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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 23 January 2019 at 4.00 pm

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Pat Midgley (Chair), Sue Alston (Deputy Chair), Steve Ayris, David Barker, Mike Drabble, Adam Hurst, Talib Hussain, Francyne Johnson, Bob Johnson, Mike Levery, Martin Phipps, Chris Rosling-Josephs, Jackie Satur, Gail Smith 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
23 JANUARY 2019

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

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

Primary Care

7. Healthwatch Briefing on Access to and Quality of Primary Care (Pages 13 - 16)
For information.

8. Update on Primary Care (Pages 17 - 26)
Report of Nicki Doherty, Director of Delivery of Care Outside of Hospital.
NHS Sheffield CCG.

9. Overview of Sheffield General Practice (Pages 27 - 32)
Report of Mandy Philbin, Chief Nurse, NHS Sheffield CCG.

10. Update on the Work of the Accountable Care Partnership (Pages 33 - 48)
Report of Becky Joyce, Accountable Care Partnership Programme Director.

11. Work Programme (Pages 49 - 58)
Report of the Policy and Improvement Officer.

12. Date of Next Meeting

The next meeting of the Committee will be held on 27th February, 2019.

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 14 November 2018

PRESENT: Councillors Pat Midgley (Chair), Sue Alston (Deputy Chair), Steve Ayris, David Barker, Mike Drabble, Adam Hurst, Francyne Johnson, Mike Levery, Martin Phipps, Jackie Satur, Gail Smith and Garry Weatherall

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor 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 The Chair, Councillor Pat Midgley, declared a personal interest in agenda Item 5 (Prevention) by virtue of being a member of the Manor and Castle Development Trust.

4. PUBLIC QUESTIONS AND PETITIONS

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

(a) What input does this Scrutiny Committee have into the work of the Joint Health Overview and Scrutiny Committee for South Yorkshire and Bassetlaw/Mid-Yorkshire and North Derbyshire Scrutiny Committee, the Chair, Councillor Pat Midgley, advised that she had attended every meeting of the Joint Committee and she would arrange a meeting with Ms. Cobbett and Councillor Chris Peace, Cabinet Member for Health and Social Care, to discuss this.

(b) Greg Fell (Director of Public Health) had made a statement that 60% of children in some parts of Sheffield were living in poverty, and Ms. Cobbett asked how can small changes outlined in the Prevention report come anywhere near to “solving social issues” and changing health chances. In reply, Greg Fell said that he would provide a written response to Ms. Cobbett.

(c) How can we be sure that managing demand for care will not simply reduce people's expectations, which, the report suggests, were already low? Also, what will be done to monitor people managed away from social care to ensure that their needs are met in a proactive way and what would be done to address the pressures on staff, as outlined on page 84 of the report? Does the Committee understand the maths of focused reablement outlined on page 79? In response Sara Storey (Head of Access and Prevention) stated that there were successes and challenges and maybe some administrative errors had been made, but ongoing support to those who needed it, was still being given.

4.2 The Chair, Councillor Pat Midgley, stated that Prevention will by no means solve all the issues regarding health, but one of the major issues is health inequalities, which was something the Council needed to tackle.

5. PREVENTION

5.1 The Chair, Councillor Pat Midgley outlined the format of the item of business. She said that the aim of the item was to give an overview of the Council's strategic approach to prevention and gain an understanding of how this was working in practice through some of the prevention projects going on across the city, and Members had an opportunity to hear from a range of individuals and organisations about their experiences and views on prevention.

5.2 In attendance for this item were Councillor Chris Peace (Cabinet Member for Health and Social Care); Councillor Jackie Drayton (Cabinet Member for Children and Families); Greg Fell (Director of Public Health); Nicola Shearstone (Head of Commissioning for Prevention and Early Help, Sheffield City Council (SCC)); Nicki Doherty (Director of Delivery, Care Outside of Hospital, NHS Sheffield CCG); Emma Dickinson (Commissioning Manager, SCC); Bluebell Smith (Health and Wellbeing Lead, Voluntary Action Sheffield); Kath Horner (Sheffield Dementia Action Alliance); Bev Mullooly (Head of Neighbourhood Services, SCC); Elaine Goddard (Health Improvement Principal, SCC); Jim Millns (Deputy Director of Mental Health Transformation, NHS Sheffield CCG); Sara Storey (Head of Access and Prevention, SCC); Maddy Desforges (Chief Executive, Voluntary Action Sheffield); Debbie Matthews (Chief Executive, Manor Castle Development Trust); Matt Dean (Chief Executive, Zest) and Ian Drayton (Partnership Manager, SOAR).

5.3 Greg Fell referred to the information contained in the report which he said gave an insight into some of the work that was ongoing by working in a more preventative way. He gave a brief introduction and strategic overview of the Council's approach to prevention which, he acknowledged, was easier said than done. As a large organisation, there was a need to work together with all agencies, the NHS and the voluntary sector by providing the correct social care to the people of Sheffield of all ages. He added that there was a need for prevention to become almost as a default so that the needs of people could be dealt with and did not necessarily escalate into something more.

5.4 Nicola Shearstone outlined the prevention principles and stated that there needed to be a culture change, to drive forward the principles. She said there was a need

to build connections within communities and assess how social care impacts on communities as a whole, not just individuals. There was a strengths-based principle which aimed to give communities a sense of belonging and feeling connected within that community as a whole, which, in turn, would enable neighbourhoods to thrive and tackle inequalities. Ms. Shearstone stated that all organisations involved in providing social care needed to nurture relationships within communities through co-operative working. She further stated that the key to delivering excellence was a strong locality model which included locally accessed services and both the public and staff being aware of these; good communication and feedback; shared data; an understanding of the local population; simplified referral pathways and easy access to specialist services; shared premises and responsibilities across organisations and a strong multi-disciplinary workforce. She finished by saying that in Sheffield great things were happening with the creation of 16 neighbourhoods aimed at improving health and care outcomes, the quality of care particularly long term conditions, reducing unnecessary health and care service use and provision of services closer to home.

5.5 Councillor Chris Peace stated that if the City Council as an organisation wanted to be the leader in pushing forward this initiative, it needed to get things right by looking at health inequalities amongst those in the most deprived areas and moving towards a situation where people needed the NHS less, by working together across the board. She added that, as a Council, there were major problems of funding following eight years of austerity but the aim was for hospital beds not being full.

5.6 Councillor Jackie Drayton, speaking as Cabinet Member whose portfolio covered young people, stated that early help and intervention was key to keeping young people healthy and active and supporting them going forward. She said that in the city, the number of children living in poverty was rising, particularly amongst low wage working families and this needed to be addressed. She felt there was a need for organisations to work together towards delivering care for all.

5.7 In response to questions from Members of the Committee, it was stated that people using the NHS during the first 50 years from its inception, suffered maybe one illness at a time, whereas now there was a tendency for people to have four or five different illnesses going on at the same time. Resources and workforce was reducing in primary care and the NHS was no longer fit for purpose for health care needs. The 16 neighbourhoods were not coterminous and talks were ongoing with the CCG and the voluntary sector on how to overcome the boundaries to deliver the best care possible.

5.8 Emma Dickinson referred to “Social Prescribing” and stated that healthcare, at most, only contributes to 40% of people’s health. It was considered to be a means of local authority, health and other organisations linking people to a range of local, non-clinical services to improve health and wellbeing. She said ways of people keeping well was to provide advocacy support for a number of everyday problems, to encourage people to have healthier lifestyles and also encourage them to be more active through a whole range of activities. She gave an example of someone with low esteem who, through recommendation of a practice nurse, to a referral hub, and with the help of a health trainer, had regained some of her lost

confidence and was continuing to improve and need services less.

5.9 Bluebell Smith gave an overview of the work of Voluntary Action Sheffield and she stated that feedback from a recent review had revealed that cross-sector working was working well encompassing a wide variety of agencies, but varied from area to area. She said that boundary alignment could be very challenging but that the voluntary sector was flexible, although the same could not be said regarding GP Neighbourhoods. She added that one of the strengths was that if people were keeping well, it tended to make the voluntary sector more accessible. The client group was shifting however, and the level of need seemed to be on the increase, so therefore there needed to be an increase in investment in workforce.

5.10 Kath Horner stated that Sheffield was one of the first cities in the country committed to being a Dementia Friendly Community. The aim of the community was for cities, towns, villages and local businesses and organisations to come together to help and support people to live well with dementia, helping them remain independent for longer and also offer support and advice to people caring for those with dementia. She further stated that in Sheffield, organisations were being encouraged to sign up to the Dementia Action Alliance which was committed to improving the quality of life for all people with dementia and their carers and each member organisation had created an action plan outlining improvements they would make to support people affected by dementia and give them another option. Ms. Horner said that in Sheffield there were 80 Dementia Champions raising awareness and there were 72,000 “dementia friends” who could do so much more towards prevention. The South Yorkshire Police had donated funds to the Alliance to help dementia sufferers be aware of fraud and also there was work with the utility companies to help those who are vulnerable. She added that it was thought that following a “mediterranean” diet reduced the risk of being diagnosed with dementia as well as diabetes. She went on to say that in the Porter Valley, with funding from five local GP surgeries, a “Dementia Café” was opened twice a month and she hoped that many more would be set up throughout the city.

5.11 Bev Mullooly stated that Housing+ was a “patch-based” service in which Neighbourhood Officers have responsibility for all Council homes and deliver housing services within a geographical area. She further stated that there were seven teams in the City and the aim was to give Council tenants one point of contact. There were 39,000 tenants in the city and the aim was to visit every household annually. Although some tenants were worried about such visits, it was intended to reassure people and help to identify their needs and offer support if needed. To date, 27,000 visits had been carried out and although some tenants didn’t need support of any kind, the Teams had uncovered households with diverse, complex needs and there was a need for other services to work with those with mental health problems, to help those people become more resilient and to focus on prevention and early intervention to achieve better outcomes. Ms. Mullooly stated that although there were good working relationships between city council services and partner agencies, gaps had been uncovered, and that the next steps were to develop and establish closer relationships with local GP practices. It was recognised, however, that not all housing was under local authority control.

5.12 Elaine Goddard outlined the work of Community Support Workers (CSWs) and how they could contribute towards prevention. She said the service works in collaboration with GP practices, intermediate care services and voluntary sector partners and provides a person-centred short term intervention for adults who may be at risk of needing long term care, with the aim of preventing unnecessary hospital admission. She stated that anybody could be referred to the service, either by a GP or, in some cases, self-referral, and a worker will give assistance for usually about three weeks. Ms. Goddard said that CSWs were based in GP services but there were some inequalities with the service – some people found it easier to access than others, people might only hear about it by word of mouth in the community or local knowledge. One of the issues that needed to be addressed was social isolation and the knock-on effect that this has, so clubs had been set up to help. CSWs were different to social workers in that they did not have caseloads, they just provided an interim short-term service.

5.13 Sara Storey stated that Social Workers, Care Managers, Occupational Therapists, Community Support Workers, Prevention Officers, Travel Trainers and Sensory Impairment Officers together make up 50% of the Adult Services Department within the City Council, and by working together could create a local access point which would benefit people needing very early intervention and prevention and receiving information and advice from Adult Social Care. With regard to mental health, Sara Storey said that there needed to be a commitment from the city in the first instance, by tackling mental illness at the earliest possible opportunity by encouraging people to talk more openly about mental health. Secondly, intervening earlier by increasing the focus on children and young people, given that 50% of mental health problems are established by the age of 14 and 75% by the age of 24, and develop an all-age approach to mental health services in Sheffield. Lastly, address the determinants of mental ill health e.g. employment, housing, debt, domestic abuse, lack of physical exercise etc.

