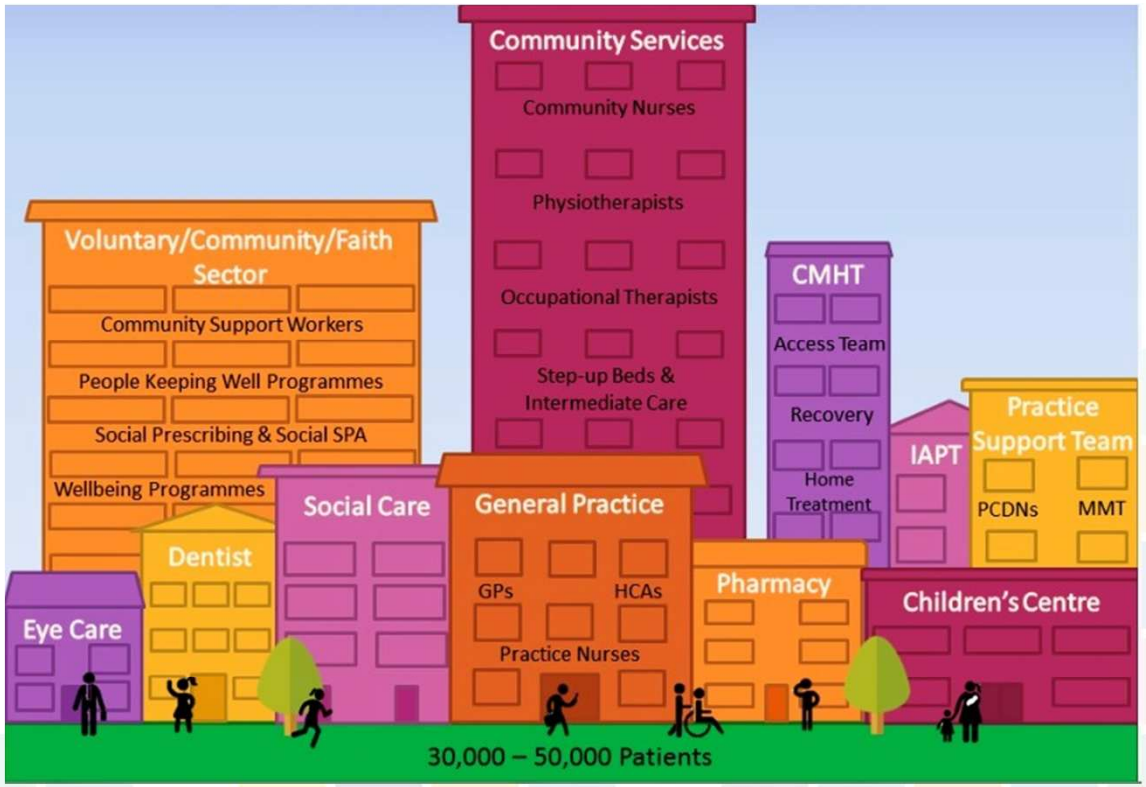
Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Sheffield



16 Neighbourhoods

Aim to …

- Improve health and care outcomes
- Improve quality of care particularly Long Term Conditions
- Reduce unnecessary health and care service use
- Provide health and care services closer to home

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

How do Neighbourhoods affect Sheffield Patients?

You won't go to hospital unless you really need to thanks to more pro-active joined-up care in the community – especially older people and those with long-term conditions.

You have the opportunity to work directly with health services in your community to ensure the right health, social care and community services are accessible now and in the future.

You can improve your quality of life with better support to manage your own health and wellbeing.

In the near future, you'll have one unified patient record which means you're less likely to have to repeat 'your story' to different professionals, in different parts of the 'system'.

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Prioritising local needs first

- Take a look at the 'Welcome to our Neighbourhood' factsheets
- Local vs citywide

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

What's happening in Neighbourhoods right now?

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

What's happening in Neighbourhoods right now?

- **Closer working** – practices attend regular Neighbourhood meetings together now to share ideas, knowledge and planning.
- **Proactive care for older people** – better case management planning for older people e.g. Crystal Peaks.
- **More joined up services** –Upper Don Valley Neighbourhood are working with their local Community Forum.
- **Social prescriptions** – citywide approach utilising community support workers, People Keeping Well work.

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

What's happening in Neighbourhoods right now?

- **Improve access to mental health** – Sheffield has recently been awarded over £2m to join up Improving Access to Psychological Therapy (IAPT) services with 10 condition pathways such as musculoskeletal, pain, Long Term Conditions etc. They're working with Neighbourhoods now to develop these both at local and citywide level. These will help Neighbourhoods with specific Mental Health needs and improve identification of anxiety and depression.
- **Workforce sharing** – One Neighbourhood is using WhatsApp as a way to manage rotas and fill in gaps if a staff member calls in sick.
- **Extending teams** –
- **Hospital discharge** – lots to come on this that will help avoid people being delayed when being discharged into the community.

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

What's happening in Neighbourhoods right now?

- **Support families living with dementia** – setting up cafes, drop-ins for family members etc. with local voluntary and community organisations.
- **Digital health skills** – Sheffield has been chosen as a pilot to trial improving digital literacy with NHS England & Good Health Foundation.
- **One patient record** – this is on its way.
- **Virtual wards** – successful pilot in GPA1 Neighbourhood – now being tested across 4 Neighbourhoods in Central locality (20 practices) with hope we can spread citywide later in year.

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Wednesday 28th February 2018

Report of: South Yorkshire Housing Association on loneliness and social isolation in people aged 50+

Subject: Age Better in Sheffield (funded by the Big Lottery Fund)

Author of Report: Ruby Smith – Head of Co-design & Improvement (SYHA)

Summary:
In 2016 The Big Lottery Fund awarded £6m to Sheffield to reduce loneliness and social isolation in people aged 50+. SYHA are the lead organisation and have delivered the programme in Sheffield for the past 3 years in partnership with organisations across the city. The programme is at its half way point, with a further 3 years of funding remaining.

The purpose of this report is to:
- Summarise the progress of the programme to date
- Highlight the planned next steps in the programme delivery
- Seek the views of the Scrutiny Committee on the next 3 years of the programme

The reason for this report being presented to Scrutiny Committee is:
- Age Better in Sheffield is a high profile and high priority programme for the city
- The delivery team at SYHA are keen to understand the perspectives of different people across Sheffield to build a picture of how the city wants the programme to develop over the 3 remaining years

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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	
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 for the next 3 years of the Age Better in Sheffield programme.

_____

Background Papers:

Please see below links to national evidence and information about loneliness and social isolation

https://www.campaigntoendloneliness.org/about-loneliness/
https://www.jocoxloneliness.org/pdf/a_call_to_action.pdf
https://www.ageuk.org.uk/information-advice/health-wellbeing/loneliness/

Category of Report: OPEN

Report by South Yorkshire Housing Association

Age Better in Sheffield

1 Introduction/Context

1.1 The following information on loneliness and social isolation is taken from the Jo Cox Commission on Loneliness: a call to action:

1.2 *Loneliness is a subjective, unwelcome feeling of lack or loss of companionship, which happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want. It is often associated with social isolation, but people can and do feel lonely even when in a relationship or when surrounded by others.*

1.3 *Studies have found relatively consistent levels of chronic loneliness among older people – with between five and 15 per cent reporting that they are often or always lonely.*

1.4 The following statistics shows the devastating impact directly on people, communities and the

- *Three out of four GPs say they see between 1 and 5 people a day who have come in mainly because they are lonely, and one in ten sees between six and ten such patients daily. (Campaign to End Loneliness)*
- *Weak social connection is as harmful to health as smoking 15 cigarettes a day. (Holt Lunstad)*
- *Loneliness costs UK employers £2.5 billion per year. (Co-op)*
- *Disconnected communities could be costing the UK economy £32 billion every year. (Big Lunch)*

2 Age Better in Sheffield – Overview

2.1 Age Better in Sheffield is governed by the Age Better in Sheffield Core Partnership. The Core Partnership is made up of people from key organisations and institutions in Sheffield (e.g. Sheffield City Council) and by individuals who are aged 50+ and have insight into issues relating to social isolation.

2.2 The Age Better Core Partnership has commissioned a range of services to reduce loneliness and isolation. They include:

- Wellbeing Practitioners – This project is delivered by Sheffield Mind. Qualified counsellors work with people who are experiencing isolation to such an extent that they feel unable to leave their home. They provide counselling in the home on a one to one basis to help people overcome psychological barriers to socialising and leaving their home.

- Peer Mentoring – This project, delivered by Voluntary Action Sheffield, works with people who are at risk of loneliness and social isolation at key

life events; e.g. bereavement, retirement, ill health. Peer support is provided to prevent loneliness and social isolation

- Start Up – Delivered by Ignite Imaginations, this project supports people to set up groups or activities catering to their own personal interests. For example, an over 60's taekwondo group was set up with support from Ignite Imaginations to find a venue, advertise, find funding etc. The aim of this project is to reach people who feel that current activities are suited to their personality or interests.

- Access Ambassadors – Delivered by SYHA, this project works with people to overcome travel barriers enabling people to fully access their community. Volunteers are trained as Access Ambassadors and they provide 1:1 support to people who are facing travel barriers.

2.3 These are just four examples of services Age Better has provided. The full details of the commissioned activities can be seen on the Age Better in Sheffield website – www.agebettersheff.co.uk

3 Age Better in Sheffield – Outcomes

3.1 Age Better in Sheffield has four main objectives:

- older people are less isolated
- older people are actively involved in their communities with their views and participation valued more highly
- older people are more engaged in the design and delivery of services that help reduce their isolation
- services that help to reduce isolation are better planned, co-ordinated and delivered, and better evidence is available to influence the services that help reduce isolation for older people in the future

3.2 In the past three years the Age Better in Sheffield programme has worked with1,952 people across Sheffield who are experiencing loneliness and social isolation. 425 volunteers have been involved in delivering the programme of activities to reduce loneliness and social isolation. 46% of people we have worked with have a limiting health condition and 44% have low mental wellbeing.

