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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 20 March 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
20 MARCH 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 - 10)
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

7. Prevention Update
Cabinet Member to provide verbal response to the Scrutiny Prevention findings.

8. Continuing Healthcare
Report of NHS Sheffield CCG, Healthwatch and Sheffield City Council.

9. Improving Quality in Adult Social Care
(a) For information – HealthWatch Sheffield's report into Home Care.

(b) Report of the Director of Adult Services, Sheffield City Council.

10. Date of Next Meeting
The next meeting of the Committee will be held on a date to be arranged.

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 27 February 2019

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

Non-Council Members (Healthwatch Sheffield):-

Margaret Kilner

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Chris Rosling-Josephs.

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 The following questions were asked by Alistair Tice:-

The Scrutiny Committee rejected the main Clinical Commissioning Group/Primary Care Commissioning Committee (CCG/PCCC) proposals to close the Minor Injuries Unit at Hallamshire Hospital and to close the Broad Lane Walk-in Centre last September, and would probably have referred the CCG's decision to the Secretary of State had the PCCC decided not to go ahead with their proposals.

Given the above, will the Scrutiny Committee make it clear to the CCG/PCCC that if they propose the same Urgent Care plans again, that the Scrutiny Committee will once again reject these proposals and if necessary refer any such decision to the Secretary of State?

Furthermore, will the Scrutiny Committee call upon the CCG/PCCC to explore the "alternate options" that were proposed during the previous consultation and which the CCG/PCCC said they would develop after deciding not to go ahead with their original proposals on 20th September, 2018 of which there is no mention in the Report of the Director Of Commissioning put before this meeting?

4.2 The Chair, Councillor Pat Midgley, responded on behalf of the Committee stating that, following the local elections to be held in May, and whoever the Members appointed to the Committee might be, a collective approach towards the proposals will be given to the CCG/PCCC to ensure that the needs of the citizens of Sheffield are met. Brian Hughes, NHS Sheffield CCG, stated that these questions would be covered by the presentation in the item relating to the Urgent Care Review, which would highlight that the new approach will not be a re-hash of the former proposals.

4.3 Sharon Milsom asked the following questions:-

Will the Scrutiny Committee keep in mind the following during the process:

- Accessibility – will the waiting times be revisited?
- Disability – what measures are being considered with regard to the distances travelled by many disabled and/or elderly people?

4.4 Councillor Douglas Johnson asked the following questions:-

1. What are the current aims of this piece of work?
2. Does the CCG accept some people can't get to see GPs when they need them?
3. Does the CCG know which surgeries are the problem?
4. Does the CCG know what improvements are needed at each surgery?
5. What can they do to bring them about?
6. Does the CCG still intend to pursue closure of the Minor Injuries Unit and Walk In Centre? If so, why?

4.5 Brian Hughes responded again stating that these questions would be covered by the presentation in the item relating to the Urgent Care Review.

4.6 The Chair indicated that a number of other questions had been received on behalf of Sheffield Save Our NHS and these would most likely be covered during discussions and the presentation in agenda Items 7 and 8 and responded to accordingly.

5. JOINT COMMISSIONING FOR HEALTH AND CARE

5.1 The Committee received a report of the Director of Public Health, which provided a summary of proposals to establish a Joint Commissioning Committee between the City Council and the Clinical Commissioning Group (CCG). The report also summarised proposals for a joint commissioning plan and identified the priority areas for commissioning new preventative services, seeking to reduce inequalities, increase the capacity of community based services and reduce demand on acute services.

5.2 Present for this item were Greg Fell (Director of Public Health), Brian Hughes (Director of Commissioning, CCG), and Councillor Chris Peace (Cabinet Member for Health and Social Care).

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

- Building on the Preventative Model, Sheffield has the ability to move forward so that health and social care can be integrated, to improve health outcomes and reduce inequalities for the people of Sheffield. To achieve this, proposals are being developed to strengthen the way health and care is jointly commissioned between the CCG and the City Council.

- It is proposed that the Joint Commissioning Committee will be comprised of four Cabinet Members and four members of the CCG Governing Body, working towards a single voice, a single plan.

- The three main priorities for 2019/20 are to consolidate and build on the integrated mental health work; develop a partnership approach to special educational needs and disabilities; and develop a service improvement framework for frailty to encourage preventive interventions.