5.14 Maddy Desforges outlined the infrastructure of Voluntary Action Sheffield (VAS) and she echoed many of the views expressed at the meeting. She said that VAS sees gaps in the services provided and believed that, through better resources, investment and closer working partnerships, those gaps would be filled, and added that there was a need to identify where investment would have the greatest impact.

5.15 Debbie Matthews stated that she had worked in the Manor Castle area for 21 years as a Health Promotion Development Worker. For the first 15 years of that time, she had seen improvements in the Wards the area covered, which were considered to be amongst the most disadvantaged Wards in the city, however for the last five years, things had started to decline. She said there was a need for a much more joined up approach towards helping people, by creating an intensive one-to-one approach rather than having a revolving door when people were seeking help. She said there were 14 different social landlords in the area which inhibited the fostering of a good relationship within the community. Ms. Matthews went on to say that 10 years ago, people had problems with debt or obesity but now they had more complex needs and/or addictions and these often led to suicidal thoughts. She said that the food bank in the area had been created initially to deal with crisis, but this was becoming the normal thing to do and was

creating dependency. She felt that the prevention agenda was all about dealing with crisis in whatever form and seeing what's working to prevent this.

5.16 Matt Dean commented that Zest was an award winning community enterprise delivering high quality and responsive services to local people, very much along similar lines to the Manor Castle Development Trust. He said that Zest worked passionately to tackle local inequalities and improve community wellbeing.

5.17 Ian Drayton explained that SOAR was a community regeneration charity that provided a range of services designed to improve a person's health, well-being and employability. He outlined many of the activities SOAR had helped to develop and provide assistance with. He felt that money was not always spent where it was needed the most and more investment should be made towards prevention. He added that the social determinants of health, as described in the report, were proof that healthcare only contributed to 40% of people's health, and that lifestyle and social factors had a greater impact on our wellbeing.

5.18 The Chair asked Council Officers and Partners what one main issue would they like to see achieved through prevention, and comments were as follows:-

- Maddy Desforges – Collaboration – to work with, not against, each other
- Bluebell Smith – Money – full city coverage of the People Keeping Well programme would require £140,000 additional investment.
- Ian Drayton – there needed to be a culture change. He said the City Council was aware that money was going to be withdrawn by Central Government and there was very little evidence to show measures being put in place to reduce the impact of this.
- Debbie Matthews – there was a need to treat the voluntary sector as a partner rather than a supplier, as those working in the sector didn't feel as though they were treated as partners. She added that the voluntary sector has roots in communities and those roots were not valued, there needed to be joined-up commissioning and a push needed to be made to do better.
- Matt Dean said there needed to be maximum impact on the People Keeping Well framework.
- A member of the public stated that he had heard about the prevention agenda and suggested that if the statutory services were to succeed, they wouldn't be able to do so without the voluntary sector ???
- Kath Horner said that we need to listen to those people with dementia and their carers, to identify their needs.

5.19 RESOLVED: That the Committee:-

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

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

(c) recognises that there was a need, as a city as a whole, to make improvements towards prevention; and

(d) requests that:-

(i) a small working group be set up to consider the notes taken at this meeting and produce a report to be taken to a meeting of the Cabinet; and

(ii) the Voluntary Sector be invited back to attend a meeting of this Committee in April 2019, to give an update on any changes that have been made in the Voluntary Sector.

6. WORK PROGRAMME

6.1 The Committee received and noted its Work Programme for 2018/19.

7. MINUTES OF PREVIOUS MEETING

7.1 The minutes of the meeting of the Committee held on 10th October, 2018, were approved as a correct record, subject to the addition of the words “via TUPE transfers” after the word “redeployed” on the last line of the seventh bullet point in item 5 (Urgent Care – NHS Sheffield Clinical Commissioning Group – Response to Scrutiny).

8. DATE OF NEXT MEETING

8.1 It was noted that the next meeting of the Committee will be held on Wednesday, 23rd January, 2019, at 4.00 p.m. in the Town Hall.

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Briefing on Access to and Quality of Primary Care Services

Prepared by Matt Blomefield, Policy & Evidence Assistant, 15 January 2019

for the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

This briefing is a summary of feedback shared with Healthwatch Sheffield about the quality of, and access to, primary care services between January and December 2018 inclusive.

GPs, dentists, pharmacists and other primary care professionals are usually the first point of contact when we need support with our health. This means that primary care is the topic we hear most about. Last year out of 778 reviews on our feedback centre, 447 were about primary care.

Most of the experiences shared with us were about GPs; however, we also received feedback about dentistry, pharmacies and opticians.

There are some recurrent messages about what people want these services to do:

- Make it easier to see a doctor, nurse or dentist quickly.
- Involve them in decision making about treatment and care.
- Talk to them about what happens next and give them information so they can make an informed decision.

Summary

Our feedback centre allows people to rate their overall experience of services out of 5. The infographic shows how many reviews each service received during January-December 2018 and their average rating:

Dentists	74	★★★★☆
GPs	357	★★★½☆
Pharmacies	13	★★★½☆
Opticians	3	★★★★½

Key Themes

General Practice

Administration

- 144 reviews were recorded about administration, including booking appointments and appointment availability.
- 20% (29) described a positive experience; key messages were reception staff arranging consultations with doctors quickly, and appointment booking systems being improved.
- 78% (112) described a negative experience; key messages were difficulty getting through on the telephone and waiting for long periods of time.
- 2% (3) described a neutral experience.

Waiting times

- 83 reviews were recorded on our feedback centre about waiting times.
- 25% (21) described a positive experience; key messages were responsiveness of reception staff and short waiting times for telephone consultations.
- 71% (59) described a negative experience; key messages were waiting times for referrals and booked appointments, as well as urgent appointments.
- 4% (3) described a neutral experience.

Staff attitude

- 146 reviews were recorded about staff attitude.
- 67% (98) described a positive experience; key messages were people feeling listened to and supported by staff members.
- 30% (44) described a positive experience; key messages were people feeling ignored and appointments feeling rushed.
- 3% (4) described a neutral experience.

Treatment and care

- 131 reviews were recorded about treatment and care.
- 76% (100) described a positive experience; key messages were staff responsiveness, efficiency and understanding.
- 22% (29) described a negative experience; key messages were feeling that appointments were too short and that people were not sufficiently involved in decisions made about appointment times or treatment options.
- 2% (2) described a neutral experience.

Communication

- 25 reviews were recorded about communication.
- 16% (4) described a positive experience; key messages were that notifications of appointments were clear, and advice was given which people could understand.
- 80% (20) described a negative experience; key messages included a lack of communication between health care staff, as well as with patients and carers about their appointments.
- 4% (1) described a neutral experience.

Dentistry

Treatment and care

- 32 reviews were recorded about treatment and care.
- 75% (24) described a positive experience; a key message was staff providing a clear treatment explanation.
- 25% (8) described a negative experience, a key message was difficulty in getting urgent care when needed.

Staff attitudes

- 38 reviews were recorded about staff attitudes.
- 79% (30) described a positive experience; a key message was staff members were welcoming.
- 21% (8) described a negative experience; a key message was appointments felt rushed.

Pharmacies

Waiting times

- 5 reviews were recorded about waiting times.
- 20% (1) described a positive experience; a key message was members of staff were efficient.
- 80% (4) described a negative experience; a key message was waiting times for prescriptions were too long.

Staff

- 7 reviews were recorded about staff, including staff attitude.
- 71% (5) described a positive experience; a key message was staff members were supportive.
- 29% (2) described a negative experience; a key message was feeling that staff members were unprofessional.

What else do we know?

Community Engagement

During 2018, Healthwatch Sheffield awarded small grants to community groups to carry out health or social care related engagement within their communities.

In total organisations gathered the views of around 540 people, hearing from a diverse range of people, including:

- Asylum seekers and refugees
- People with lived experience of mental health distress
- People with learning disabilities
- People with physical disabilities including amputees and wheelchair users
- Young people
- Young men from Black, Asian, Minority Ethnic and Refugee (BAMER) communities
- Women from BAMER communities
- Members of the Chinese community.

The importance of primary care was evident in that access to GPs was a cross-cutting theme across nine of the eleven projects.

Difficulties getting GP appointments were raised by a number of groups. This was cited by Black, Asian, Minority Ethnic and Refugee (BAMER) men as a reason why they do not attend the GP. Others talked about their frustration with the triage system whereby GP receptionists determine how urgent a patient's need to see the GP is.

Refugees and asylum seekers find the health system confusing and do not know about the different services available to them. Printed information and letters are often too full of text. BAMER women

gave positive examples about accessing health services but also found printed information and letters about clinical information difficult to understand.

A good number of people with learning disabilities knew their doctor or surgery by name and 2/3 of those consulted either didn't mind or actually liked going to see their GP.

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

Date of Meeting: January 23 2019

Report of: Director of Delivery Care Outside of Hospital, NHS Sheffield CCG

Subject: **Update on Primary Care**

Author of Report: Abby Tebbs, Deputy Director of Strategic Commissioning and Planning

Summary:

This paper provides the Committee with an update on progress to date and future plans to achieve the priorities identified in the Sheffield Place Based Plan and GP Transformation Plan priorities by:

- ensuring a consistent quality offer to patients;
- developing a different way of working through neighbourhoods
- enhancing system understanding

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 on Primary Care in Sheffield

1. Introduction

Access to good and timely primary care is the foundation of the CCG's long term strategy, reflected in the Place Based Plan *'Shaping Sheffield'*. Variation in the quality of, and access to GP services across Sheffield, and people's experience at different surgeries or in different areas of the City, is a focus of work plans now and in the future.

The GP Forward View (GPFV) set the national strategic direction for primary care in England. In response to this the CCG, in partnership with key stakeholders across the City, developed an ambitious transformation plan for services. Figure 1 overleaf presents GP transformation and the key initiatives to achieve high quality, sustainable care described in the transformation plan. The priorities identified to achieve this are:

- supporting delivery of core services;
- investing to deliver transformation;
- securing sustainability and resilience moving forward;
- longer term investment for new models of care, practices, neighbourhoods, and communities – requires consistency;
- neighbourhood approach supporting different models to suit areas, reflecting and investing to recognise deprivation and need.