3.3 The programme has four target wards; Beauchief & Greenhill, Burngreave, Firth Park and Woodhouse. 67% of our activity to date has happened with people who live outside these ward areas.

3.4 Due to the temporary nature of the funding, Age Better support is designed to be a short-term intervention; 60% of people are supported for between 1-6 months.

3.5 All of the services commissioned by Age Better are designed and developed with older people across the city who have experience of social isolation. We are supporting our partners to co-produce their services and have supported them to do this through workshops, training and shared methodology.

4 What does this mean for the people of Sheffield?

4.1 We have a further three years of Big Lottery Fund investment in this programme. At this halfway point in the project the Age Better Core Partnership has decided to invest time in refreshing our vision and strategy for the programme and coproducing its next phase.

4.2 The current Age Better in Sheffield provision will change. The future provision will be designed in collaboration with organisations and individuals across Sheffield.

4.3 SYHA will lead an extensive co-design and research project from February and will co-commission the future Age Better Activity in summer 2018.

5 Questions for the Committee

5.1 The committee is asked to review this paper and provide views and comments. In particular we are interested in the committee views on the following questions:

A. What citywide initiatives should Age Better in Sheffield connect with in order to achieve greatest reach and impact?

B. From your perspective, what would you be interested to see commissioned in the next phase of Age Better in Sheffield?

C. How would you like to be involved in driving action to reduce loneliness and social isolation in Sheffield?

Please note, we are asking these questions of hundreds of people across Sheffield and identifying the key themes. Answers provided will be considered alongside the views of many of people and organisations in Sheffield. Decisions made by the Core Partnership will be made using the findings of our consultations and will also be informed by other research and evidence.

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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
February 28th 2018

Report of: Policy and Improvement Officer

Subject: Work Programme 2017/18

Author of Report: Emily Standbrook-Shaw, Policy and Improvement Officer
Emily.Standbrook-Shaw@sheffield.gov.uk
0114 273 5065

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	
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 and Adult Social Care Scrutiny & Policy Development Committee
Draft Work Programme 2017/18

Chair: Cllr Pat Midgley
Vice Chair: Cllr Sue Alston

Please note: the Work Programme is a live document and so is subject to change.

Topic	Reasons for selecting topic	Lead Officer/s	Agenda Item/ Briefing paper
Wednesday 21st March 5-8pm			
Dementia Strategy	What progress is being made on refreshing the dementia strategy - opportunity for Committee to influence its development	Greg Fell, Dawn Walton, Mandy Philbin	Agenda Item
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, CCG.	Briefing Note
Scrutiny Annual Report 2017-18 Draft Content	This report asks the Committee to consider a summary of its activities over the municipal year for inclusion in the Scrutiny Annual Report 2017-18.	Policy and Improvement Officer	Agenda Item

Future items to be scheduled - scope to be determined			
Sheffield Children's Hospital Quality Accounts	Annual consideration of Quality Accounts	Sally Shearer	
Accountable Care Partnership and Shaping Sheffield	To consider how the Accountable Care Partnership is developing, in advance of the Partnership Board moving out of its shadow phase.	NHS Sheffield CCG, Sheffield City Council	
Social Prescribing	To consider Sheffield's approach and how effective it is.	TBD	
Home Care Update	To hear from Service Users on whether changes to home care have been successful – link into work being carried out by HealthWatch	TBD	
Adult Safeguarding	Scope to be determined – possibly include a session with Safeguarding Customer Forum.	Jane Heywood, Simon Richards	
Emergency Preparedness	To seek assurances that Sheffield's health system is prepared for major incidents.	STH/CCG	
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	
Joint Strategic Hospital Services Review	To consider the outcome of the review and the potential impact on Sheffield (the regional JHOSC is also considering this.	NHS Sheffield CCG	
Urgent Care Consultation and Outcome	Committee to keep watching brief. Particular concerns over detail of proposals - esp location of 'hub' surgeries.	Kate Gleave, NHS Sheffield CCG	

Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee
28th February 2018

Report of: Policy & Improvement Officer

Subject: South Yorkshire, Derbyshire, Nottinghamshire and Wakefield (SYDNoW) Joint Health Overview and Scrutiny Committee Update.

Author of Report: Emily.Standbrook-Shaw@Sheffield.gov.uk
0114 27 35065

Summary:

This report updates the Committee on activity undertaken by the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee. Sheffield is represented on the Joint Committee by the Chair of the Healthier Communities and Adult Social Care Scrutiny Committee.

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

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

The Scrutiny Committee is being asked to:
Note the papers from the SYDNoW Joint Health Overview and Scrutiny Committee.

Category of Report: OPEN

South Yorkshire, Derbyshire, Nottinghamshire and Wakefield (SYDNoW) Joint Health Overview and Scrutiny Committee Update.

1. Introduction

1.1 The Joint Committee was initially established in 2015 to consider health service reconfiguration over the "Commissioners Working Together" footprint (Barnsley, Derbyshire, Doncaster, Nottinghamshire, Rotherham, Sheffield, Wakefield) – looking at changes to children's surgery and anaesthesia, and hyper acute stroke services. Papers for previous meetings of the Committee can be found here.

2. Update on activity

2.1 The Joint Committee met on the 29th January and considered:

- The refreshed terms of reference for the Joint Committee
- The Hyper Acute Stroke Services Reconfiguration
- Children's non specialist surgery and anaesthesia – progress on implementation
- Independent Hospital Review
- Review of Specific Hospital Services.

The papers and presentations are attached for the Committee's information.

2.2 The Joint Committee has agreed to continue to meet quarterly to consider any future health service reconfigurations across the footprint, but each local authority reserves the right to consider issues at a local level.

3. Recommendation

3.1 The Committee is asked to note the update and the papers from the SYDNoW Joint Health Overview and Scrutiny Committee.

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South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Scrutiny Committee

18 January 2018

Dear Member

Joint Health Scrutiny Committee

Please attend the meeting of the **Joint Health Scrutiny Committee** to be held on **Monday 29 January 2018** in **Committee Room 1, County Hall, Matlock, Derbyshire DE4 3AG, from 3.00pm – 5.00pm.**

The agenda for the meeting is set out below.

A G E N D A

1. Declarations of Interest (if any)
2. Apologies for absence
3. To confirm the Minutes of the meeting held on 31 July 2017 (attached)
4. Review of the Terms of Reference of the JHSC (report attached)
5. Implementation of Hyper Acute Stroke Services Reconfiguration
6. Children's non-specialist surgery and anaesthesia – progress on implementation
7. Independent hospital review - update
8. Review of Specific Hospital Services – Briefing Paper (attached)

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Monday, 31st July, 2017

Present:- Councillor Simon Evans (Rotherham MBC) (in the Chair); Councillors Pat Midgley (Sheffield City Council), Cynthia Ransome (Doncaster MBC) and David Taylor (Derbyshire County Council)
Also in attendance:-

Scrutiny Officers:- Anna Marshall (Barnsley MBC), Christine Rothwell (Doncaster MBC), Roz Savage (Derbyshire County Council), Janet Spurling (Rotherham MBC), Emily Standbrook-Shaw (Sheffield City Council) and Andy Wood (Wakefield MDC)

NHS:- Steve Allinson (North Derbyshire CCG), Dr. Peter Anderton (Commissioners Working Together), Lisa Bromley (Bassetlaw CCG), Will Cleary-Gray (NHS England), Alison Knowles (NHS England), Kate Laurance (Sheffield CCG), Dr. Tim Moorhead (Sheffield CCG), Maddy Ruff (Sheffield CCG), Lesley Smith (Barnsley CCG), Helen Stevens (NHS England) and Professor Chris Welsh (Yorkshire and The Humber Clinical Senate)

Apologies for absence:- Apologies were received from Councillors Keith Girling (Nottinghamshire County Council), Wayne Johnson (Barnsley MBC), Andrea Robinson (Doncaster MBC) and Betty Rhodes (Wakefield MDC).

1. INTRODUCTIONS

The Chair welcomed everyone to the meeting and attendees introduced themselves.

An additional agenda item on the Hospital Services review had been agreed by the Chair, as this meeting was a good opportunity to present this information to Members at an early stage.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

Two questions had been received in advance of the meeting, with copies circulated to Members, including the introductory text for each question.

(1) Nora Everitt, Barnsley Save our NHS

As we feel that this Joint Health Scrutiny Committee do not currently demonstrate either consistency in the recording of its deliberations or independence in carrying out its scrutiny functions, in order to inspire the confidence of local people that they do fulfil their Statutory functions and demonstrates their statutory powers will they change their current practice/Terms of Reference by:

- Showing a clear independence from the NHS body attendees they invite to inform their scrutiny committee

- Clarifying, rather than confusing, the respective roles of the Scrutiny Committee and of the NHS bodies attending their Committee by request
- Reverting back to the name of their committee that describes the local authorities making up the Joint Committee and to cease using the new name that describes the NHS bodies that they scrutinise
- Meeting in Town Halls as is the accepted practice for scrutiny committees
- Clearly recording their deliberations, questions and decisions
- Considering live streaming their meetings '*to allow local people, particularly those who are not present at scrutiny-hearing meetings, to have the opportunity to see or hear the proceedings*' (Department of Health Local Authority Scrutiny 2014)?

Barnsley Save Our NHS were thanked for their timely question as the terms of reference were being reviewed and the points raised would be considered during the review.

(2) Doug Wright, Keep Our NHS Public Doncaster and Bassetlaw

I believe that the needs of local people are not considered when each core partner HAS to sign up to the South Yorkshire and Bassetlaw MOU, in order to receive the extra funding given to the new South Yorkshire and Bassetlaw Regional Accountable Care Systems. How can this this coercive approach be eliminated by this Committee in the proposed terms of reference to assist the core partners ensuring that the needs of local people .....?