- There are no firm plans yet regarding accountability. The Cabinet would still make executive decisions and the role of this Scrutiny Committee would remain unchanged.

- The Voluntary, Community and Faith (VCF) sectors are not yet involved, although VCF representatives do form part of the Accountable Care Partnership Board. It is recognised the vital role the VCF sector plays within communities.

- There would be no duplication between the roles of the Joint Commissioning Committee and the Accountable Care Partnership as the focuses are very different, but with the same outcome of developing and delivering the best possible health and social care for the people of Sheffield.

- The proposals for the Joint Committee are very much in the infancy and any issues that have been raised at this meeting will be put forward and presented in a report to Cabinet at its meeting to be held on 20th March, with a view to the Joint Committee being in place by April.

- The recently published Green Paper by NHS England outlining healthcare plans for the future did not include social care and it is felt that by establishing a local Joint Commissioning Committee, this would go some way towards tackling some of the problems. When people need help, they just want to access the best possible care available.

5.4 RESOLVED: That the Committee:-

(a) thanks Greg Fell (Director of Public Health), Brian Hughes (Director of Commissioning (CCG) and Councillor Chris Peace, (Cabinet Member for Health and Social Care) for their contribution to the meeting;

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

(c) requests that an update report on the work of the Joint Commissioning Committee be brought back to the Committee in six months' time.

6. URGENT CARE REVIEW

6.1 The Committee received a report from Brian Hughes, Director of Commissioning, NHS Sheffield Clinical Commissioning Group (CCG), outlining a new approach to the review of urgent care by identifying the key problems and issues in urgent care services in the City, which were raised in 2018 and necessitated that a different approach to the proposals was made.

6.2 Also present for this item were Kate Gleave, Rachel Dillon and Lucy Ettridge, NHS Sheffield CCG.

6.3 Brian Hughes introduced the report and stated that since this was brought before the Committee in October, 2018, no decisions have been taken on how to deliver urgent care within the city and that the CCG was going back to basics when consulting with its partners and the public. The report was supported by a presentation given by Kate Gleave, which informed the Committee on the new approach and current position of the Review, and the work undertaken so far to determine the key problems and issues which needed to be addressed. She referred to workshops that had been carried out with public and partners and the plan to engage with groups not engaged with in the first consultation. This included engaging with community groups; staff working in the urgent care services; students; individual GPs; the homeless; people with substance misuse problems; insitu surveys with patients in the walk in centre, minor injuries unit and A&E, and also through surveys carried out on social media.

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

- The outcome of the previous consultation has not affected the approach towards the consultation, but lessons have been learnt and the focus is, and has always been, on getting it right for the people of Sheffield.

- The first phase of the new approach, which commenced in December, 2018, is to gather as much information from partners and the public and it is hoped that this will be completed by the end of March, which should then determine the focus of the work going forward, but there is no definite timescale for the review to be completed.

- The previous approach was cost neutral, as will be the new approach. It is not about saving money, but making the best use of the money available.

- The focus has to be on what are the most important issues in terms of services, patient journeys, advice and treatment of both mental and physical health and prioritise the top five issues.

- There is a lot of work being carried out regarding prevention, helping to manage conditions, this review is to lead on urgent care and will link with the prevention work.

- The CCG has created a group consisting of representatives from different groups of the population across Sheffield to reflect on the feedback received, the group is made up of members of Healthwatch, Councillors and local political groups, not just health champions.

- It was hoped that members of the public and staff complete the online survey or contact NHS Sheffield CCG to voice their views and provide details of what services they use and why, to give a better understanding of who uses urgent care services in the city. The results of this survey would be brought back to the Committee in June/July this year.

6.5 RESOLVED: That the Committee:-

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

(b) notes the contents of the report and presentation, and the Member and officer comments.

7. PREVENTION SCRUTINY WORKING GROUP

7.1 The Committee received a report of the Policy and Improvement Officer which outlined the findings of the Prevention Working Group that had been established in November, 2018. The report highlighted the key issues and concerns regarding the relationship the City Council and statutory partners have with the voluntary sector and stressed the need to work in partnership with the voluntary sector and support them in the vital work they undertake throughout the city. Another concern was that a preventive way of working requires a shift in the way the whole Council works; are we doing it right to build in health and wellbeing considerations into the decision making process. Finally, concerns were raised regarding locality working, with differing locality boundaries and the implications for joined up service delivery.