This paper provides the Committee with an update on progress to date and future plans to achieve these priorities. In summary this work falls into three key approaches which are described in greater detail in the following update:

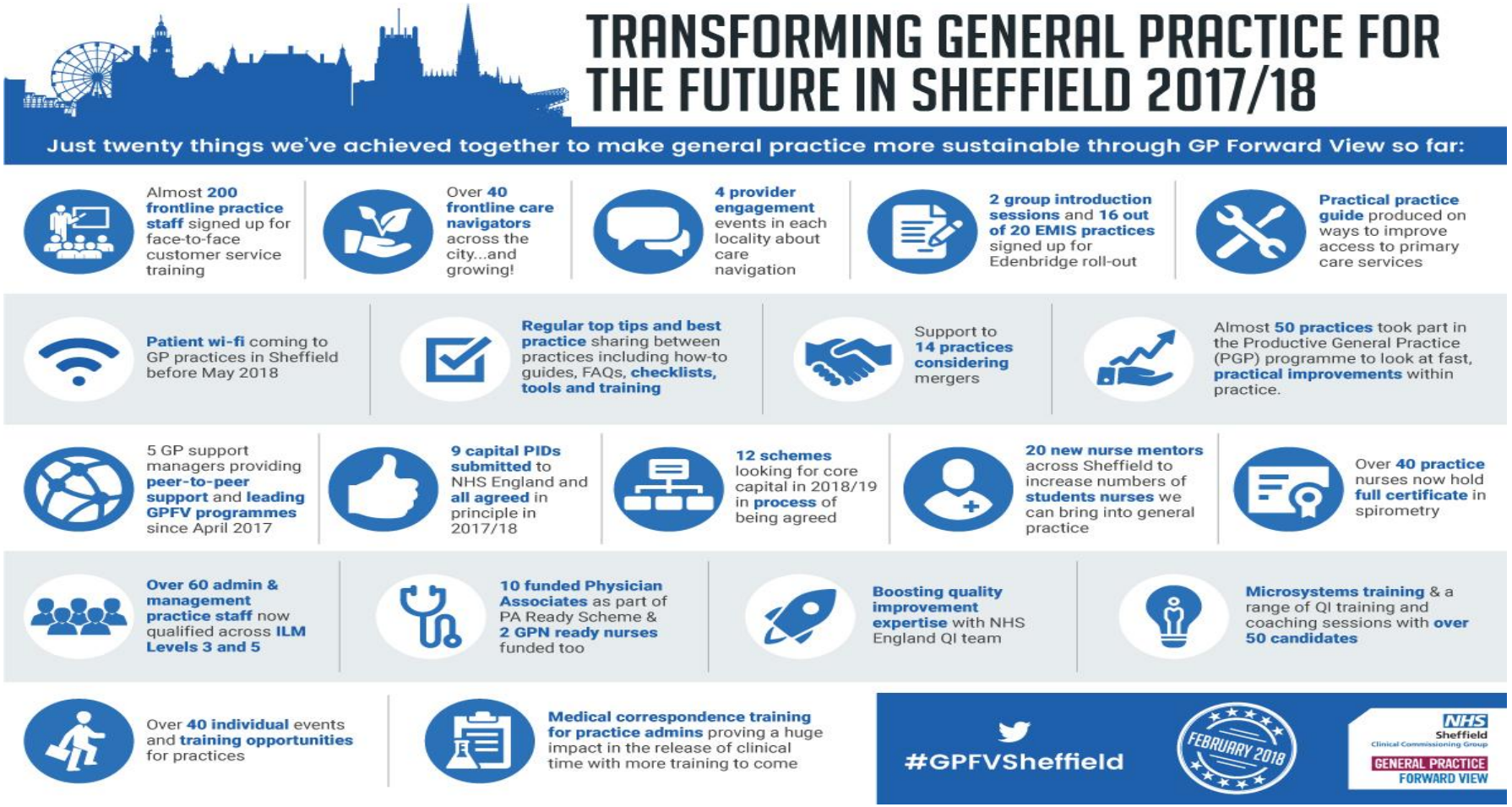
- ensuring a consistent quality offer to patients;
- developing a different way of working through neighbourhoods to support efficient use of professionals ensuring their time is spent in the right places;
- enhancing system understanding – effective ways of working, care navigation and communications with patients and partners.

2. Where Are We Now?

Sheffield CCG is committed to improving the quality of care for the population of Sheffield, therefore assessing and monitoring the performance and quality of services commissioned directly from primary care providers is essential.

Whilst practices, as independent contractors, are accountable for the quality of services they deliver and must undertake their own quality monitoring, NHS England and CCGs have a shared responsibility for quality assurance and improvement.

Figure 1: Plans for the Future of General Practice in Sheffield



The CCG continues to develop and improve processes to monitor and manage intelligence on the quality and performance of practices and the integration of patient experience information into this process is central to our objectives.

These steps support our intention to move to a preventative and supportive model of care in partnership with primary care and other stakeholders through People Keeping Well.

2.1. CQC

The CQC have now completed all their inspections of Sheffield based general practices. The accompanying paper from the Chief Nurse presents further detail on the results and actions being taken. Overall there has been an improvement in ratings between 2017 and 2018 and the results at December 2018 are set out below in table 1.

Table 1: Overall Practice CQC Ratings at December 2018

Practice Overall Rating (December 2018)	No. Practices	% of Practices
Good	83	97.7%
Requires Improvement	2	2.3%
Inadequate	0	0.0%
Outstanding	0	0.0%

Those practices rated as 'requires improvement' or 'inadequate' are being supported by the CCG Quality team to ensure that action plans to meet the requirements identified in the CQC report are in place and being appropriately implemented.

2.2 Patient Survey

We review patient feedback from a variety of sources including the national GP patient survey, the Friends and Family Test, complaints, and online feedback on websites such as Care Opinion, Healthwatch, and social media sites assist us to identify practices were patients are reporting issues, such as problems with access and address these within our plans.

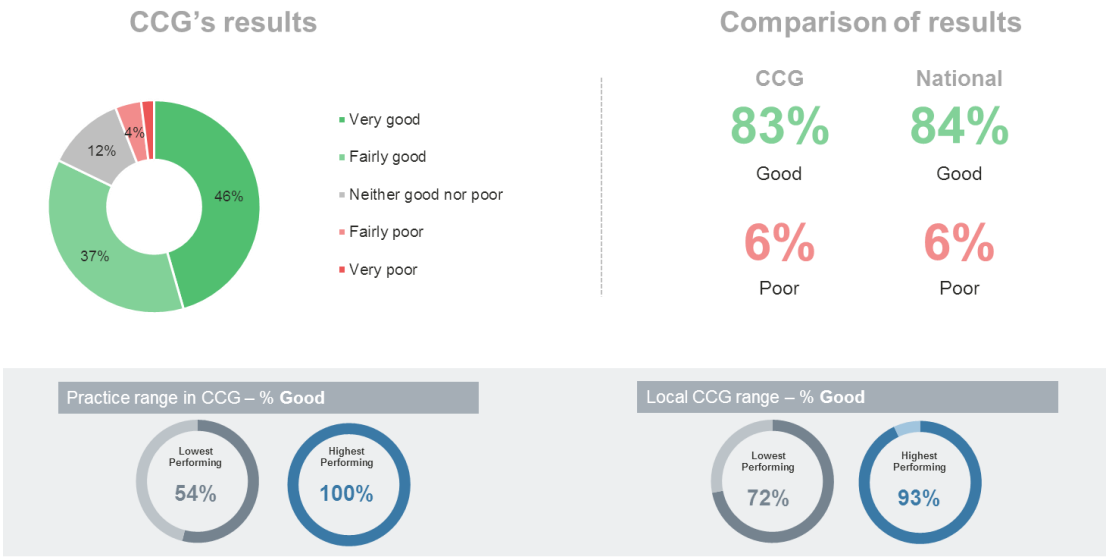
The GP Patient Survey measures patients' experiences across a range of topics, including making appointments, perceptions of care, practice opening hours, out of hours services. The survey demonstrates the range of patient satisfaction with quality and access to primary care services across the City.

Although the annual survey, which is conducted independently, has limitations, including the small sample size at practice level and lack of qualitative data, it enables practice level and organisational comparisons using a consistent methodology.

The latest survey was published in August 2018 and highlights the issues on which the CCG is focussing. We know that while overall satisfaction with

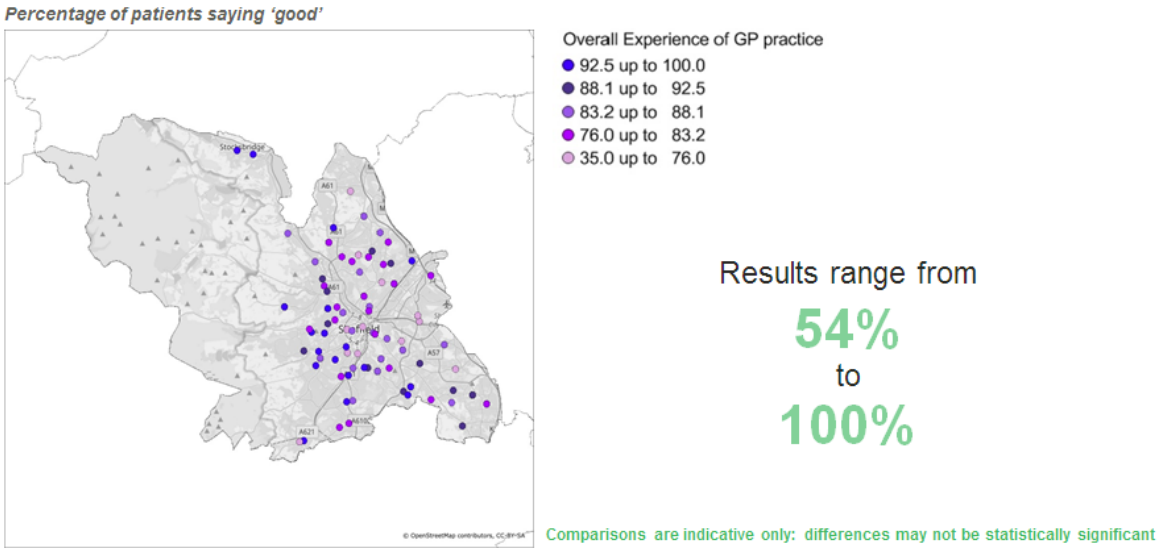
practices in the city is very close to the national mean there is much wider variation is levels of satisfaction between practices in Sheffield than nationally. Figure 2 overleaf compares results and range at CCG and national level.

Figure 2: Percentage of Respondents Rating Overall Experience of GP Practice as Good at CCG and National Level (source: IPSOS Mori)



Mapping practice overall satisfaction levels shows close correlation to other intelligence received by the CCG and highlights differences across the City with less satisfaction in the north, centre and east of the City.

Figure 3: Percentage of Respondents Rating Overall Experience of GP Practice as Good by Practice (source: IPSOS Mori)



2.3 Quality Framework

The CCG approved a new Quality Framework for primary care in May 2018, it aims to provide a consistent and equitable approach to managing practice quality and performance across practices in Sheffield.

The purpose of this framework is to ensure that the three domains of quality, patient safety, clinical effectiveness and patient experience, are monitored using all internal and external intelligence available:

- patient safety - safeguarding, reporting patient safety incidents, access;
- clinical effectiveness - delivery of service specifications; learning from audits, Primary Care Webtool;
- patient experience - Friends and Family Test (FFT), patient survey; CQC inspections.

The framework also sets out an escalation process where issues are identified with individual practices.

The newly established Primary Care Intelligence Group will monitor information and intelligence in order to identify potential or actual risk and will make decisions on escalation to appropriate committees.

Information is obtained from a range of sources covering the following domains:

- patient safety and experience;
- continuity of service;
- length of time required to remedy the concern;
- provider's reputation;
- wider health economy and partner organisations.