Supplementary - Why are Mid Yorkshire and North Derbyshire Councils included in this terms of reference?

Keep Our NHS Public Doncaster and Bassetlaw were thanked for their question. It was clarified that the Joint Health Overview and Scrutiny Committee (JHOSC) had been established to scrutinise the Commissioners Working Together Programme that covered seven local authority areas including Wakefield and Derbyshire. The terms of reference referred to this workstream and not to the South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformation Plan (STP) which had a different geographical footprint.

3. MINUTES OF THE PREVIOUS MEETINGS HELD ON APRIL, 2017

Due to membership changes the minutes of the previous meeting were noted.

4. DECLARATIONS OF INTEREST

There were no declarations of interest from Elected Members.

5. HOSPITAL SERVICES REVIEW

Professor Welsh, Independent Review Director for the SY&B Accountable Care System Hospital Services Review gave a brief verbal update on this workstream.

This was an independent review and would take ten months to April 2018. The first stage would be to define the criteria to help understand what a sustainable hospital service was. Then the review would be looking at services and defining those which were non-sustainable and advising on future models of delivery to ensure long term sustainability.

The work was at a very early stage with the team in place for four weeks. They had met with commissioners in SY&B, providers and clinical commissioning groups. A programme of public engagement would be running going into the autumn and with local Elected Members over the coming months.

Discussion and questions ensued covering the following points:-

- How would the review want to involve Elected Members and the JHOSC?
  There was a timetable of engagement with Elected Members into the autumn and it would be expected to return to the JHOSC in the future as the work progresses.

- For it to be positive it needed the clinical requirements now and for the public to be informed about what the review was aiming to achieve.
  It was to ensure high quality patient care in each place within SY&B. The review would make recommendations but the expectation would be that the majority of care would still be at people's local hospital, although some things were technology dependent or depended on high quality skills in the workforce.

  Very specific care may mean travel elsewhere, as now for example with coronary care. It was a case of getting people as quickly as possible to the place where they would receive the best high quality care, which might not be their local hospital.

It was suggested that further discussion was needed about how scrutiny may wish to be involved, including at different stages, possibly linked in with scrutiny arrangements for the SY&B STP below.

Resolved:- That the timescales for the consultation and the work on the hospital services review be provided at the next JHOSC meeting.

6. CHILDREN'S NON SPECIALISED SURGERY AND ANAESTHESIA UPDATE

Dr. Moorhead introduced a short briefing paper summarising the key issues regarding the proposals for children's non specialised surgery and anaesthesia. Attention was also drawn to the powerpoint slides attached to the minutes of the last meeting summarising the case for change, options, travel impact, and the consultation process and outcomes.

A unanimous decision had been made by the Joint Committee of Clinical Commissioning Groups and Hardwick Clinical Commissioning Group to approve the decision making business case for children's non specialised surgery and anaesthesia on 28 June, 2017.

Approval of the preferred model enables the majority of surgery to continue to be delivered locally and the development of three hubs, Doncaster Royal Infirmary, Sheffield Children's Hospital and Pinderfields General Hospital in Wakefield.

The decision means that once implemented around one or two children per week needing an emergency operation for a small number of conditions, at night or at a weekend, will no longer be treated in hospitals in Barnsley, Chesterfield and Rotherham, and will receive their treatment at one of the three hubs.

It is very early days in terms of implementation but a mobilisation plan is under development, including the ongoing designation process and development of a managed clinical network. It has been agreed to implement within existing commissioning and contracting arrangements and it is anticipated that implementation will commence from quarter four 2017/18 onwards.

Members sought clarification on hospital capacity in the case of a major incident such as a road traffic accident involving a large number of injured children. - The major trauma centre was located at Sheffield Children's Hospital and although the hospital had finite capacity if necessary it would assume the lead for overall co-ordination across local hospitals.

It was confirmed that plans for implementation would be in place by the end of December 2017 and that a further update could be brought to the Joint Health Overview and Scrutiny Committee (JHOSC) in two to three months.

Cllr Midgley informed the JHOSC that if Members were interested visits could be arranged to see the improvements made at Sheffield Children's Hospital.

Resolved:- (1) That the current position to progress the changes to children's non specialised surgery and anaesthesia be noted.

(2) That future updates on implementation be received by the Committee.

7. UPDATE ON HYPER ACUTE STROKE SERVICES

Lesley Smith introduced a short paper setting out the current position regarding the review of hyper acute stroke services and the development of the business case.

No decision had been made yet and it was likely to be October before the final decision was taken as work was still ongoing, particularly with the region's hospitals. Although the clinical case for change was strong it was in the context of a complex set of interactions and the full implications on all partners, staff and patients needed to be understood to enable an informed decision on the future of services.

Numbers and the pathway for people with suspected strokes needed to be considered further.

It was acknowledged there were potential risks with deferring the decision to reconfigure hyper acute stroke services and work would continue with hospitals to manage these to ensure existing services were supported. For example the stroke pathway for Barnsley had for a while seen thrombolysis carried out elsewhere.

Resolved:- (1) That the current progress with the hyper acute stroke services transformation be noted.

(2) That an update be provided to the Committee in October following the meeting of the Joint Committee of Clinical Commissioning Groups.

8. REVIEW OF JHOSC TERMS OF REFERENCE

There was a brief discussion with regard to formalising arrangements for receiving and responding to questions from members of the public. For example whether a specific length of time should be incorporated in the agenda and whether they should be submitted with a few days' notice, such as by the end of the Wednesday before the meeting, in order to facilitate the response.

No other suggestions were made at the meeting with regard to the principles, membership or working arrangements but it was agreed that more time was necessary for discussion.

In light of the issues around the current remit of the JHOSC and the different geographical footprints involved for various NHS workstreams, NHS

England highlighted the interconnectivity and commented that they would welcome one place for joint scrutiny.

Resolved:- (1) That the scrutiny officers and Elected Members work on the review of the terms of reference and amend them to take account of points made in the questions from the public.

9. DISCUSSION REGARDING SCRUTINY ARRANGEMENTS FOR THE SOUTH YORKSHIRE AND BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN

It was suggested that it would be helpful to have or create a scrutiny committee for the SY&B footprint and that scrutiny officers could work with the Elected Members to determine when this would be appropriate.

NHS England commented that as patient flows crossed boundaries some changes would not be confined to the SY&B footprint but would also involve Mid Yorkshire and Chesterfield. They added that the current JHOSC membership would also work for the hospital services review.

This complexity might mean it would be a case of identifying the best memberships according to the workstreams.

Dr. Moorhead confirmed that 80% of the Sustainability and Transformation Plan (STP) was at a local level and there would be no need to replicate local scrutiny. The other 20% was wider and could potentially be scrutinised by this JHOSC.

Clarity was sought on the timescale for having a clear plan and programme for the STP, in particular the wider 20% beyond the individual place plans. – Proposals could be brought to the next JHOSC meeting to help identify future work.

Resolved:- (1) That this issue be discussed in conjunction with the review of the terms of reference.

(2) That the STP proposals be presented at the next meeting for Members' consideration.

10. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Joint Health Overview and Scrutiny Committee be held in October 2017, date and time to be confirmed.

South Yorkshire, Derbyshire, Nottinghamshire and Wakefield

Joint Health Scrutiny Committee

29 January 2018

Chairman's Report

Review of the Terms of Reference for the Joint Health Overview and Scrutiny Committee

1. Purpose of the Report

To outline the issues considered during the review of the terms for of reference for the Joint Health Overview and Scrutiny Committee that was established to consider health service changes in South and Mid Yorkshire, Bassetlaw and North Derbyshire, and to seek the Committee's approval for the recommended amendments to the terms of reference and ways of working.

2. Background Information

When health service providers develop proposals to reconfigure services they are required to inform and consult with the Health Scrutiny Committee of the appropriate local council. Frequently proposed service changes impact on a specific area and, as such, are the responsibility of a single Health Scrutiny Committee. However, where the proposed changes are substantial and affect more than one local authority area, councils are required to form a Joint Health Overview and Scrutiny Committee (JHOSC) to consider the proposals and ensure that consultation with local communities is effective.

This JHOSC was established in 2015 for the purpose of overseeing the NHS "Working Together" programme. It was set up following a formal request made by the NHS Clinical Commissioning Groups (CCGs) that provide services in the South and Mid Yorkshire, Bassetlaw and North Derbyshire. The request was made to the local authorities with responsibility for scrutinising health services across the same geographical footprint.

3. Current Situation

At the meeting of the JHOSC on 31 July, it was resolved that the local government officers supporting the Committee would meet to review the terms of reference. This was in light of:

- Health service providers indicating that future work streams may result in service reconfigurations that will impact on part or all of the geographical footprint of the local authorities represented on the JHOSC.
- Public questions seeking clarity of the Committee's, name, scope and remit
- Committee Members being cognisant of the demands placed on NHS resources and the desire to streamline attendance of NHS representatives.

- The need to ensure that the meetings are accessible to the public and that the Committee is in a positon to provide appropriate and timely responses to public questions.

The proposed revised Terms of Reference are attached as an appendix to this report.

4. Recommendations

Following consideration of the issues described above, and subsequent conversations with Members, the Committee is requested to agree that:

1. The name of the JHOSC is revised to reflect the Local Authorities represented on the Committee. Therefore the name of the Committee will be the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield JHOSC.

2. Future JHOSC meetings are held in the Town Hall of the local authority hosting the meeting.

3. Members of the public are encouraged to submit their questions three working days prior to the meeting to allow Committee Members time to consider the issues raised and provide an appropriate response at the meeting.

4. Public questions are included as a standard agenda item at future meetings and that the time allowed on the day of the meeting, for public questions, is managed at the discretion of the Chairperson.