7.2 RESOLVED: That the Committee:-

(a) thanks the Prevention Working Group for the work they had done;

(b) endorses the findings of the Working Group and agrees to them to Councillor Jackie Drayton (Cabinet Member for Children and Families), Councillor Jim Steinke (Cabinet Member for Neighbourhoods and Community Safety) and Councillor Chris Peace (Cabinet Member for Health and Social Care) and requests that an interim report be given at the meeting of this Committee to be held on 20th March, 2019; and

(c) agrees to forward the findings to the Accountable Care Partnership Board and Health and Wellbeing Board for information.

8. MINUTES OF PREVIOUS MEETING

8.1 The minutes of the meeting of the Committee held on 23rd January, 2019 were approved as a correct record.

9. WORK PROGRAMME 2018/19

9.1 The Committee received a report of the Policy and Improvement Officer which set out the Committee's Work Programme for 2018/19.

9.2 The Policy and Improvement Officer read out a question that had been received from Mike Simpkin regarding a statement to be made the following day regarding an NHS England review into the Culture and Leadership of NHS Sheffield CCG. Members asked for the Policy Officer and Chair to establish the most appropriate way for the Scrutiny Committee to consider this issue, preferably this municipal year.

9.3 RESOLVED: That (a) a report on Improving Quality in Adult Social Care and an update on Continuing Health Care be brought to the next meeting and (b) the Chair determines the most appropriate way to consider the CCG review.

10. DATE OF NEXT MEETING

10.1 It was noted that the next meeting of the Committee will be held on Wednesday, 20th March, 2019, at 4.00 p.m., in the Town Hall.

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

27th February 2019

Report of: Scrutiny Prevention Working Group

Subject: Findings on Prevention

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

Summary:

In November 2018, the Healthier Communities and Adult Social Care Scrutiny Committee held a meeting to consider 'Prevention'. Following that meeting, the Committee established a small working group to consider the issues in more detail.

The findings of the working group are attached for the Committee to consider/comment/agree.

If the Committee agrees the report, it will be submitted to the relevant Cabinet Members, with the request that a formal response comes back to the Committee in due course.

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

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

The Scrutiny Committee is being asked to:

- Consider and comment on the findings of the Prevention Working Group
- Agree the findings of the Prevention Working Group
- Submit the findings to the relevant Cabinet Members and request a formal response.

Healthier Communities and Adult Social Care Scrutiny Committee

Prevention Working Group

Findings on Prevention

Through our work this year, we've heard lots about the need to work in a more preventive way – to stop and delay people becoming ill, to shift resources up stream, to help people stay well in their communities – both because it's the right thing to do in terms of people's wellbeing, and because with reducing budgets and rising demand for public services, its financially necessary.

We wanted to unpick this – working in a more preventive way is talked about a lot, but what does this mean in practise? How successful are we in it, and is it working?

It quickly became clear that this is not an easy task – the prevention agenda is huge in scale and scope, even the word 'prevention' means different things to different people. We invited a range of people to our meeting in November to get their take on prevention. We talked to the Director of Public Health and the Head of Commissioning for Prevention and Early Help about the Council and partners' strategic approach to prevention; to Council officers delivering services across a range of areas; and to voluntary and community organisations about what their view is. Some members of the Committee also went out to visit projects going on across the City and talk to people working in, and using services.

There were some really clear messages to come out of this work – primarily around the importance of collaboration and partnership working with the Voluntary and Community Sector.

We became aware of some work, in its early stages being done around a prevention framework, and felt that the most appropriate way for us to report was to highlight the issues we are concerned about to Cabinet Members, so that our findings can help to shape the wider work on prevention.

We'd like to request that a report comes back to the Scrutiny Committee at an appropriate point responding to the issues we've highlighted, and will consider including them on our work programme if more detailed work is required. We also recognise that this is not just an issue for the Council, and we will continue to raise these issues in our discussions with partners such as the CCG.