The CCG will use the development and implementation of the Quality Framework to enable early identification of emerging problems and to support practices to address concerns preventative approach to addressing future problems by supporting practices

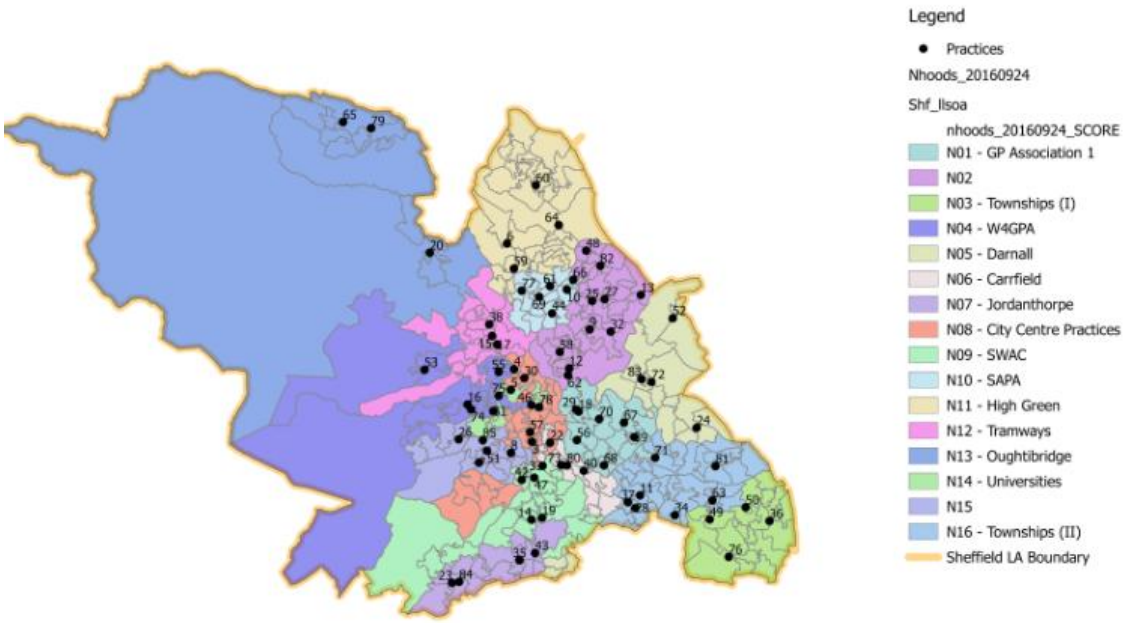
2.4 Quality Contract

The development of a comprehensive quality contract with practices to ensure consistent outcomes and high quality services above core contract requirements, regardless of provider and will form part of the universal support for practice development. Phase one of the contract will be implemented in April 2019, development has included a stocktake of existing provision and learning from audits of existing locally commissioned services and other intelligence. To qualify for payment under the quality contract practices must demonstrate consistent provision of good quality core services and we will use the Quality Framework to support this.

2.5 Neighbourhoods

As previously reported to the Committee, 16 neighbourhoods have been established to cover Sheffield and every practice has been assigned to one of these, the map at figure 4 shows how these are divided to cover the City.

Figure 4: Map of Sheffield Neighbourhoods



The CCG has developed and maintains a maturity assessment of the neighbourhoods as they develop. This is being used to inform plans for support and investment that will enable the neighbourhoods to both develop their leadership and deliver their goals.

The evolution of neighbourhoods as a vehicle for the development and delivery of new models of care is fundamental to our vision for the long term transformation of primary care in the City, enabling models of care delivery to be far more responsive to the particular needs of different populations across the City. Delivery of care at a neighbourhood scale also facilitates the most effective use of professional resources by allowing care to be provided across practice populations where this is desirable and clinically appropriate.

Care Navigation is supporting patients to access healthcare directly from the most appropriate service including opticians, pharmacies, nurses, family services, or support groups rather than visit the GP and to ensure that GP waiting times are shorter when seeing a GP is the best course of action.

The CCG has commissioned support and training to help develop Care Navigation in Sheffield. This has included developing receptionists' knowledge, introducing new IT systems and forming stronger partnerships with other service providers. Regular Care Navigation events have been hosted by the CCG to help increase the number of practices involved, as well as share knowledge and ensure patients across Sheffield receive consistent advice.

2.6 Communications

Further engagement on Urgent Primary Care will commence shortly. Learning from previous engagement and consultation exercises it is clear that there is a lack of understanding about the primary care provision currently in place both among the public and within partner organisations.

The CCG is working to strengthen communications and put in place a more robust communications plan to support primary care discussions on Urgent Care and more widely with the public and partners.

2.7 Extended Access Arrangements

The CCG has completed a procurement to secure ongoing provision of extended hours services and the contract had been awarded to Primary Care Sheffield. Through the tender and contract award the CCG now has an opportunity to make services more accessible for patients, there will also be greater access to GP slots for practices.

3. Building for the Future

We will continue to build on these achievements to deliver our shared vision for the transformation of primary care in Sheffield, in particular focussing on the following to support delivery of our plans.

3.1 Strengthen Accountable Care Partnership (ACP) Plans and Quality Framework

A series of workshops are planned by the ACP to refresh the Place Plan across all work streams, these plans will allow further in-depth exploration of priorities with key stakeholders and the wider public. Primary Care plans will be refreshed to reflect any adjustments to strategy emerging from these events and the recently published *'Long Term Plan'* for the NHS.

Neighbourhood development remains a key theme for the achievement of many of the ACP's objectives in primary care and beyond. The CCG will build on work with partners to further strengthen the system wide approach to neighbourhood development as part of the ACP 'system approach'.

The CCG will continue to build on the implementation of the Quality Framework to further enable the development of a high quality primary care offer across the City.

3.2 Investment at Scale

The CCG will continue to invest significantly in developing a universal offer of primary care across the city, through the neighbourhood approach described in our transformation plan. This core investment in supporting resilience, range and quality in primary care will be driven through the expansion of the Quality Contract among other initiative including neighbourhood development and support to develop neighbourhood leadership and integrated services.

3.3 Targeted Investment

Over and above this city-wide funding the CCG will focus targeted resource in areas of need to build services that deliver the high quality services we expect for all our people. This targeted funding will align with health need and aligns closely with the ACP priorities.

4. Recommendation

The Committee is asked to note the report in particular the three key messages about the approach taken to improve the quality of and access to primary care services across the City by

- ensuring a consistent quality offer to patients;
- developing a different way of working through neighbourhoods to support efficient use of professionals ensuring their time is spent in the right places;
- enhancing system understanding – effective ways of working, care navigation and communications with patients and partners.

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

Date of Meeting: January 23rd 2019.

Report of: Chief Nurse Sheffield CCG

Subject: Overview of 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**

Overview of Sheffield General Practice

1.0 **Introduction**

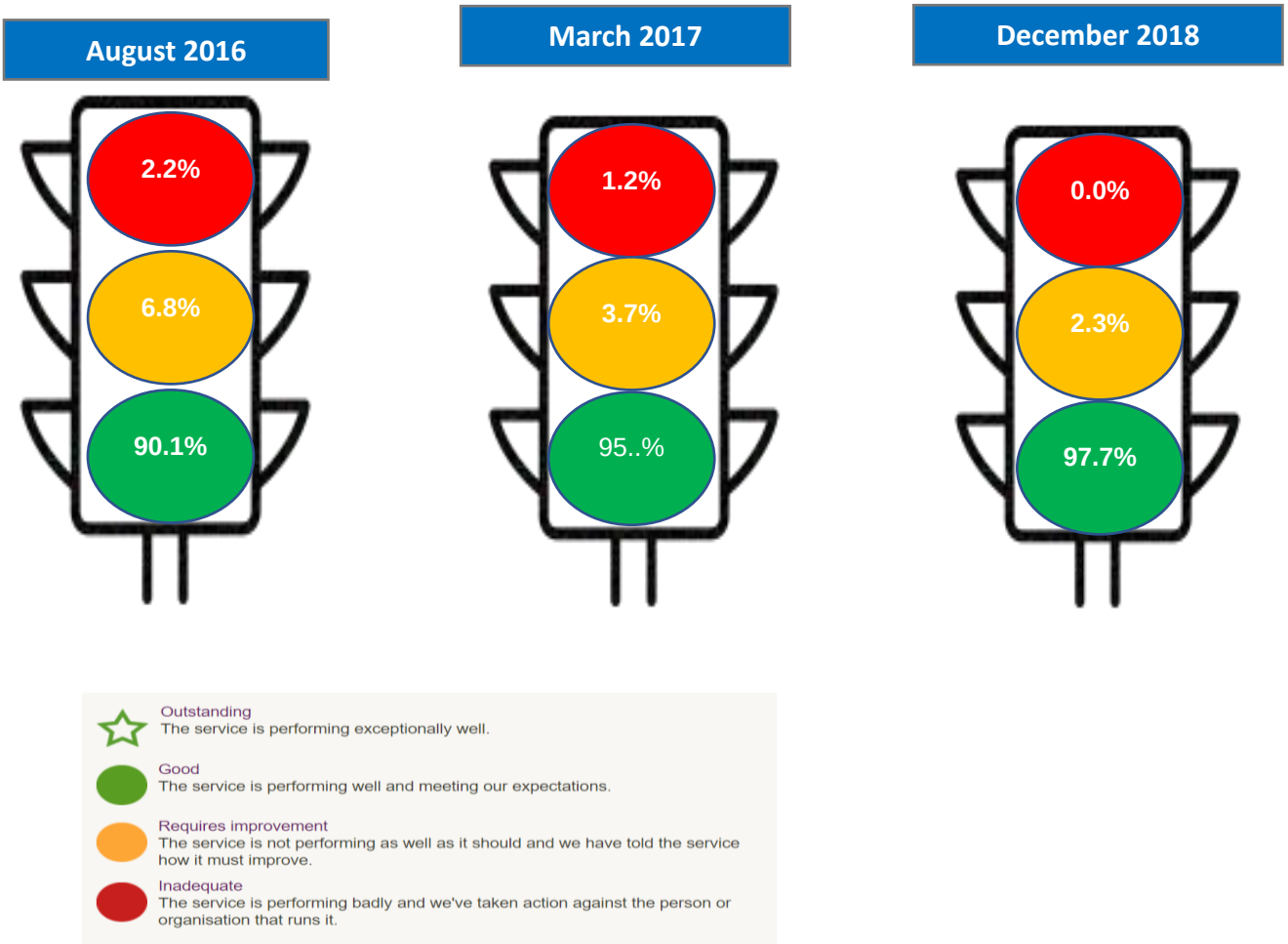
1.1. All Providers are required to register with the Care Quality Commission (CQC). The CQC will carry out inspections and will rate the provider against 5 key questions these are: Are services safe? Are services effective? Are services caring? Are services responsive? and Are services well led? The CQC will give an overall rating to providers as 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

1.2. The CQC have now completed all their inspections of Sheffield based general practices. The CCG collates the CQC ratings, as well as reviewing the trends and themes. When required Sheffield CCG (SCCG) will offer support and guidance to practices to ensure that any areas of concern are addressed.

1.3. The Committee has requested a paper from a previous Committee meeting.

2.0 **CQC Ratings**

2.1 The Care Quality Commission (CQC) have inspected and rated all Sheffield, General Practices. The CQC gives each provider an overall rating for the practice, which can be 'Outstanding', 'Good', 'Requires Improvement' or 'Inadequate'.



https://www.cqc.org.uk/what-we-do/how-we-do-our-job/ratings **Diagram 1 Overall Practice CQC Ratings**

2.2 Overall the CQC ratings for Sheffield General Practices have improved since 2016. Currently there are no practices in Sheffield with an overall Outstanding rate

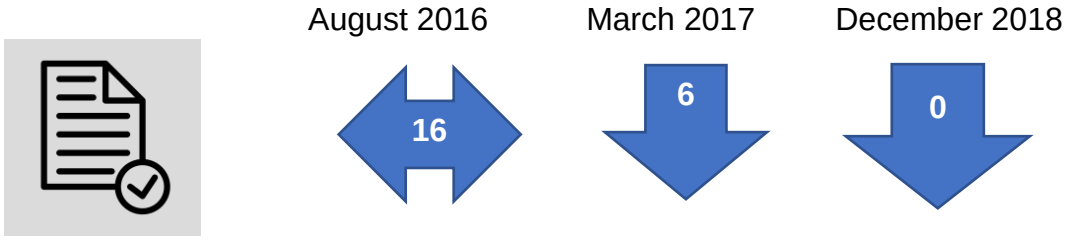
2.3 During the inspection the CQC will ask 5 key questions which are individually rated and form part of the overall rating. Each of the five key questions are broken down into a further set of questions, which are called key lines of enquiry (KLOE). There has been an overall improvement against each of the 5 areas since March 2017 to December 2018. This is presented in diagram 2 below. There are 5 practices that have achieved Outstanding against Responsive.