5. Quorum for the JHOSC meetings will be three Members from geographical areas directly affected by the proposals under consideration.

6. As new NHS work streams and potential service reconfigurations emerge the JHOSC will determine whether it is appropriate for the committee to jointly scrutinise the proposals under development. Each local authority reserves the right to consider issues at a local level. This decision will be based on information, provided by the relevant NHS bodies, setting out the scope and timeframes of future work streams and the geographical footprint that may be affected by the potential changes.

7. That NHS witnesses attending the meeting will be limited to officers and/or health professionals presenting reports or information to Members, plus any additional witnesses specifically requested to attend by Members.

Cllr David Taylor (Derbyshire County Council)

(JHSC Chairman for Meeting 11 December 2017)

Appendix

Terms of Reference for the South Yorkshire, Derbyshire Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee

The South Yorkshire, Derbyshire Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee is a joint committee appointed under Regulation 30 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218 and is authorised to discharge the following health overview and scrutiny functions of the authority (in accordance with regulations issued under Section 244 National Health Service Act 2006) in relation to health service reconfigurations or any health service related issues covering this geographical footprint:

a) To review and scrutinise any matter relating to the planning, provision and operation of the health service in its area, pursuant to Regulation 21 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

b) To make reports and recommendations on any matter it has reviewed or scrutinised, and request responses to the same pursuant to Regulation 22 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

c) To comment on, make recommendations about, or report to the Secretary of State in writing about proposals in respect of which a relevant NHS body or a relevant health service provider is required to consult, pursuant to Regulation 23 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

d) To require a relevant NHS body or relevant health service provider to provide such information about the planning, provision and operation of the health service in its area as may be reasonably required in order to discharge its relevant functions, pursuant to Regulation 26 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2014.

e) To require any member or employee of a relevant NHS body or relevant health service provider to attend meetings to answer such questions as appear to be necessary for discharging its relevant functions, pursuant to Regulation 27 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Principles

- The purpose of the committee is to ensure that the needs of local people are an integral part of the delivery and development of health services across this geographical footprint.
- The committee's aim is to ensure service configuration achieves better clinical outcomes and patient experience.
- As new NHS work streams and potential service reconfigurations emerge, the JHOSC will determine whether it is appropriate for the committee to jointly scrutinise the proposals under development. Each local authority reserves the right to consider issues at a local level.
- All Members, officers, members of the public and patient representatives involved in improving health and health services through this scrutiny committee will be treated with courtesy and respect at all times.

Membership

- The Joint Committee shall be made up of seven (non-executive) members, one from each of the constituent authorities.
- A constituent authority may appoint a substitute to attend in the place of the named member on the Joint Committee who will have voting rights in place of the absent member.
- Quorum for meetings of the Joint Committee will be three members from local authorities directly affected by the proposals under consideration.

The 7 Committee Member Authorities are:

Barnsley Metropolitan Borough
Council Derbyshire County Council
Doncaster Metropolitan Borough Council
Nottinghamshire County Council
Rotherham Metropolitan Borough
Council Sheffield City Council

Wakefield Metropolitan District Council

Covering NHS England and the following 8 NHS Clinical Commissioning Groups (CCGs):

Barnsley CCG
Bassetlaw CCG
Doncaster CCG
Hardwick CCG
North Derbyshire
CCG Rotherham
CCG Sheffield CCG
Wakefield CCG

Working Arrangements:

- The Committee will meet on an ad-hoc basis as topics require scrutiny.
- On a rotating basis for each meeting, each local authority will Chair and provide administrative support to that meeting. Meetings will take place in the Town Hall of the local authority hosting the meeting.
- Agenda, minutes and committee papers will be published on the websites of all the local authorities 5 working days before the meeting.
- There is a standing agenda item for public questions at every meeting. Time allocated for this will be at the discretion of the Chair.
- Members of the public are encouraged to submit their questions 3 working days in advance of the meeting to enable Committee Members time to consider issues raised and provide an appropriate response at the meeting.
- The Committee will identify and invite the appropriate NHS witnesses to attend meetings.

Briefing paper to the Joint Health Overview Scrutiny Committee

Meeting: 29 January 2018

Review of Specific Hospital Services

Request to the Joint Health Overview and Scrutiny Committee comprising : Barnsley Metropolitan Borough Council, Doncaster Metropolitan Borough Council, North Derbyshire County Council, Nottinghamshire County Council, Rotherham Metropolitan Borough Council , Sheffield City Council and Wakefield District Council.

Background

The JHOSC has already considered, under its health overview and scrutiny functions, proposals to change out of hours children's surgery and anaesthesia services and hyper acute stroke services across the geography of Barnsley, Bassetlaw, Doncaster, North Derbyshire, Rotherham, Sheffield and Wakefield.

The Joint Committee of CCGS, as part of the South Yorkshire and Bassetlaw Accountable Care System, is now reviewing the health services provided to our communities as part of a Hospital Services Review. This Review includes five service areas that are carried out in Barnsley Hospital NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Rotherham Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust and, Mid Yorkshire Hospitals NHS Trust (the latter trust is involved but the patient numbers are very small).

The services are: urgent and emergency care; maternity services; hospital services for children who are particularly ill; services for stomach and intestines conditions (gastroenterology), including investigations (endoscopy); and stroke (early supported discharge and rehabilitation).

Request

The JCCCG expects to bring change proposals to patients and the public formally within the next year and would like to continue to share cases for change with the JHOSC before we proceed to formulate, engage and consult on any options for future service configuration. In this way, we can work with you to shape these options and the subsequent engagement and consultation so that we develop robust proposals which provide safe care for local people.

Under the Terms of Reference of the JHOSC, there is provision for the Committee to consider 'any other health related issues covering the same geographical footprint' in addition to the programmes within Commissioners Working Together. The Committee is therefore asked to continue to convene to carry out its duties under section 30 (5) of the regulations for the relevant scrutiny functions to be exercised by a joint scrutiny panel as proposals develop around the Review.

The Joint Committee may also wish to consider at this stage if it would like a joint representative of the Healthwatch bodies within the footprint to assist (in a non-voting capacity) and advise it for the purposes of the consultation process.

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Children's Non Specialised Surgery and Anaesthesia Update

Joint Overview and Scrutiny Committee

29th January 2018

Author(s)	**James Scott, Maternity & Children's Workstream, South Yorkshire and Bassetlaw Accountable Care System** **Marianna Hargreaves, Transformation Programme Lead, South Yorkshire and Bassetlaw Accountable Care System** Additional material provided by Prof Des Breen, Medical Director, Working Together ACC Vanguard Partnership Emma Andrews, Interim Clinical Networks, Project Consultant
Sponsor	**Will Cleary-Gray, Director of Transformation and Sustainability, SYB Accountable Care System** **Chris Edwards – SRO Maternity and Children's Workstream**

Is your report for Approval / Consideration / Noting

For Noting

Are there any resource implications (including Financial, Staffing etc)?

N/A

Summary of key issues

- A decision was made by the Joint Committee of Clinical Commissioning Groups and Hardwick Clinical Commissioning Group to approve the decision making business case for children's non specialised surgery and anaesthesia on Wednesday 28th June 2017.

- Approval of the preferred model enables the majority of surgery to continue to be delivered locally and the development of three hubs, Doncaster Royal Infirmary, Sheffield Children's Hospital and Pinderfields General Hospital in Wakefield.

- The decision means that once implemented around one or two children per week needing an emergency operation for a small number of conditions, at night or at a weekend, will no longer be treated in hospitals in Barnsley, Chesterfield and Rotherham, and will receive their treatment at one of the three hubs.

- Implementation is now progressing with detailed work being undertaken to agree clinical pathways through the Managed Clinical Network, and a series of designation visits (to be completed by mid-February 2018). There has been some slippage from the anticipated due date of end Q4 2017-18 however implementation is still expected in Q1 2018-19.

Recommendations

The Joint Overview and Scrutiny Committee members are asked to note the progress to enable the changes to children's non specialised surgery and anaesthesia.

Children's Non Specialised Surgery and Anaesthesia Update

Joint Overview and Scrutiny Committee

29th January 2018

1. Purpose

The purpose of this brief is to update the Joint Overview and Scrutiny Committee on the progress to implement approved changes to Children's Surgery and Anaesthesia (CS&A) services. JCCCG approved the decision making business case to progress the changes in a meeting in public on Wednesday 28th June 2017. The JHOSC were able to hear and scrutinise the decision making business case at this time. This paper follows an earlier update to the JHOSC in July 2017.

2. Introduction

A decision was made by the Joint Committee of Clinical Commissioning Groups and Hardwick Clinical Commissioning Group to approve the decision making business case for children's non specialised surgery and anaesthesia on Wednesday 28th June.

Over the last three years clinical commissioners and hospital trusts providing services in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham and Sheffield have come together to review and improve the care and experiences of all children needing an emergency operation in our region.

By working together better across all hospitals and commissioning organisations, new ways of working have been developed which means the number of children affected by these changes reduced significantly since the launch of the consultation in October 2016 and this has given staff working in the services more opportunities to improve and enhance their skills.

Approval of the preferred model enables the majority of surgery to continue to be delivered locally and the development of three hubs, Doncaster Royal Infirmary, Sheffield Children's Hospital and Pinderfields General Hospital in Wakefield.

The decision means that once implemented around one or two children per week needing an emergency operation for a small number of conditions, at night or at a weekend, will no longer be treated in hospitals in Barnsley, Chesterfield and Rotherham and will instead have their surgery at Doncaster Royal Infirmary, Sheffield Children's Hospital or Pinderfield's General Hospital where the right staff, with the right skills, will be available 24 hours a day, seven days a week. The service at Bassetlaw Hospital will remain the same as it already does not provide acute surgery for children out of hours.

3. Implementation Progress

Implementation is progressing with the Managed Clinical Network taking a lead role. In particular progress has been made to -

- **Complete the designation visits**. There has been strong engagement from all the Trusts in populating teams for these visits and to date the three proposed 'hubs' visits are complete and in the process of receiving feedback, with the three non-hub visits to be complete by mid February 2018.