We know that a lot of what we're saying isn't new, but we hope that in highlighting these issues and asking for reports back, we can help to move this agenda forwards. We're keen to see that our actions match our ambitions.

Key Issues and Concerns

1 Relationship with the Voluntary Sector.

The key message we have heard in considering this work is the crucial role that the VCF plays across the city in the prevention and wellbeing agenda. At a time when we are trying to deliver more services at community or neighbourhood level, VCF organisations are well placed to be the glue joining up communities and areas. We didn't just hear this message from the VCF - we spoke to a GP who reported that increasingly people are presenting with social, rather than medical issues – and that their local VCF organisation is a 'saving grace' in terms of taking on difficult cases and making real improvements to people's lives. Council officers also told us that improving the way we work with the VCF is important.

The message we took away from VCF representatives was that the Council and statutory partners need to work in partnership with the VCF. Rather than using the VCF as a 'supplier', we should be working together, in partnership, from the earliest stages to identify the issues we need to deal with and the most appropriate solutions. Co-design, co-production and collaboration were all highlighted as areas we need to work on in Sheffield. Our approach to commissioning and procurement should facilitate a thriving and stable voluntary sector.

We heard that whilst, for example, the People Keeping Well partnerships have been good for building relationships between the statutory partners and the VCF organisations involved, there are many smaller organisations doing vital work all over the city, and we need to consider how we can best provide support for these, and emerging organisations to grow in a sustainable, well governed way, and ensure that these organisations are linked in to the 'system'. It's become clear to us from our visits with social prescribing organisations that a successful system relies on this network, or 'web' of organisations but we have found it hard to get a comprehensive sense of which organisations are providing what services across the city. We feel that it is important that organisations and residents know what's going on in their communities, so referral routes are effective and people can access help when they need it. We feel that a mapping exercise would be useful, so we can understand what's going on across the city; identify any gaps and areas where we may need to develop, grow and invest in the VCF; as well as learn from, and spread good practice. Ward Councillors could play a useful part of any mapping exercise, given their insight into their local areas.

Key Questions

- How can we improve our relationship with the voluntary sector, including our approach to commissioning, procurement and investment?
- How can we get a comprehensive understanding of what and where VCF organisations are operating in the City?

- Can we nourish and grow the VCF in areas that need it, including smaller and emerging organisations.

2 Are we doing it right, and is it working? How do we know?

It was made clear to us that a preventive way of working requires a shift in the way the whole Council works. We've heard a lot about the need for us to become a preventive organisation, however it is less clear how we plan to achieve this culture change.

We've heard from Council Officers about really good examples of services and projects that are working in a preventive way – so we know that good work is going on, but we found it hard to get a measure of how well we are doing in terms of progressing the prevention agenda. Are we shifting resources to preventive work? And is it working? Can we develop a set of indicators to help us understand whether we are achieving our ambitions?

Health and wellbeing is everyone's business, and is as much about an inclusive economy, green space and transport as health and social care services. To encourage this move towards prevention across all areas of work, it would be helpful to build in health and wellbeing considerations into the decision making process.

Key Questions

- We've heard a lot about the need for us to work in a more preventive way – but what is actually happening to achieve this shift?
- What does success look like, and how can we measure it? Is it possible to develop a set of indicators to help us understand whether we are achieving our ambitions?
- How can we build consideration of health and wellbeing issues into the decision making process?

3 Locality Working

We're hearing more about the move into neighbourhood/locality/community working across a range of organisations such as GP practices, neighbourhood policing, social work teams. We have some concerns about the different locality boundaries and their implications for joined up service delivery. We heard examples where People Keeping Well Partnerships were unable to bid for funding from GP Neighbourhoods because the PKW partnerships were operating outside of the boundaries of the Neighbourhood, and vice versa. Is coterminous boundaries across all organisations operating in the city a realistic prospect?

We also heard about how different areas are at different levels of 'maturity' in terms of relationships between organisations. Whilst we recognise that every area is

different, and has different needs, we think that we need a citywide vision for how we work more effectively in neighbourhood.

We've heard that our frontline staff are facing more complex and complicated cases than ever before. Given this, we need to make sure that they are trained, equipped and enabled to build strong and effective partnerships with other organisations working in their area.