Diagram 2 Practice Achievement against CQC 5 Key Questions

3.0 Top 10 Areas for Improvement

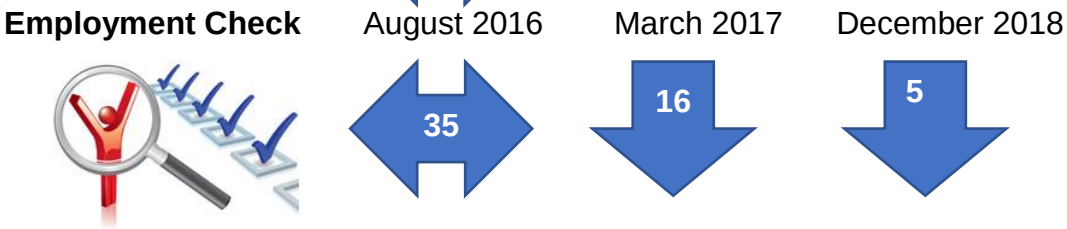
3.1 The CQC report will identify areas for improvement. Sheffield CCG has reviewed all Sheffield General Practice CQC reports and has identified the trends and themes. Since 2016 there has been an overall improvement in all areas. Diagram 3 below presents the Top 5 Trends and Themes from August 2016 to December 2018 and number of times these issues was identified by CQC. Just to note that practices may have been rated as Good and that the themes will remain unchanged until a practice is re-inspected by CQC.

Governance, Record Keeping and Policies Maintenance.

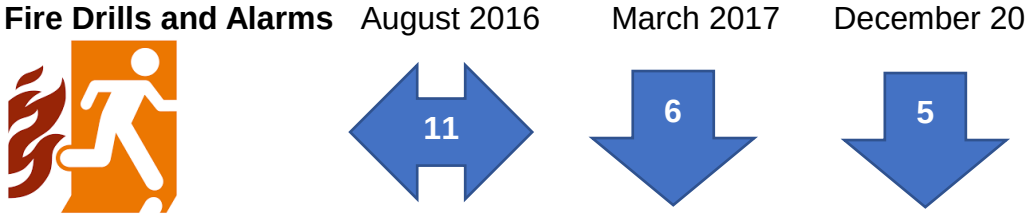


Infection Control

Employment Check



Fire Drills and Alarms



Staff Immunisation

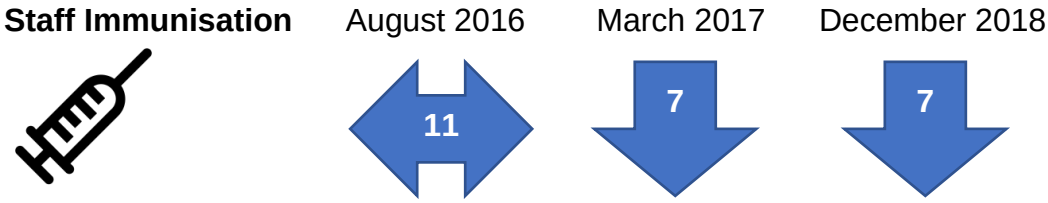


Diagram 3 Top 5 Trends and Themes for Improvement from CQC Reports

3.2 When the CQC has identified areas for improvement, SCCG will work with the practice to develop an action plan to address concerns and will monitor the practice until all actions have been completed and assurance has been gained. SCCG has developed and implemented a Quality Framework to monitor and manage practices when concerns arise. Diagram 4 below provides examples of work that has and continues to be undertaken.

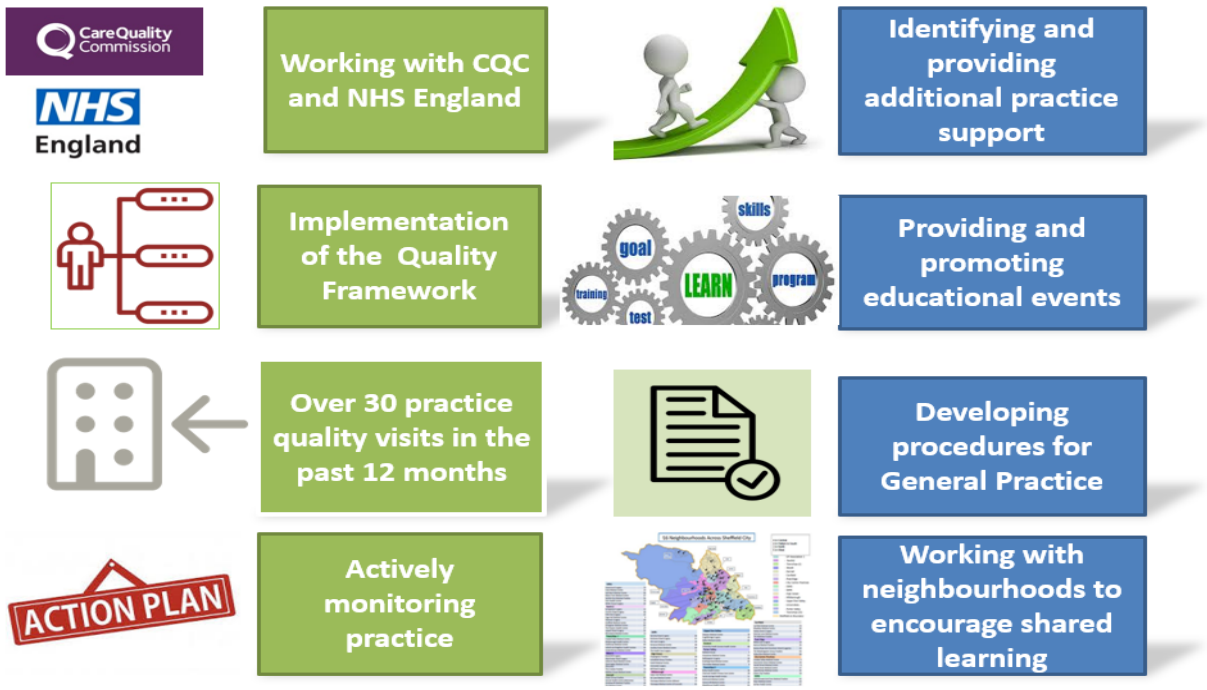


Diagram 4 Areas of Work Sheffield CCG Has Been Undertaking

4.0 Patient Experience

4.1 The 2018 GP patient survey was published in August 2018 and focused on access, booking appointments and experience of care. On the whole Sheffield scored within 4% of the national average in experience of booking an appointment.

83% patients reported that their overall experience of their GP practice was good, compared to a national score of 84%.

66% patients reported that their overall experience of making an appointment was good, compared to a national score of 69%.

67% patients reported that their experience of getting through on the phone was good, compared to a national score of 70%.

5 What does this mean for the people of Sheffield?

5.1 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 and demonstrates that there has been improvement. SCCG continues to provide support and guidance for practices and manage concerns within the Quality Framework.

5.2 The report also provides the highlights from the GP patient survey and although the are areas for improvement the results are in line with the national picture. SCCG will be using this information to inform decisions about actions to be taken.

6.0 Recommendation

6.1 The Committee is asked to note the report

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

Report of: Cllr Christine Peace - Cabinet Member for Health and Social Care and Dr. Tim Moorhead, Chair of the CCG

Subject: Update on the work of the Accountable Care Partnership

Author of Report: Rebecca Joyce - ACP Programme Director

Summary:

The Sheffield Accountable Care Partnership (ACP) comprises seven partner organisations in the City (Sheffield City Council, NHS Sheffield Clinical Commissioning Group, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield Ltd, Voluntary and Community Sector). The ACP vision, signed by the original 6 partners in September 2017 (with VCSE offered and accepting full membership in June 2018) is as follows:

> *"Improving the health and wellbeing of Sheffield's residents through the promotion of a health and wellbeing culture in all we do and the development and delivery of a world class health and care system"*

This report is the first of a 6 monthly report to Scrutiny. It therefore provides an overview of the strategic and operational development of the ACP and will take the following structure:

1. Introduction and context
2. Strategic Background to the Development of the ACP
    a. National context
    b. Regional and City Strategic Context
    c. Fit of the ACP within the overall Health and Care System
3. What is the ACP and what does it do?
4. ACP Transformation Approach
5. Progress Made by an ACP way of working
    a. Outcomes already achieved
    b. Work currently underway
6. What's next for the ACP
7. What does this mean for the people of Sheffield
8. Recommendations for the Scrutiny Committee

In the final section Scrutiny will be invited to debate what it wants to achieve from the 6 monthly updates and how it can best scrutinise the work of the ACP.

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	

SCC Scrutiny Committee is asked to note and consider:

- National, regional and local strategic background to the development of the Sheffield ACP, progress and key next steps.
- Key next steps towards developing "Shaping Sheffield: The Plan" and supporting delivery plan to bring together the work of the ACP.
- The importance of the CQC Local System Review work to the overall direction of the ACP
- The progress on public accountability to the development of the ACP.
- The ACP team acknowledges the unique position of elected members on Scrutiny to represent their community and the people within them. Therefore we ask Scrutiny colleagues to debate what it wants to achieve from the 6 monthly updates and how it can best scrutinise the work of the ACP.

Background Papers:

There are a number of wider city and regional documents which provide strategic context to the work of the ACP:

- State of Sheffield Report 2018, produced by the Sheffield Partnership Board LINK
- The work of the Health and Wellbeing Board LINK
- Shaping Sheffield Plan LINK
- The Joint Strategic Needs Assessment (which provides over-arching information on the current and future health and wellbeing needs of Sheffield people) LINK to website
- The wider vision and plans of the South Yorkshire and Bassetlaw Integrated Care System LINK

At national level, the following reports provide important strategic background:

- Social care: the forthcoming Green Paper (England) House of Commons Library Briefing Paper, No 8002 (published 14 December 2018) LINK
- The NHS Long Term Plan (January 2019) LINK

Category of Report: OPEN

Report of the Cabinet Member for Health and Social Care and the Chair of the CCG

An Update on the Accountable Care Partnership

1. Introduction/Context

The ACP is a partnership comprising seven partners in the City (Sheffield City Council, NHS Sheffield Clinical Commissioning Group, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield Ltd, Voluntary and Community Sector).

The ACP vision, signed by the original 6 partners in September 2017 (with VCSE offered and accepting full membership in June 2018) is as follows:

> *"Improving the health and wellbeing of Sheffield's residents through the promotion of a health and wellbeing culture in all we do and the development and delivery of a world class health and care system"*

This vision statement is being reviewed as part of the extensive consultation taking place to refresh and build on Shaping Sheffield: The Plan.

This report is the first of a 6 monthly report to Scrutiny. It therefore provides an overview of the strategic and operational development of the ACP and will take the following structure:

1. Introduction and context
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4. ACP Transformation Approach
5. Progress Made by an ACP way of working
    a. Outcomes already achieved
    b. Work currently underway
6. What's next for the ACP
7. What does this mean for the people of Sheffield
8. Recommendations for the Scrutiny Committee

Finally a set of recommendations will be made with Scrutiny invited to debate what it wants to achieve from the 6 monthly updates and how it can best scrutinise the work of the ACP.