- **Develop and agree clinical pathways**. Working groups have been set up for each clinical pathway facilitated by the Managed Clinical Network. Through these groups good progress has been made to develop pathways or adopt existing pathways where possible and appropriate to do so. The aim is for the majority of clinical pathways to be ratified at the Managed Clinical Network meeting in February.

There remains an expectation that transfer numbers, given the adherence to the designation standards, will be low. Agreeing the necessary transport arrangements to facilitate these transfers is a key part of the plan going forward.

Overall there has been some slippage from the anticipated due date of end Q4 2017-18 however implementation is still expected in Q1 2018-19.

4. Power of Referral

The JHOSC has not yet informed the JCCCG if it wishes to use its referral power in regard to the decision on Children's non specialised surgery and anaesthesia. The JHOSC is asked to update the JCCG on its intentions.

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Review of proposals to change hyper acute stroke services in South and Mid Yorkshire, Bassetlaw and North Derbyshire

Joint Overview and Scrutiny Presentation

January 2018

Hyper acute stroke services

- the case for change

Why change?

- **Compelling national evidence** that organised stroke care in a designated stroke unit – hyper acute stroke unit with rapid access to treatment –

  - improves outcomes
  - reduces avoidable disability
  - contributes to reduced mortality and length of stay
    - London reduced 90 day mortality by 5% (absolute reduction of 1.1%) and
    - reduced LOS by 1.4 days (London) and 2 days (Manchester)
  - and where higher patient numbers, have improved thrombolysis rates and increased adherence to guidelines, associated with improved stroke outcomes

Why change?

Current variation in quality - Scope to improve

- Most SYB stroke units have improved their performance on indicators in the Sentinel Stroke National Audit Programme (SSNAP), yet significant variation persists, with several providers unable to perform well in the areas that are relate to hyper acute care.

- Barnsley and Rotherham services have a low percentage of patients who have been reviewed by a stroke specialist consultant within 24 hours (reflecting the inability to provide 7 day consultant working).

- All units have thrombolysis rates below the national average but they are particularly low in Rotherham and Barnsley (prior to redirection to other units).

Why change?

Current variation in quality - Scope to improve

- There is a need to improve and ensure equity of care across SYB, the proportion of patients who
  - receive brain scanning within an hour
  - thrombolysis
  - are admitted to a stroke unit within 4 hours
  - are seen by a stroke specialist within 14 hours and
  - the timeliness of some therapy assessments, especially speech and language therapy

- **It would not be possible to achieve improvements in all these areas across all existing service provision.**

- The evidence base indicates that larger units are more likely to achieve quicker access to CT scans and have higher thrombolysis rates.

Why change?
Workforce challenges

- The combination of a national shortage of staff for some stroke specialist disciplines and increased staffing requirements to meet national standards (eg 7 day access to stroke specialist consultants, 7 day therapy assessments) are creating increasing challenges for existing services.

- The impact of insufficient medical staff is unsustainable rotas and over reliance on locums (particularly in Barnsley and Rotherham), with services becoming increasingly fragile.

- The workforce challenges mean that it is not possible for us to meet all the requirements for hyper acute stroke care set out in the NHSE Clinical Standards for seven day services and the national standards for stroke care across all existing services.

- Consolidation of hyper acute care at fewer hospitals would enable us to meet the Clinical Standards for seven day services & national standards and thus deliver high quality care that

Why change?

Clinical & Cost Effectiveness

- The Clinical Senate endorsed the national expert view that the total number of patients to access a hyper acute stroke service should be a minimum of 600 confirmed stroke patients a year to maintain clinical competency with a maximum of 1500 to avoid workload pressures.

- Not all existing SYB units admit above the recommended minimum threshold of admissions to ensure provision of a clinically effective unit (600 per year).

- All existing units except Sheffield fall below the number of admissions for a cost effective unit (ie the break even point based on national tariff and 100% best practice tariff is 900 patients per year).

One proposal on which we consulted:

- If you live in South Yorkshire and Bassetlaw and North Derbyshire and have a stroke, you would receive hyper acute stroke care in
  - Doncaster Royal Infirmary,
  - Royal Hallamshire Hospital in Sheffield,
  - Chesterfield Royal Hospital

- The proposal means that patients who would previously have been admitted to Barnsley Hospital or Rotherham hospital for hyper acute stroke care will in future receive care at Doncaster Royal Infirmary , Royal Hallamshire Hospital in Sheffield, or Pinderfields Hospital in Wakefield.

- After on average 72 hours of critical hyper acute care, they would be transferred to back to Barnsley or Rotherham for the remainder of their care.

Impact of the proposals

Criteria we need to take account of	What the evidence shows
Ambulance travel - access meets 45 minutes for 95% of population	Travel impact assessment and analysis confirms journey times within 45 – 60 mins
HASU activity levels - Clinical critical mass, of >600 and <1,500 stroke admissions per annum	Two (South Yorkshire and Bassetlaw) units would be within the range
Transformation should minimise cross-boundary impact	All patient flows remain within the original planning footprint
Is there a 7 day service being offered?	Greater opportunity to achieve through organised units & consolidating activity into 2 units
Adequate workforce - performance against SSNAP scores (case for change)	As above
Impact of change on visitors and carers travel time (pre consultation)	Travel impact assessment confirms journey times within 45 – 90 mins

Travel impact

- The vast majority of the population is within 30 – 45 minute drive-time to the proposed HASUs – with cost of parking actually being less than they would currently pay at their local centres for up to 4 hours.

- 26 and 27% of Rotherham and Barnsley don't have cars (census data) and so we analysed the impact of travelling by public transport. Majority can get to a site within 90 minutes (as a visitor) on buses, trains or trams.

- For places outside this travel time, they would mostly be treated/travel to a different NHS region (eg, very west of North Derbyshire would likely go to Manchester or Stockport and Cottam (Bassetlaw) are more likely to go to Lincoln).

- Travel by public transport from Barnsley to Pinderfields as a visitor would mean an increased cost due to crossing the South to West Yorkshire border.

The consultation process

There were a number of ways in which all internal and external stakeholders could respond to the consultation, these were:

- Online consultation questionnaire
- Paper surveys
- Meetings and events eg, public meetings and focus group
- Individual submissions eg, via telephone, email or letter
- Representative telephone survey
- Online poll

Communications and engagement activity

- **Digital communications and engagement**
  - 8,318 unique visitors used the CWT website
  - 62,000 page visits to the consultation webpages
- **Broadcast and print media releases**
  - 19 pieces of coverage in local, regional and national media
- **Social media**
  - Tweets generated more than 55,000 impressions
  - CWT's 21 Facebook posts reached 16,991 people and saw 939 users take action
- **Public consultation events**
- **Specific interest engagement** via email, hard copies of the consultation documents and meetings

Communications and engagement activity

- **Seldom heard group** engagement via email, hard copies of the consultation documents and discussion groups
- **Stakeholder briefings** including local MPs and councillors, Health and Wellbeing Board, Health Overview and Scrutiny Committees
- **Staff briefings** via internal communications channels, newsletters, forums and groups
- **Hard copies** of the consultation documents, postcards and flyers distributed to hospitals, GP practices, libraries and children's centres, dental practices, campaign groups, town halls, community venues and organisations and at public events. 50,000 copies of the consultation document were printed and distributed on request through these channels

The responses

- **1109 for hyper acute stroke services**

  - 282 were from the online survey
  - 58 were from the paper survey
  - 740 were from the telephone survey
  - 6 individual written submissions
  - 6 from partner organisations
  - 16 public meetings/focus groups/local groups
  - 1 petition

Hyper acute stroke services

	Consultation survey respondents		Telephone survey respondents	
CCG area	Actual	%	Actual	%
Barnsley	132	39%	72	10%
Bassetlaw	14	4%	33	4%
Doncaster	52	15%	98	13%
North Derbyshire and Hardwick (combined)	16	5%	227	31%
Rotherham	75	22%	106	14%
Sheffield	41	12%	139	19%
Wakefield	3	1%	65	9%
Other	3	1%	0	0%
Did not say	4	1%	0	0%
Total	340	100%	740	100%

What did people say?

Stroke

- Mixed response to the three centre option. 54% of self-selecting consultation survey respondents disagree with this option and 50% of telephone survey responses agree with it.

- The patterns of agreement are similar across both survey channels except for Bassetlaw, Sheffield and Wakefield where the majority of self-selecting consultation survey respondents disagree with the three centre option compared to the telephone survey respondents in those areas.

- There are high levels of support for the three centre option in Doncaster and North Derbyshire and Hardwick (which cover hospitals where the hyper acute stroke services are being proposed). There is low level of support for this option in the Barnsley CCG area.

Where disagreed, themes were:

- Not being able to access high quality care quickly and patient safety
- Social impact
- Other concerns (lack of funding for the NHS, wish to have a centre in local area so could access high quality care, additional pressure on the ambulance service)

Where agreed, themes were:

- Quick and easy access to high quality care
- Better quality of care and improved health outcomes
- More effective allocation of resources
- Other comments

A number of people **didn't feel they could comment.**

Alternative suggestions

- Almost half of the consultation survey respondents had alternative suggestions to make. The majority were making the case for Barnsley District General Hospital to have a hyper acute stroke service to make sure that local people could have quick access to time-critical care.

- The other main suggestions were to have a hyper acute stroke service in every hospital and to start investing in the right calibre of staff to make this happen.

Meetings

- The themes emerging from the meetings are the same as those from the consultation and telephone responses.

Written submissions

- 3 written submissions by individuals
- All our hospitals, except Sheffield Children's and Mid Yorkshire Hospitals
- Dan Jarvis MP
- Barnsley Save Our NHS

The themes emerging from the written public submissions mirror those in the surveys.