2. Strategic Background to the Development of the ACP

2.1 National Context

2.1.2 On 7 January 2019, the Long Term Plan for the NHS was published. A 1 page summary is provided in the appendix. The main chapters of the report focus on the following topics:

- Chapter 1 Strategic intent to develop a more integrated care model
- Chapter 2 Strengthening prevention, focusing on health inequalities
- Chapter 3 NHS priorities for care quality and outcomes improvement
- Chapter 4 Transforming and supporting workforce
- Chapter 5 Technology and digitally enabled care
- Chapter 6 Financial settlement & performance and payment systems
- Chapter 7 Next steps for implementation

The Long Term Plan builds on the commitment of the 5 year Forward View to "make the biggest national move to integrated care of any major western country" (from the 5 Year Forward View Update, 2017). It provides very consistent context to the work of the ACP with themes from the Plan including:

- A greater focus on prevention and primary and community services
- The development of "genuinely integrated teams of GPs, community health and social care staff"
- A move to a more home based model of care as an alternative to hospitalisation.
- A focus on reducing demand on the emergency pathway and turning patients around through ambulatory care more quickly.
- A greater focus on prevention programmes (smoking, reducing obesity, etc) and an intention to direct resources to areas of greater need.
- Greater focus on digital enablement of care for patients and carers to better manage their own conditions and to improve inter-professional communication (through integrated e-health records etc).
- The need to redesign workforce to better attract and retain staff and to enable more general, integrated roles to support the new models of care.
- A continued move to deliver "triple integration of primary and specialist care, physical and mental health services, and health with social care."
- A changing organisational infrastructure with more integrated provision, integrated "place based" commissioning and increasingly shared decisions between commissioners and providers on population health and service redesign.
- The roll out of ICSs everywhere by April 2021.

The intent for legislative change to accelerate progress in line with these aims is outlined. The extent to which the finances provided supports these ambitions can be debated. Specifically the report outlines that investment in mental health and primary medical and community services, will grow at a faster growth rate than the increase in the overall NHS budget.

In terms of timetable for next steps, the report states its expectation that by April 2019 there will be publication of local plans for 19/20 and by Autumn 2019

the publication of 5 year plans. This timetable fits with the agreed timetable for Sheffield of reaching a draft "Shaping Sheffield: The Plan" for April 2019.

From an ACP perspective it remains disappointing that this is not yet a joined up national report for NHS and Social Care given the emphasis on integration.

The forthcoming Green Paper on Social Care will be crucial strategic context. The paper was promised around the same time as the NHS Long Term Plan, but will now be published "at the first opportunity in 2019". The Government has said that the proposals in Green Paper will "ensure that the care and support system is sustainable in the long term". We can expect other topics that will be included to include integration with health and other services, carers, workforce, and technological developments, among others (Dec 2018 House of Commons Briefing Paper on Forthcoming Green Paper on Social Care, LINK)

It is useful to note the seven guiding principles for the forthcoming Green Paper, confirmed by The Health and Social Care Secretary, Matt Hancock:

•Quality and safety embedded in service provision

• Whole-person, integrated care with the NHS and social care systems operating as one

• The highest possible control given to those receiving support

• A valued workforce

• Better practical support for families and carers

• A sustainable funding model for social care supported by a diverse, vibrant and stable market

• Greater security for all – for those born or developing a care need early in life and for those entering old age who do not know what their future care needs may be.

This national context will inform the developing "Shaping Sheffield: The Plan".

2.2 City and Regional Strategic Context

At city wide and regional level, there are a number of wider city and regional documents which provide strategic context to the work of the ACP:

- The work of the Health and Wellbeing Board LINK
- Shaping Sheffield LINK
- The Joint Strategic Needs Assessment (which provides over-arching information on the current and future health and wellbeing needs of Sheffield people) LINK to website
- The Director of Public Health Report LINK

Scrutiny will be familiar with this strategic context from a city perspective.

At a regional level, South Yorkshire and Bassetlaw are one of 10 vanguard Integrated Care Systems nationally. The wider vision and plans of the South Yorkshire and Bassetlaw Integrated Care System can be found here LINK

2.2.3 There are five “places” across SYB which have set up ACP arrangements; Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. Workstreams are taking place at both place level and SYB level to co-ordinate care in the most effective way.

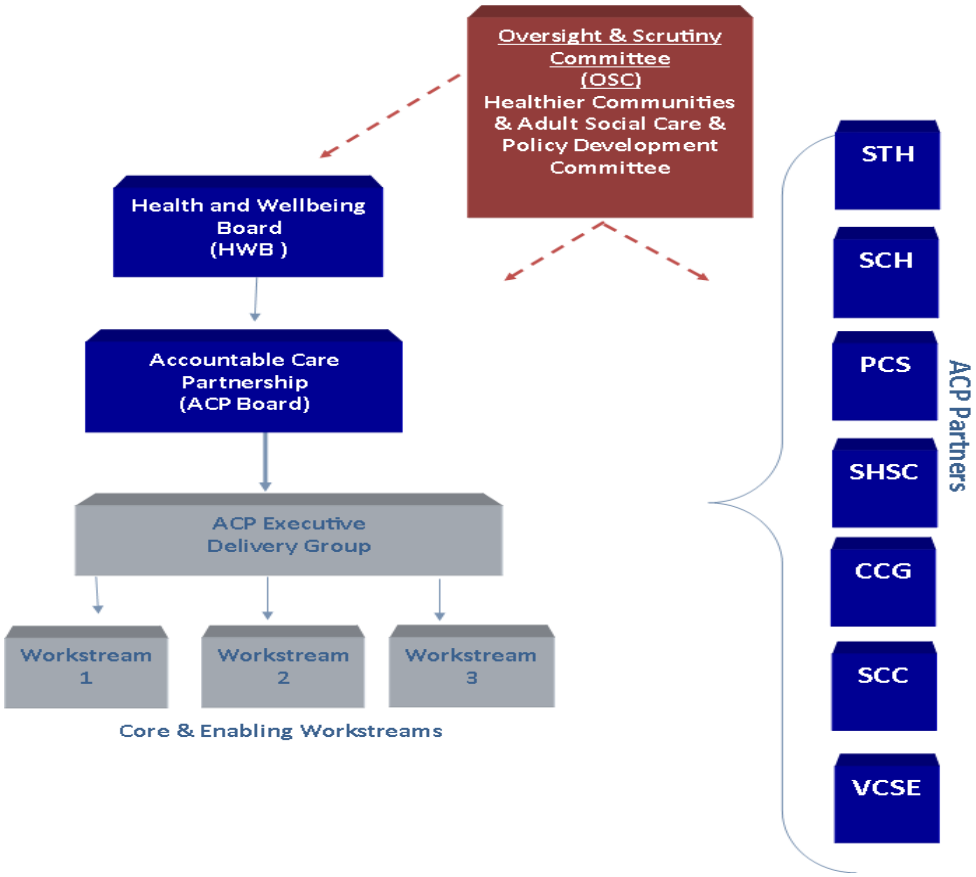
2.2.4 The ICS works on a principle of subsidiarity with around 80 % of transformation intended to be driven at place level. The ICS takes a lead for areas of work that naturally require a larger geographical footprint (for example the Hospital Service Review). A number of Sheffield NHS CEOs have leadership responsibilities at ICS level as well as within the Sheffield ACP.

2.3. Strategic Fit of the ACP within The Overall Health and Care System in Sheffield

The Sheffield ACP focuses on partnership working and integration within the Sheffield context. In late 2018 the relationship between the Health and Well-Being Board and Strategy and the ACP was clarified.

All partners are clear that the Health and Well-Being Board sets the overall strategic direction for Health and Well-Being in the city. The ACP, then, is the delivery vehicle for health and care aspects of that strategy.

The diagram below summarises the relationship between the HWB, ACP and partner Boards and indeed the scrutiny function:



It should be noted that the ACP currently has no legislative framework. Therefore any decisions made by the ACP Board needs to be referred to individual member boards for support.

Following its inception, the ACP was criticised for a lack of public transparency and indeed this was criticised by the CQC in their Local System Report. In 2018, the concern was addressed and the ACP Board was made a public meeting

3. What is the ACP and what does it do?

3.1.1 The ACP is a partnership comprising seven partners in the City (Sheffield City Council, NHS Sheffield Clinical Commissioning Group, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust, Primary Care Sheffield Ltd, Voluntary and Community Sector).

3.1.2 The ACP vision, signed by the original 6 partners in September 2017 (with VCSE offered and accepting full membership in June 2018) is as follows:

> *"Improving the health and wellbeing of Sheffield's residents through the promotion of a health and wellbeing culture in all we do and the development and delivery of a world class health and care system"*

3.1.3 This vision statement is being reviewed as part of the extensive consultation taking place to refresh and build on Shaping Sheffield: The Plan.

3.1.4 The high level objectives of the ACP originally agreed are:

- Improve population health
- Improve care and quality
- Close the finance and sustainability gap
- Deliver a person-centred approach

3.1.5 Specifically the partners have outlined their intent to:

- Deliver tangible improvements in local health and wellbeing
- Tackle persistent health inequalities
- Ensure the sustainability of the Sheffield care economy
- Support a happy, motivated and high-performing workforce
- Improve public engagement and empowerment

3.1.6 The partnership works in the context of the general national move towards greater health and care integration set out in the NHS 5 Year Forward View and consolidated by the Long Term Plan as outlined above.

3.1.7 In October 2018 it was agreed that an independent chair should chair the ACP. In the interim before appointment it was agreed by both the ACP B and HWB that the current joint chair arrangements in which the CCG Chair and the Cabinet Member jointly chair both the HWB and ACP Board should be changed. The interim arrangement will be that the Cabinet Member chairs the Health and Wellbeing Board and the CCG Chair chairs the ACP Board. This

was in response to feedback from the CQC in their Local System Review that suggested the clarity of this relationship could be improved.

3.1.8 The small central ACP team, which is funded and works on behalf of all partners (and hosted by the CCG) has three aims:

- To help **shape the vision, strategy and direction** of the ACP on behalf of the 7 CEOs and the system as a whole;
- To **support and strengthen the delivery of the overall transformation plan** working collaboratively across the system;
- **To develop our system's culture and leadership** to develop a more integrated, preventative, system approach.

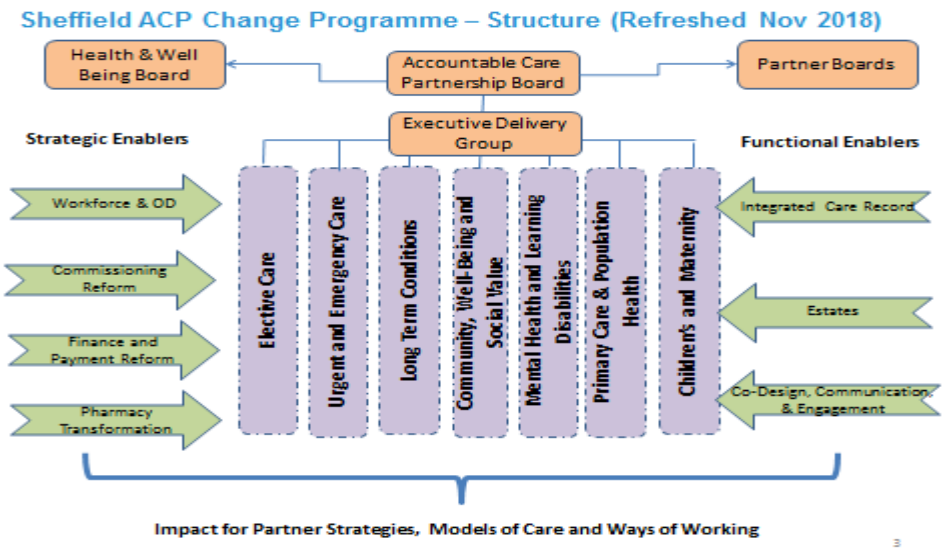
3.1.9 It is acknowledged that the cultural challenge of system working, is as great as the delivery challenge. Therefore the structure of the team reflects this, with one Deputy Programme Director supporting system wide development, and the other delivery.

3.1.10 **Healthwatch** have been appointed as the **ACP VCSE partner on public and service user voice** and is funded to support the ACP on this work, whilst retaining that important independent focus. This arrangement commenced from November 2018 for a period of 12 months. This provides a great opportunity to build the public and service user voice to the strategic and operational development of the ACP, alongside focusing on agreed priorities, such as Older People's experience.