The themes emerging from the organisations can be summarised as:

- Support for the proposals
- Clarification on maintaining outcomes and quality of care for local populations
- Clarification on repatriation and ambulance service protocols
- Staff retention and development
- The potential adverse impact of increased activity levels (where a hospital could see more patients as a result of change)
- Financial viability/affordability

Online poll

- Mid-point analysis highlighted the complexity of the narrative on the proposals and the difficulty in engaging people on the issues.
- Recommendation from the Consultation Institute to create a short poll. At the end of the poll, respondents were directed to full details of the consultations on the CWT website.
- The questions were developed to capture people's thoughts on the proposals in a different way and were checked by a market research agency.
- The themes within the poll are the same as those within the main consultation.
- The results do not inform the main consultation survey analysis and are simply intended to provide further data on people's opinions

Concluding comments

- As with all public consultations, the public response cannot be seen as representative of the population as a whole but instead is representative of interested parties who were made aware of the consultation and were motivated to respond

- Within the analysis we cannot be clear the extent to which responses are informed by the supporting information that has been provided

- The telephone survey was undertaken with a randomly selected and representative cross-section of residents to ensure that the consultation process accurately captured the views of the wider population of South and Mid Yorkshire, Bassetlaw and North Derbyshire.

- A consistent picture - there is mixed support for the proposals

- Potential changes to services, particularly where loss of services are involved, understandably cause apprehension among those who may be affected and there has been clear and vocal opposition in some areas where this is potentially the case

- The main concern highlighted across all consultation feedback is the impact on the ability for patients and families to access high quality care closer to home if the proposed changes are introduced.

- The outcomes of the consultation process will need to be considered alongside other information available

Hyper acute stroke care

The Proposed Model

The Proposed Model

- A **Stroke Managed Clinical Network (MCN)** to support the development of networked provision of stroke care across the South Yorkshire and Bassetlaw Accountable Care System.

- **Consolidation of hyper acute stroke care** at the following units –
  - **Doncaster Royal Infirmary**
  - **Royal Hallamshire Hospital**
  - **Pinderfields Hospital Wakefield**
  - Plus the continuation of hyper acute stroke care at Royal Chesterfield Hospital.

- The hyper acute stroke model above will be supported by
  - **NHS England commissioning and gradual implementation of mechanical thrombectomy**
  - A review of the wider stroke pathway as part of the Hospital Services Review

- There is also a need to continue improvements in primary and secondary prevention of stroke risk factors.

The Proposed Model

The **Stroke Managed Clinical Network** will

- Support all operational aspects of delivery, ensure effective care pathways and clinical collaboration and coordination between sites.
- Facilitate cross organisational, multi professional clinical engagement and patient/carer engagement to improve care pathways.
- Fulfil a key role in assuring providers and commissioners of all aspects of quality, in addition to coordinating provider resources to secure improved outcomes for patients.

The Proposed Model - Consolidation of hyper acute stroke care

- Hyper acute stroke care will be delivered at
  - **Doncaster Royal Infirmary**
  - **Royal Hallamshire Hospital**
  - **Pinderfields Hospital Wakefield**
  - Plus the continuation of existing HASU care at Royal Chesterfield Hospital.

- Patients who would previously have been admitted to Barnsley Hospital or Rotherham hospital for hyper acute stroke care will in future if they present within 48 hours of onset of symptoms (the critical period for hyper acute stroke care) receive care at Doncaster Royal Infirmary , Royal Hallamshire Hospital in Sheffield, or Pinderfields Hospital in Wakefield.

- Work has been undertaken with the ambulance service to understand the new anticipated patient flows and to inform the total number of patients expected to receive their hyper acute stroke care in each of

The Proposed Model - Consolidation of hyper acute stroke care

- On arrival at a SYB HASU patients will receive an initial assessment and for those felt to have had a stroke a CT scan.

- After admission to a SYB HASU it is expected that patients will -
  - receive thrombolysis if clinically indicated,
  - have a consultant review (within 14 hours, 7 days a week)
  - have neurological and physiological monitoring until stable and appropriate stroke nurse assessments
  - have their swallow assessed and receive nutritional support if required
  - Have therapy assessments and therapy will be commenced while on HASU where clinically indicated (7 day therapy)

- After on average 72 hours of critical hyper acute care, patients will be transferred back to Barnsley or Rotherham for the remainder of their care and rehabilitation.

The Proposed Model – Mechanical Thrombectomy

- The hyper acute stroke care model will be supported by NHSE commissioning and the gradual implementation of mechanical thrombectomy to be delivered in neuroscience centres (Sheffield, Leeds, Hull and East Yorkshire for Yorkshire and the Humber).

- Plans are under development and it is likely that we will have a ‘drip and ship’ model with patients initially assessed by the HASUs, with transfer to a neuroscience centre for eligible patients.

- Further planning is required, but if current flows to neuroscience centres for other conditions are mirrored then patients admitted to Doncaster HASU will go to Sheffield and patients admitted to Mid Yorkshire HASU will go to Leeds.

The Proposed Model – Anticipated Benefits

- **Delivery of an improved, more resilient and sustainable service**
    - Through an established Managed Clinical Network, resulting in an enhanced ability to attract and retain a specialist stroke workforce and facilitate 7 day provision.
- **A service that delivers improved clinical quality** (clinical effectiveness, patient safety and patient experience)
    - All HASUs (except Chesterfield) will have the recommended patient numbers (600-1500) to provide a clinically effective service and will be above the 900 (patients a year) identified as necessary for a cost effective service
    - An enhanced ability to meet evidence based national stroke standards (NICE, RCP and STP guidelines) for HASU care eg increased proportion of patients scanned in an hour and thrombolysed.
    - It will be possible for SYB HASUs to meet all the NHSE Urgent and Emergency Care Standards for seven day care without the need to significantly increase consultant numbers.

The Proposed Model – Anticipated Benefits

- **Reduced inequalities in access, patient experience, quality of care and outcomes**
  - All patients across SYB will have access to high quality hyper acute stroke care that meets the national best practice standards.

- **Contribution to improved health outcomes**
  - A reduction in in hospital and overall mortality from stroke
  - A reduction in disability from stroke and improved quality of likfe
  - A higher proportion of people who have had a stroke able to return home to live independently and return to work
  - A reduction in the number of patients newly discharged to care homes/continuing health care

- A reduction in stroke mortality was seen after the consolidation of stroke care in London.

Themes from the Public Consultation -

Themes from the public –

- Not being able to access high quality care quickly and patient safety
- Social impact
- Other concerns (lack of funding for the NHS, wish to have a centre in local area so could access high quality care, additional pressure on the ambulance service)

The themes from the organisations were:

- Overall support for the proposals
- Clarification on maintaining outcomes and quality of care for local populations
- Clarification on repatriation and ambulance service protocols
- Staff retention and development
- The potential adverse impact of increased activity levels (where a hospital could see more patients as a result of change)
- Financial viability/affordability

Addressing themes identified in the consultation -

A number of themes were identified from the consultation, from both the public and organisations. All have been considered and informed the development of the proposed model.

- **Not being able to access high quality care quickly and patient safety**
  Performance against SSNAP indicators is currently variable.
  The proposed new model should enable us to improve performance on key indicators and ensure equity of care.

- **Social Impact**
  The new model is about providing hyper acute stroke care (on average the first 72 hours) differently, after which patients would be repatriated for their ongoing care and rehabilitation to Barnsley and Rotherham.

  The travel analysis showed most people could get to a site (as a visitor) within 90 minutes, with most journeys well under 90 minutes. Parking charges for visitors at Sheffield and Doncaster would reduce, albeit a potential increase in public transport costs for visits to Pinderfields Hospital. For people on low or no income, hospital travel

Addressing themes identified in the consultation -

A number of themes were identified from the consultation and all have been considered and informed the development of the proposed model.

- **Clarification on maintaining outcomes and quality of care for local populations** (not being able to access high quality care).
  Performance against SSNAP indicators is currently variable.
  The proposed new model should enable us to improve performance on key indicators and ensure equity of care.

- **Clarification on 'repatriation' and ambulance service protocols**
  A clinical working group has been established to develop a policy. The ambulance service is involved and if the proposals are approved a plan will be developed with ambulance protocols. More work on the data shows less people will require repatriation than initially anticipated.

- **Staff retention and development**
  A workforce group – made up of the different professions - is developing a strategy focusing on staff recruitment, retention and development. There are plans to look at joint medical posts.

Addressing the themes identified in the consultation -

- **The potential adverse impact of increased activity levels** (where a hospital could see more patients as a result of change)
  All the units that would see more patients have developed plans that set out how they would manage the increase.

  The implementation would be taken forward in phases. Not all the change would be made at once, making it safe for patients and manageable for providers and we would closely monitor it together. All the new HASUs will be below 1500 patients annually.

- **Financial viability**
  The new model is driven by a strong clinical case for change and would need investment.

  If we do nothing, the variation in quality and workforce issues are likely to worsen and it may no longer be possible to deliver the existing service. If this happened, urgent and ad hoc arrangements would need to be put in place – which would require investment.

Managing Stroke Mimics

- Some patients who paramedics or A&E staff initially think may have had a stroke, turn out not to have had a stroke (stroke mimics).

- One of the concerns raised upon considering the consolidation of hyper acute stroke care was that many patients from Barnsley and Rotherham could be transferred to a HASU and found to be a stroke mimic and then need to be repatriated.

- Learning from Greater Manchester indicates that it is possible to improve the recognition and identification of stroke mimic conditions at the outset to reduce unnecessary transfer to HASUs (work with paramedics & A&E staff)

- Recent audit work in Sheffield predicts that only a small proportion of Barnsley and Rotherham patients with a stroke mimic condition will need repatriating. If we assume similar rates in the other two HASUs – the total estimated number of stroke mimics who are likely to need repatriation is approx 1 per week each – Barnsley and Rotherham.

Managing Risks - Mitigation Plans

- **Do nothing**
  - There is a risk that doing nothing will result in more challenges for existing services and potential deterioration in the quality and safety of provision.
  - **To mitigate against unplanned service change** there is established dialog between providers and the ambulance service.

- **Stroke mimics**
  - There is a risk that transfer could result in their management and experience of care being adversely impacted.
  - **To mitigate this** action will be taken to improve the identification of stroke mimics by paramedics and A&E staff and increase patient/carer input to maximise the potential to improve patient experience and minimise adverse impacts.
  - There is also a risk that assumptions around their identification and flow are not fulfilled.
  - **To mitigate this** audit work has been completed and predicts that the numbers requiring repatriation are likely to be low.

Managing Risks - Mitigation Plans

- **Repatriation**
  - There is a risk that it will not be possible to repatriate patients in a timely manner due to transport availability or bed capacity.
  - To mitigate this transport requirements are included in the business case and a ‘patient flow’ policy will be agreed by all.

- **Ensuring benefit realisation**
  - There is a risk that it may not be possible to timely realise all the anticipated benefits and that focusing on HASU alone will not maximise the possible improvements in patient outcomes.
  - To mitigate this work has been undertaken to articulate the benefits and what needs to be in place to realise them. The MCN will have a key role in benefits realisation & ensuring a pathway approach as will working with other workstreams (such as prevention) to maximise potential to improve outcomes.

- **Wider implications**
  - Acute stroke care is facing increasing challenges and as such has been included in the hospital services review.

- The proposed new model is to improve the quality of care
- Although there are risks associated with the proposed new model it is possible to mitigate these so that they are manageable
- The most significant risks that are difficult to mitigate are those associated with not progressing the new model, doing nothing will result in increasing challenges for already fragile services in Rotherham and Barnsley Hospitals and potential deterioration in the quality and safety of provision.
- Due to the fragility of existing services and their inability to consistently meet all national standards relating to stroke care, on balance the risks and challenges of the proposed model are less than the risks of doing nothing.
- The evidence base indicates that it will be possible to improve the quality of care, sustainability and cost effectiveness that would not be possible through continuing to try to improve and deliver hyper acute care at all current sites.

Commissioning Implications

- The business case for the reconfiguration of hyper acute stroke care in South Yorkshire and Bassetlaw has been assured by NHS England.

- The proposed new model of hyper acute stroke care requires investment from commissioners of circa £1.8M for higher average tariffs at the HASU sites, additional best practice tariffs and patient transport.

- It is recommended that the approach is to commission once with a system commissioner, a single contract for a hyper acute stroke service with a consistent approach to acute stroke care with a group of providers.

- Procurement advice confirms that there is a clear rationale for the use of a negotiated procedure without prior publication approach ahead of awarding the contract for the new model.

- Due to the scale of the change it is proposed that implementation is phased, given that arrangements are already in place to redirect

South Yorkshire and Bassetlaw Accountable Care System

The Hospital Services Review

Presentation to the JHOSC

29 January 2018

Outline

- Aims and objectives of the review
- Services in scope and developing options
- Public and clinical engagement
- Next steps

Aims and objectives of the review

Aims and objectives of the review

- **Define and agree a set of criteria** for what constitutes 'Sustainable Hospital Services' for each Place and for South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire

- **Identify any services** (or parts of services) **that are unsustainable**, short, medium and long-term including tertiary services delivered within and beyond the STP

- **Put forward future service delivery model** or models which will deliver sustainable hospital services

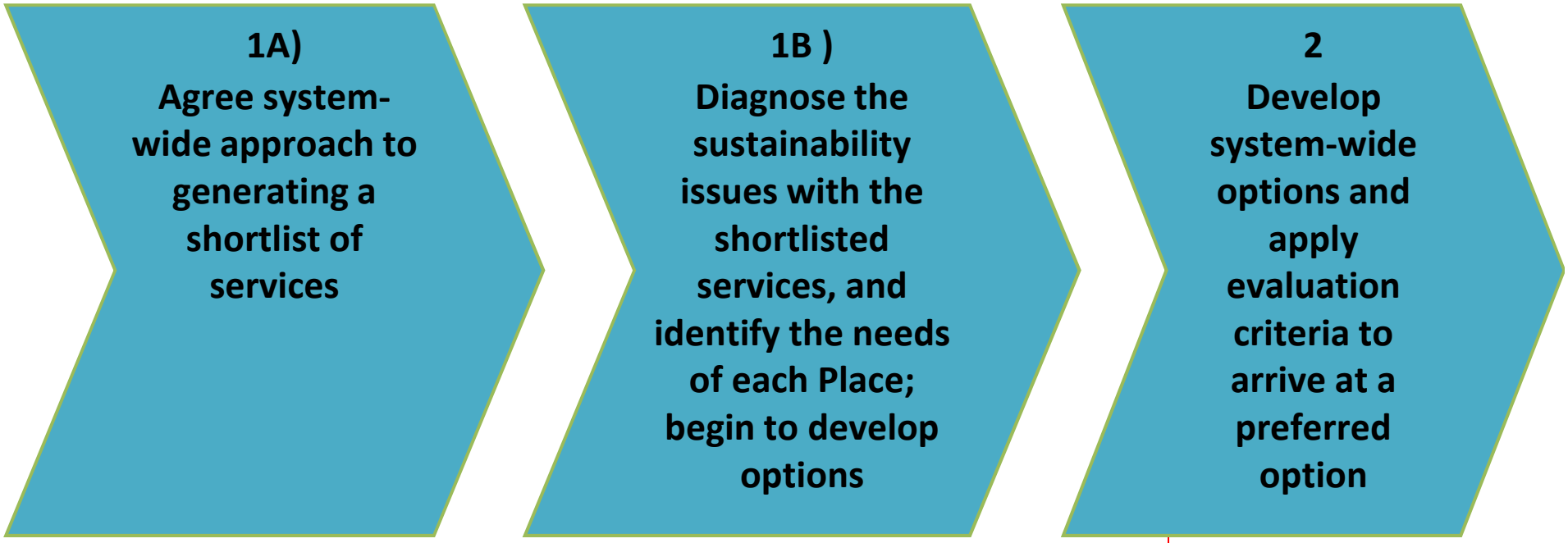
- **Consider what the future role of a District General Hospital** is in the context of the aspirations outlined in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) and emergent models of sustainable service provision

Definition of sustainability

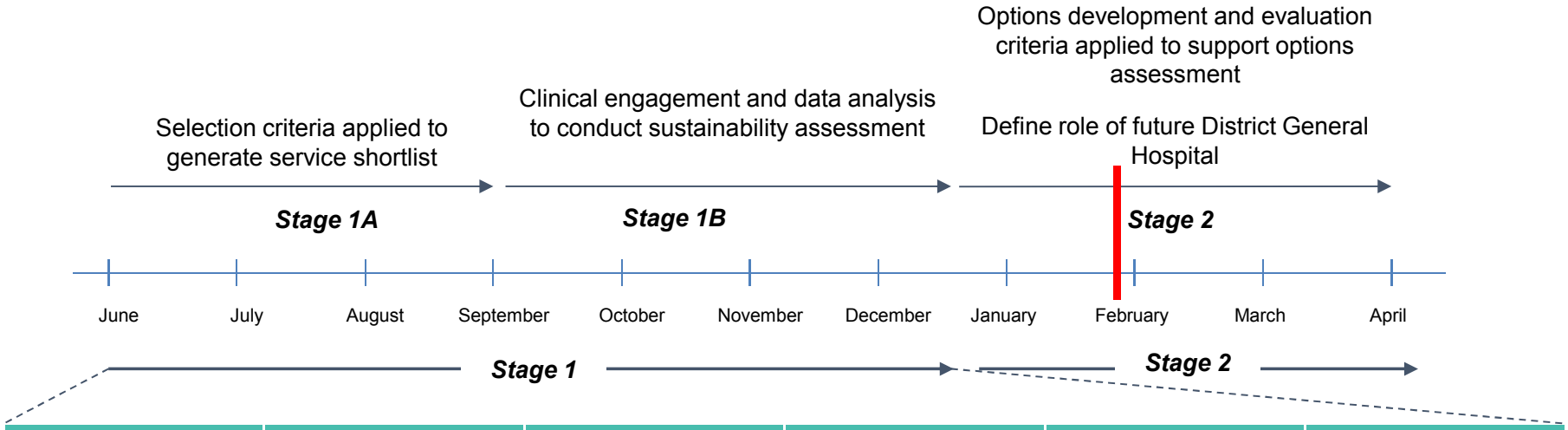
A sustainable service…

- sees and treats **enough patients** to operate a safe and efficient service
- has an **appropriate workforce** to meet staffing needs
- has **interdependent clinical services** in place and in reach to operate core services safely and effectively
- is likely to be deliverable within the **resource envelope** that is likely to be available

Process


1A)
Agree system-wide approach to generating a shortlist of services
1B)
Diagnose the sustainability issues with the shortlisted services, and identify the needs of each Place; begin to develop options
2
Develop system-wide options and apply evaluation criteria to arrive at a preferred option
Jun-Sep 2017
Oct-Dec 2017
Jan-Apr 2018
We are here

Progress so far



July	August	September	October	November	December
Agreed **approach** to sustainability review	Delivered **interim analysis** on the shortlist of services Held large **public engagement event** to review the scope and approach of the review	Drafted the **Stage 1A report** on the shortlist of 5 services	**Published** the Stage 1A report on the shortlist of 5 services Launched the **public survey** for the Hospital Services Review Agreed **evaluation criteria** to assess future changes to clinical services	Completed all **15 Clinical Working Groups** across 5 services	Drafted **Stage 1B sustainability report** on the challenges facing the 5 shortlisted services Held large **public engagement event** to understand the sustainability challenges with services across SYB