3.1.11 In terms of accountability for the ACP team, the CEO of Sheffield Health and Social Care FT acts on behalf of the CEOs to chair the ACP and line manage the Programme Director.

4. Transformation Approach within the ACP

4.1.1 The ACP's transformation structure is as follows:



4.1.2 The focus over the last 12 months has been getting these workstreams set up, identifying priorities and establishing effective delivery and governance.

4.1.3 In August 2018, the CEOs reviewed the ACP in a Time Out session, and alongside streamlining some architecture, agreed the following five priorities:

- Building community resilience through effective neighbourhood working
- Reducing smoking prevalence
- Reducing obesity and promoting physical activity
- Improving the experience of Older people in the care system
- Early years – developing more resilient families and communities

4.1.4 The ACP also coordinates the system wide response to **the CQC Local System Review** which reviewed care for Older People in the city in March 2018, with a report published in summer 2018 LINK.

4.1.5 The city's action plan is coordinated by the ACP and this work is embedded within workstream with actions against the 5 key themes of the Sheffield action plan:

- A way of working that is built around acknowledging and improving older people's views and experiences and which drives a citywide vision (sections 1 and 2 of the action plan).
- A shared citywide workforce strategy to support front-line staff in delivering this vision and in particular further develops multi-agency working (sections 3 and 4 of the action plan).
- Developing clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for VCSE (sections 5 and 6 of the action plan).
- A meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability (sections 7 and 8 of the action plan).
- A strong system focus on enabling the right support from the right person in the right place at the right time, to give the best possible experience (section 9 of the plan, covering the Why Not Home Why Not Today Work)

4.1.6 There is considerable work taking place in response to this plan with a quarterly update coordinated by the ACP team provided to the ACP Board and ultimately the Health and Well-Being Board.

5. Progress Made by an ACP Way of Working

5.1 Outcomes Already Achieved

5.1.1 The city has demonstrated outcomes through an ACP way of working across the city, which has been developing for a number of years. There are a number of excellent **models of commissioning and provision** which illustrate excellent partnership working, a population focus and more innovative payment and contracting models, underpinned by strong public and patient co-design and an outcomes focus. Examples include:

- 5.1.2 **Musculoskeletal care model** (SCCG, STHFT, VCSE, SHSC) – over recent years the city has transformed its model of care, developing an integrated virtual triage through greater inter-professional working across primary, community, voluntary and secondary services, enabling the patient to be directed to the right service on receipt of referral. The model was co-designed with patients, carers and local patient groups, alongside staff from across community, primary secondary, independent and voluntary sector. Access to secondary care services has significantly improved through the changes, alongside genuinely integrated working across departments and sectors, to ensure patients get to the right place, first time. A patient reported outcomes framework and virtual care record, "My Pathway" has been implemented, improving patient management of their pathway. The Improving Access to Psychological Therapies (IAPT) team have integrated with Physioworks within the MSK care model, providing integrated advice on managing pain and supporting individuals back to employment. This is hugely important given MSK is one of the leading causes for sickness absence from employment in the city. This joint work has been cited as a good practice example by NHS-England.
- 5.1.3 **Psychiatric Liaison Service** (STH/ SHSC) ensures patients attending A&E and wards with mental health needs are quickly supported and directed to the right place, improving access and diagnosis. The joint protocols and joint working across STH and SHSC staff has been crucial to this successful delivery.
- 5.1.4 **For children's care** (SCC, SCH, SCCG, VCSE) the city is moving forward to establish integrated and locality based working using 'Ryegate in the Community' as a model. This is providing parents/cares with a trusted NHS service title to bring care closer to home using integrated teams. There is progress in the establishment of a citywide emotional wellbeing and mental health offer in primary and secondary schools. Healthy Minds has demonstrated positive impact through its evaluation. In addition there is a newly designed 'all age' Eating Disorders pathway and steps are being taken to develop an 'all age' mental health service. Integrated children's pathways have been developed through partnership working for sleep, continence, allergy, challenging behaviour and advice and guidance.
- 5.1.5 **Sheffield IAPT** is a wave 2 site for IAPT-Long Term Condition expansion, and city's new 'Health and Wellbeing Service' (HWS) commenced in October 2017. The CCG, primary and secondary care, city council and community partners are working together to deliver an ambitious and transformational service across ten condition based pathways
- 5.1.6 **Sheffield Dementia Strategy Programme** (SHSC, STHFT, SCC, SCCG, Sheffield Dementia Action Alliance, Age UK Sheffield, Alzheimer's Society, St Luke's Hospice) – There are approximately 7,000 people currently living with dementia in Sheffield. Sheffield is already one of the leading areas in the country for detection and diagnosis of the disease but more can be done to diagnose people at an earlier stage of the disease and to support people post diagnosis. A Dementia Strategy Implementation Group has been established under the governance of the Accountable Care Partnership which is led jointly by senior responsible officers from both the CCG and Sheffield City Council. This group has been established to oversee the development

and implementation of a new strategy for dementia in Sheffield. These improved relationships between providers and commissioners have enabled the testing of new dementia assess to care beds in the city and the development a draft set of citywide commitments. These commitments are currently out for public engagement and can be found here LINK.

5.1.7 From a commissioning perspective innovative contracting arrangements underpin these new models of care for patients – for example MSK Sheffield CCG and STHFT have moved away from Payment by Results to an outcomes based approach. Our city wide mental health approach is underpinned by pooled budgets and commissioning arrangements across SCCG and SCC and involve a risk and benefit share agreement with SHSC. This has moved to collective accountability and "shared issues" across the system. Examples of genuine collaborative working delivered through this include a city wide approach to perinatal, liaison and primary care mental health services. All examples have delivered better outcomes and better value for the population.

5.1.8 The ACP is about building on this work, making it more widespread across the system and strategically developing that "triple integration of primary and specialist care, physical and mental health services, and health with social care" that the NHS long term plan outlines.

5.2 Work currently underway

5.2.1 The highlights below given a flavour of progress currently being made through the ACP and areas for the future:

- 5.2.2 The importance of effective **neighbourhood/ locality development** is a key theme in many programmes, and a joined up system approach that draws together current system work is essential. A crystallised neighbourhood collaborative proposal is being finalised & builds on Sheffield wide multiple workshops and meetings in autumn 2018. It is essential this strengthened approach reflects a single "system" approach.
- 5.2.3 MH & LD and Children's and Maternity workstreams held a **joint programme** workshop on 7 December 2018 with the strategic aim of developing **all age mental health care model.** The workshop was an excellent event with very high levels of engagement from all stakeholders. The outputs relating to overall vision, priorities, and first steps are being pulled together by the programme teams.
- 5.2.4 The **"Primary Care and Population Health"** workstream is mobilising against 5 priorities:

    - Sheffield brand of General Practice
    - Local first: supporting the shift to a person centred, community and prevention focused system
    - Centre of excellence in primary care workforce, research and development
    - Neighbourhood delivery
    - Population health

- 5.2.5 Developing effective population health systems will be a key foundation of integrated care, learning from international case studies. It will

help us understand and plan for our population needs (at whole city and local neighbourhood level) and then planning appropriate interventions. The **population analytics pilot** commenced on 1st September & remains on track & will inform the longer term requirements for the future. 7 pilot neighbourhoods have been recruited to a pilot, with a co-design workshop taken place in November as part of Neighbourhoods Learning Network event.

- 5.2.6 The **Why Not Home Why Not Today** programme works as part of the Urgent and Emergency Care workstream is aiming to improve flow through the system and ultimately reduce the number of delayed transfers of care, alongside a set of other key metrics. This underpins a key theme of the CQC LSR Action plan.
- 5.2.7 **The Long Term Conditions** leadership team have articulated three priorities as part of their vision and approach:
    - Patients an carers as experts (with person centred care for the ACP being hosted here)
    - Slowing multi-morbidity
    - Developing an integrated model of care for LTC

Significant work is taking place on the integrated model of care, to improve our overall approach to admission prevention across the system. Care provider conversations and joint commissioning discussions are taking place on this topic, and this work will be brought together during quarter 4 of 2018/19. This is particularly important part of our strategic response to the Older People CQC Local System Review.

- 5.2.8 The **Elective work stream** is achieving significant momentum for developing a new model of care for skin care across primary and secondary care. Work has also commenced across primary and secondary care on Cardiology and ENT.
- 5.2.9 The **Children's Work Stream** has agreed integrated pathways for sleep, continence, allergy, challenging behaviour and advice and guidance.

5.2.10 **Enabling Workstreams**

- 5.2.11 Positive progress is being made for the delivery of **a Sheffield Care Record** and improved Patient Flow and a business case is being developed.
- 5.2.12 The **Pharmacy Work Stream** is making good progress, with a focus on 3 areas; improving medicine management across the interface, maximising the contribution of pharmacy within primary care and developing shared care. A business case for a hypertension shared care model working into neighbourhoods is being developed. Digital inter-operability is another key requirement for GPs/ Pharmacists and primary care and this is linking into the wider integrated care record work.
- 5.2.13 The **Workforce and Organisational Development programme** is working on four priorities, Older People's Workforce, Primary Care workforce strategy, Education and Skills, the Future Workforce. The 12 week planning rapid planning cycle for an Older People's workforce strategy commenced in December with over 100 staff involved from across the system, with a follow up at the end of January 2019. This is a core part

of the CQC Action Plan. A set of specific organisational development initiatives have been agreed to support this new way of working. Of note, an agreed "system leadership development course" has been trialled (Liminal Leadership) with the second course running from March 2019.

- 5.2.14 The **Payment Reform workstream** met on 3rd December. Directors agreed aims and objectives and agreed the priority of Older People for 19/20 which fits with other key work alluded to earlier in this report.

5.2.15 In addition there are a series of risks and these are reported to the Executive Delivery Group on a monthly basis, with quarterly risks reported to the ACP board.

6. What's Next for the ACP?

6.1.1 As outlined above, significant activity is now taking place across most ACP workstreams to build on the outcomes we have already achieved through an ACP style of working. There are considerable links between all of the programmes, and the overall strategy and vision needs to be developed, with the solid delivery plan underneath. The key steps are:

6.1.2 **Developing the Shaping Sheffield - The Plan (positioned in the context of the overall HWB Strategy)**: This will be a key focus of ACP work from now until the end of the financial year resulting in the "Refreshed Place Plan". The steps to this are:

- A set of workshops for staff, stakeholders and the public between 28 January and 8th February to widen the reach of discussion on the ACP and key priorities for health and care in Sheffield.

  Members of scrutiny are invited to book onto one of the events via this link:

  https://www.eventbrite.co.uk/e/shaping-sheffield-the-plan-tickets-52391317842

- This will be brought together with the work taking place on developing a Children's refreshed Health and Well-Being Strategy for Sheffield, working to a similar timescale.

- Strategy Leads from across the city have emphasised the importance of ensuring the core priorities of the plan are fed into partner business planning processes to ensure system aspirations are tied into organisational plans and become "real".

- It is intended the draft ACP – Shaping Sheffield plan will be produced by the end of March. In February and March it will be important there is opportunity for executive, Board and political leadership teams to feed in to ensure this is a genuinely shaped and owned plan by all partners.

6.1.3 **Developing credible underpinning delivery plans**: whilst considerable progress is being made there are workstreams which need further help to increase pace and the strength of their approach.

6.1.4 **Agreeing key system metrics** which define the outcomes we want to achieve and our progress towards them will be a crucial part of this.

6.1.5 Learning from external systems is informing our approach. This has included learning from a King's Fund system network alongside learning

from areas such as Wigan Council which shared their learning of the "Wigan Deal" with Sheffield Council colleagues.