The timeline over the next few months is as follows

Jan

Publish 1B report

Further work on ideas proposed in the CWGs and public engagement to develop recommendations

Ongoing public engagement

Feb

Modelling of options

Ongoing public engagement

Mar

1 March Final session of Clinical Working Groups

8 March SYB-wide session with the public

Evaluation of options

Apr

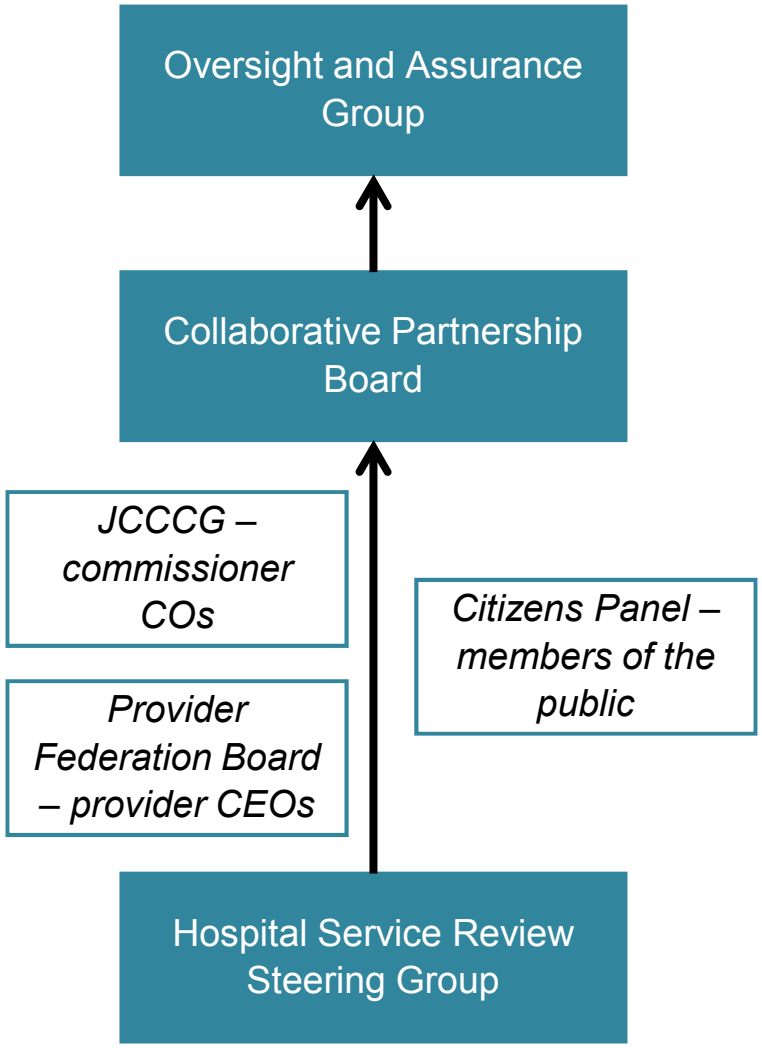
Evaluation of options

Draft and agree report, circulated through governance groups

Submit report to commissioners end April

The briefing paper that members of the JHOSC have received asks that the JHOSC continue to meet in order to discuss the services included within the Hospital Services Review going forward.

Governance structure



- commissioned the Review and will receive its reports and recommendations
- *Membership = Trust Chairs; HWB Board Chairs; CCG Clinical Chairs; lay members*

- Has oversight of the report and feeds into it.
- *Membership = Trust CEOs; local authority representatives; CCG AOs; lay members; NHSE and NHSI*

- JCCG and the Provider Federation Board are not formally part of the governance but allow AOs and trust CEOS to feed into the Review each month. JCCCG will ultimately decide which of the Review's recommendations to take forward.
- The Citizens Panel provides their views and insights

- Chaired by Professor Chris Welsh (Independent Review Director) and acts as the day-to-day advisory board for the Review
- *Membership = acute provider Medical Directors and other senior leads, YAS, CCG leads*

Services in scope, and Clinical Working Groups

The Review is focusing on the following services:

- The services identified are those which:
  - **Are facing significant difficulties with workforce and / or quality of care**
  - **Have a significant number of interdependencies:** setting these services on a more sustainable footing will significantly help to improve the service as a whole
  - **Have a significant impact on the service as a whole**

- **Urgent and Emergency Care**
- **Maternity**
- **Care of the Acutely Ill Child**
- **Gastroenterology and Endoscopy**
- **Stroke**

We will also look at a very high level at some elective (non-emergency) services

The services chosen focus largely on the emergency, 24/7 services. The review team anticipate that the review will consider how elective services might be located across the system in order to improve quality and support any proposals in these services

Within this the Review is likely to have the following key themes:

Transforming care

1) **Workforce**: how Trusts can best work together to train and support their staff
2) **Delivering the same standards of care**: how Trusts can work together to ensure that patients receive the same standard of care wherever they are
3) **Innovation**: how we draw on new technologies to support the delivery of care

Configuring services

4) **The 5 core services**: how the services can best be configured and delivered across the 5 key services
5) **Non-emergency services**: ways to improve the quality of non-emergency services

Supporting organisations

6) **Supporting trusts to work together:** what organisational structures could support collaboration between trusts

Clinical engagement

Clinician engagement through 5 Clinical Working Groups

Workshop 1:

"What are the issues and the root causes of those issues?"

Mid Oct 2017

Workshop 2:

How have other places solved these problems? What ideas should we explore?

Early Nov

Workshop 3:

Do these ideas go far enough? What would need to change to make them happen?

Late Nov / early Dec

Workshop 4

How do the options developed so far perform against our evaluation criteria?

March 2018

The Overarching Strategic Group pulls together the conclusions from across the five Clinical Working Groups

Public engagement

We are engaging with the public on the same issues as we are engaging with clinicians

Public engagement methods

- 3 SYB-wide events open to anyone (August, December, March)
- Face to face sessions open to residents in Barnsley, Bassetlaw, Doncaster, Rotherham
- Focus groups with seldom heard groups across the footprint
- Session with young people
- Online survey across the health economy
- Telephone survey of 1,000 people across the footprint to mirror demographic makeup of South Yorkshire and Bassetlaw
- Stands in receptions of some hospitals: Sheffield Children's Hospital, Chesterfield, Rotherham so far
- Information distributed through Healthwatches etc

Issues

- Feedback on problems with services now and public priorities for service change
- Feedback on priorities for evaluation criteria
- Feedback on emerging directions for the Review
- [In March] Applying evaluation criteria to potential models

Thank you

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 28th February 2018

Report of: Policy and Improvement Officer

Subject: Written responses to public questions

Author of Report: Emily Standbrook-Shaw, Policy and Improvement Officer
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0114 273 5065

Summary:

This report provides the Committee with copies of written responses to public questions asked at the Committee's meeting on 17th January 2018.

The responses are included as part of the Committee's meeting papers as the way of placing the responses on the public record.

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:

Note the report

Background Papers: None

Category of Report: OPEN

Question 1

What is the current availability of acute mental health beds and how many patients subject to compulsory admission have had to go out of area in the last year, and where have they gone to? In particular regarding patients aged 18-25

Written Response

There are currently 49 adult acute mental health beds in Sheffield. There have been no acute out-of-area admissions, due to capacity, for over 3 ½ years.

Question 2

Cuts in alcohol treatment services in the community mean that more patients are being admitted to acute wards with liver failure. Could NHS be more effective with greater community support and what steps are being taken to ensure this?

Written Response

Sheffield's alcohol treatment budget has been the same for 5 years, and has just been confirmed as the same again for 2018/19. Sheffield City Council commissions an open access alcohol treatment service where people can walk in and be seen for an assessment then and there, and 0% of service users wait over 3 weeks to begin a treatment episode after an assessment.

Liver Disease has three predominant causes: alcohol, obesity, and hepatitis. There are a number of reasons why levels of liver disease among alcohol users is increasing, which include price and availability of alcohol, and difficulties in identifying harmful alcohol use in its early stages so we can intervene early.

However, the Sheffield Alcohol Strategy 2016-2020 (available on www.sheffielddact.org.uk) sets out a clear set of priorities and actions to identify harmful alcohol use early, normalise the conversation about alcohol between non-specialist services and their service users, and ensure people are referred to treatment at the earliest opportunity. We are also raising awareness of the harms of alcohol via planned city-wide social media campaigns. In addition, current work is ongoing to source funding for a specific project to reduce the number of hospital admissions as a result of alcohol use and provide intensive support to those most at risk.

Question 3

How many acute admissions of elderly people have resulted from under funding of effective adult social care and what cost savings could be achieved by acute hospital services if social care was effectively funded?

Written Response

The question asks about under-funding of effective adult social care. It is hard to be clear about the correlation between adult social care funding and outcomes for acute hospitals. However two points seem very clear. Firstly that national funding for adult social care has been significantly constrained and this creates pressures that have affected many Local Authorities. But secondly, that Sheffield does not perform as well as many other areas with similar profiles and financial constraints, with regard to avoiding hospital admissions and ensuring people leave hospital when they are ready rather than having to be delayed.

This suggests that more can be done in Sheffield with current levels of funding. Significant work is already taking place between the Council, Sheffield Teaching Hospitals and Sheffield Clinical Commissioning Group in that regard and there have been a number of improvements that have already been reported to the Scrutiny Committee.

Council Cabinet has also agreed an Improvement and Recovery Plan for adult social care. This plan recognises that there is work that can be done to ensure that adult social care becomes more effective without the need for more funding. For example, over the last two years the Council has greatly improved the efficiency and effectiveness of its community intermediate care service (STIT) and used the money released to invest in independent sector homecare. This has helped people get more consistent and timely support that has had positive implications for the NHS as well as local people.

Overall of course more funding will have a positive impact across the NHS and social care. But it is important to acknowledge that there are still opportunities in Sheffield to improve health and care even in the current financial climate

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