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

7.1 Through this partnership, health and care partner organisations in Sheffield are committed to the delivery of improved health outcomes and improved ways of working together.

7.2 The forthcoming Shaping Sheffield: The Plan plan will refresh the overall approach and importantly put that together with a "nailed down" delivery plan and approach.

8.Recommendations

SCC Scrutiny Committee is asked to note and consider:

8.1 National, regional and local strategic background to the development of the Sheffield ACP, progress and key next steps.

8.2 Key next steps towards to a high level Shaping Sheffield: The Plan strategy and supporting delivery plan to bring together the work of the ACP.

8.3 The importance of the CQC Local System Review work to the overall direction of the ACP

8.4 The progress on public accountability to the development of the ACP.

8.5 The ACP team acknowledges the unique position of elected members on Scutiny to represent their community and the people within them. Therefore we ask Scrutiny colleagues to debate what it wants to achieve from the 6 monthly updates and how it can best scrutinise the work of the ACP.

Appendix: Summary of NHS Long Term Plan (published 7 Jan 2019)

Chapter 1: Moving to a more integrated care model

- Commitment to greater investment in primary medical and community services, at a faster growth rate than the overall NHS budget
- Redesign of outpatient service model with commitment to reduce OP attendance by 1/3, increase online digital consultations for GP appointments
- Development of "genuinely integrated teams of GPs, community health and social care staff."
- Requirement for expanded community health teams "to provide fast support to patients in their own homes as an alternative to hospitalisation and to ramp up NHS support for people living in care homes."
- Commitment to reducing pressure on the emergency system, through developments such as urgent treatment centres, "same day emergency care" (with a commitment to roll out the latter across all acute hospitals).
- Further commitment to reduce Delayed Transfers of Care through joint working between councils and NHS.

Chapter 2: Strengthened contribution to prevention and health inequalities

- Specific focus on evidence based NHS based prevention programmes to cut smoking, reduce obesity, in part by doubling enrolment in the Type 2 Diabetes Prevention Programme, to limit alcohol related A&E admissions & to lower air pollution
- NHS E to base its 5 year funding allocations to local areas on more accurate assessments of health inequalities and unmet need. Each local area will be required to set out measurable goals and mechanisms by which they will contribute to narrowing health inequalities over next 5 and 10 years – ie by cutting smoking in pregnancy, and by people with LT mental health issues

Chapter 3: NHS priorities for care quality and outcomes improvement for the next decade

- Further focus on cancer, mental health, diabetes, multi-morbidity, and healthy ageing, including dementia
- Extends focus to children's health, cardiovascular and respiratory conditions and learning disability and autism, amongst others.

Chapter 4: How current Workforce Pressures will be tackled and staff supported

- Outlines expansion of nursing and other undergraduate places
- New routes into nursing and other disciplines including apprenticeships, nursing associates, online qualification and "earn and learn" support
- International recruitment to be expanded and workforce implementation plan for shortage specialities.
- More flexible rostering to become mandatory across all trusts, increasing funding for CPD, and greater action to support diversity and a culture of respect and fair treatment.
- New roles and inter-disciplinary credentialing programme will enable more workforce flexibility across an individual's NHS career and between individual staff groups.
- Doubling of number of volunteers
- Workforce plan expected later in the year

Chapter 5- Upgrading technology and digitally enabled care across the NHS.

- Vision is for digital access to services to be widespread to enable patients and carers to better manage their health and condition and to enable clinicians to access and interact with their patient records and care plans, with ready access to decision support and Artificial Intelligence.

Chapter 6 —Financial settlement & performance and payment systems

- **NHS funding settlement of 3.4%**
- Plan states it has provided for demand growth from ageing and growing population, longstanding unmet need and increasing opportunity through science and innovation.
- Plan states it has provided for hospital funding if trends over last 3 years continue
- New financial architecture outlined, payment systems and incentives alongside new turnaround process with stated aim of returning the NHS as a whole to financial balance.
- Ongoing commitment to reducing administrative costs alongside reducing unwarranted variation (clinical and non clinical)

Chapter 7 – Next Steps

- Establishment of new NHS Assembly to strengthen ability of patients, professionals and the public to contribute
- 19/20 to be a transitional year, as the local NHS and its partners have the opportunity to shape local implementation for their populations.
- Detailed national implementation programme by autumn will take account of wider Government Spending Review decision on workforce education & training, social care, councils' public health services and NHS capital investment.
- Intent to make legislative change to support changes to accelerate progress – in meantime expectations that ICSs will be created everywhere by April 2021 to deliver "triple integration of primary and specialist care, physical and mental health services, and health with social care."
- Timetable in report states that by April 2019 there will be publication of local plans for 19/20 and by Autumn 2019 the publication of 5 year plans.

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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Wednesday 23rd January 2019

Report of: **Policy and Improvement Officer**

Subject: **Work Programme 2018/19**

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

The attached report aims to assist the Healthier Communities and Adult Social Care Scrutiny Committee to develop its work programme for 2018/19.

It covers the role and purpose of scrutiny, an overview of how the 'long list' draft work programme has been drawn up to date, and a draft work programme for the Committee's consideration and 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 comment on the draft work programme for 2018/19

Category of Report: OPEN

1 What is the role of Scrutiny?

1.1 Scrutiny Committees exist to hold decision makers to account, investigate issues of local concern, and make recommendations for improvement. The Centre for Public Scrutiny has identified that effective scrutiny:

- Provides 'Critical Friend' challenge to executive policy makers and decision makers
- Enables the voice and concern of the public and its communities
- Is carried out by independent minded governors who lead and own the scrutiny process
- Drives improvement in public services and finds efficiencies and new ways of delivering services

1.2 Scrutiny Committees can operate in a number of ways – through formal meetings with several agenda items, single item 'select committee' style meetings, task and finish groups, and informal visits and meetings to gather evidence to inform scrutiny work. Committees can hear from Council Officers, Cabinet Members, partner organisations, expert witnesses, members of the public – and has a link to patient and public voice through observer members from HealthWatch sitting on the Committee. Scrutiny Committees are not decision making bodies, but can make recommendations to decision makers.

1.3 This Committee has additional powers and responsibilities in relation to scrutinising NHS services. The Committee can scrutinise the planning, provision and operation of any NHS services, and where a 'substantial variation' to NHS services is planned, the NHS is required to discuss this with the Scrutiny Committee. If the Committee considers that the proposed change is not in the best interests of the local area, or that consultation on the proposal has been inadequate, it can refer the proposal to the Secretary of State for Health for reconsideration. Department for Health Guidance for health scrutiny can be found here – and has already been circulated to Members of the Committee.

2 Developing the Scrutiny Work Programme

2.1 Attached to this report is a draft work programme for 2018/19. The Chair has had discussions with a range of organisations, Council Officers and Cabinet Members to come up with a 'long list' of topics. There are also some issues carried over from last year's work programme.

2.2 It is important the work programme reflects the principles of effective scrutiny, outlined above at 1.1, and so the Committee has a vital role in ensuring that the work programme is looking at issues that concern local people, and looking at issues where scrutiny can influence decision makers. The work programme remains a live document, and there will be an opportunity for the Committee to discuss it at every Committee meeting, this might include:

- Prioritising issues for inclusion on a meeting agenda
- Identifying new issues for scrutiny
- Determining the appropriate approach for an issue – eg select committee style single item agenda vs task and finish group
- Identifying appropriate witnesses and sources of evidence to inform scrutiny discussions
- Identifying key lines of enquiry and specific issues that should be addressed through scrutiny of any given issue.

Members of the Committee can also raise any issues for the work programme via the Chair or Policy and Improvement Officer at any time.

3 The Draft Scrutiny Work Programme 2018/19

3.1 Attached is the draft work programme for 2018/19. Members are asked to consider it and reflect on questions such as:-

- Are there any gaps?
- Are there any issues on the list that don't feel appropriate for scrutiny?
- What are the priority issues?
- What approach should the Committee take for each item, what are the key lines of enquiry, and who is it important to hear from?

4 Recommendations

The Committee is asked to:

- Consider and comment on the draft work programme for 2018/19

Healthier Communities and Adult Social Care Scrutiny Committee Draft Work Programme 2018/19			
Topic	**Reasons for selecting topic**	**Lead Officer/s**	**Agenda Item/ Briefing paper**
Wednesday 27th February 4-7pm			
Performance - Adult Social Care	To consider the adult social care performance indicators and seek assurance that performance is improving, and where it isn't, adequate plans are in place to address this.	Phil Holmes, SCC	
Wednesday 20th March 4-7pm			
Delayed Transfers of Care	Update on performance of Delayed Transfers of Care over the winter period.	Phil Holmes SCC	
CQC Local System Review Update	*To consider progress on the CQC local system review action plan – factoring in the voice of older people.*	*Becky Joyce, Accountable Care Programme Director.*	
Continuing Health Care update	*To consider improvements to the Continuing Healthcare process following consideration by Scrutiny in September 2018.*	*NHS Sheffield CCG*	

Prevention Working Group			
Group will consider Council and City's approach to prevention, and report back to full Committee with any proposed recommendations.	Follow up from Committee meeting on prevention in November 2019.	Emily Standbrook-Shaw SCC	
Possible future items - scope to be determined			
Adult Social Care			
Quality in Adult Social Care	To consider the approach and progress that SCC is taking to improve quality in adult social care services - to include information about Home Care services (inc service user view from HealthWatch), and how SCC and the organisations it deals with deal with complaints.	Phil Holmes, SCC	
Adult Social Care Improvement and Recovery Plan	Progress report - is the plan working?	Phil Holmes, SCC	
Adult Safeguarding	To continue to develop a relationship with the Customer Forum, and receive the 2018/19 Annual Report	Simon Richards, Gillian Hallas SCC	
NHS Services			

Joint Strategic Hospital Services Review	To consider the outcome of the review and the potential impact on Sheffield	NHS Sheffield CCG	
Urgent Care	To consider developments in the review of Urgent Care Services.	NHS Sheffield CCG	
Moving Services into Primary Care	Suggested as possible area of interest by CCG, as this work will be increasing in pace. Members have already picked up on changes to the Duke St Aural Clinic.	Nicki Doherty, NHS Sheffield CCG	
Health and Wellbeing			
Joint Health and Wellbeing Strategy	To consider the draft strategy.	Greg Fell, Dan Spicer	
Mental Health - Joint Session	Dedicated session for HCASC and CYPFS Scrutiny Committees to consider mental health in the round - scope and format to be determined.		
Oral and Dental Health	Keep updated re recommendations made during 2017/18 - particularly the potential consideration of fluoridation	Greg Fell, Director of Public Health	
Health in All Policies	To consider how well the Public Health Strategy is being embedded across all areas of Council activity	Greg Fell, Director of Public Health	Agenda Item

Health and Employment	To consider activity and programmes aimed at supporting people with health conditions into work. Whats working well, what can we do more of?		
Joint Working, systems and structures			
Delayed Transfers of Care	Update following consideration in 2017/18	SCC, NHS Sheffield CCG, STH.	
Transforming Care Programme	To seek assurance that the Council and NHS are working together to deliver the Transforming Care Programme.	Phil Holmes SCC	
Mental Health Transformation Programme	Update following consideration in 2017/18 - with a focus on savings and investment		
Integrated Care System	What is its scope and parameters, purpose etc - what will we look like in 5 years - what is impact on Sheffield?		
Joint Overview and Scrutiny Committees			

South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Scrutiny Committee	This Committee meets in relation to Health Service Change across the geographical footprint. Focussing on NHS service reconfigurations - Hyper Acute Stroke Services; Children's Surgery and Anaesthesia; Joint Hospital Services Review		

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