We must ensure that the resources we deploy directly in our communities are providing the right kind of interventions, targeting the people who need it and achieving the outcomes necessary to deliver on the prevention agenda. We must also make sure that Council resources are complementing, rather than duplicating activity that is already being carried out successfully in localities by VCF organisations.

Key Questions

- How can we work with other organisations to ensure that different geographical boundaries don't adversely affect locality working?
- Are we using our resources – staff, estate, investment - to maximum effect within localities? How can we do it better?

Sheffield Continuing Healthcare
Collaborative service development

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Mandy Philbin: Chief Nurse, Sheffield CCG

Margaret Kilner – Chief Officer, Healthwatch

Phil Holmes: Direct of Adult Services, Sheffield CC

20th March 2019

Why did we focus on the CHC assessment process?

Concerns

- Individuals who had experienced the assessment process and their families
- Voluntary and community groups who support people through the process
- Advocates who have participated in the process and observed practice
- Findings of the CQC Local System Review

Opportunity

CHC Service Development Project
A collaborative effort between Sheffield CCG and Sheffield City Council to design a single health and social care CHC assessment process with the individual and their family at the centre of all decision making.

What did we do?

- Two listening sessions at Birch Avenue and Woodland View dementia care homes,
- A dedicated Voluntary, Community and Faith Sector Health & Wellbeing Forum,
- A small focus group for people who have experienced the CHC assessment process themselves or have supported someone who has been through the process.

What did we find?

Five key areas for development that we believe will improve experience and lead to better care.

- Person centred care
- Listening to people with lived experience
- Involving family carers
- Relationship between CCG and voluntary & community groups
- Values and behaviours/culture change

What we heard	The actions we are taking
The need for greater person centred collaboration in service delivery. Some staff can lack empathy. Need to move away from 'the professional knows best'.	**Values and Behaviours** Co-produced aimed at ensuring our workers deliver services in a consistent manner. Launched on the 26th March. Integrated training events planned for April.

What we heard	The actions we are taking
Lack of transparency and openness in the process Lack of accessible information	**CHC Newsletter** Co-produced aimed at improving the way in which we communicate in a more open and transparent manner. Individuals in receipt of services are helping to inform: • the type of information provided • how we will distribute (media) ▪ the frequency of communications Launched in April 2019.

healthwatch Sheffield

NHS Sheffield Clinical Commissioning Group

Sheffield City Council

What we heard	The actions we are taking
People in receipt of services need to have a strong voice in being able to provide feedback on their service experiences.	**How did we do? – Questionnaire** Co-produced aimed at quality assuring services by providing people in receipt of care with a strong voice. Feedback on people's experiences will help us to continually improve services. Launched in April 2019.

What we heard	The actions we are taking
Consistency of the Decision Support Tool (DST) assessment process.	**CHC Operating Procedure** Collaboratively developed aimed at ensuring services are delivered consistently, resulting in a high quality service experience. Launched on the 26th March Integrated training events planned for April.

What we heard	The actions we are taking
Lack of understanding of the CHC assessment process for individuals and their representatives.	**CHC Awareness Tool Kit** Co-produced aimed at improving knowledge and understanding for people in receipt of services. The tool kit will include: • Video describing the process • Slide deck providing easy read guidance • Myth busting • Frequently Asked Questions

Development/Training activities	When
CHC Operating Procedure and Disputes Resolution Policy	April 2019
Customer Services, Mentoring, Coaching and Leadership	2019-20
Workshop with workers to identify skill gaps and inform future development activities	April to June 2019-20
Reflective Practice events – collaborative approach to practice learning with health and social care workers having protected time together to reflect and share learning	April 2019
Induction Programmes – Introduction of dedicated time with counterparts from health and social care to develop awareness, empathy and relationships	April 2019

Next steps – service improvement

- **Joint Workforce Development Plan**
  Integrated approach to workforce development to deliver a consistent high quality service experience
- **A more collaborative approach across the community**
  Improved joint working arrangements which place the individual at the centre of the care
- **Care provision**
  Working in close partnership with care providers to ensure we have high quality services which meet the needs of our citizens

- **Better use of digital technology**
  Ongoing work being undertaken collaboratively to identify how we can best use technology to improve services.

NHS Sheffield Clinical Commissioning Group

healthwatch Sheffield

Sheffield City Council

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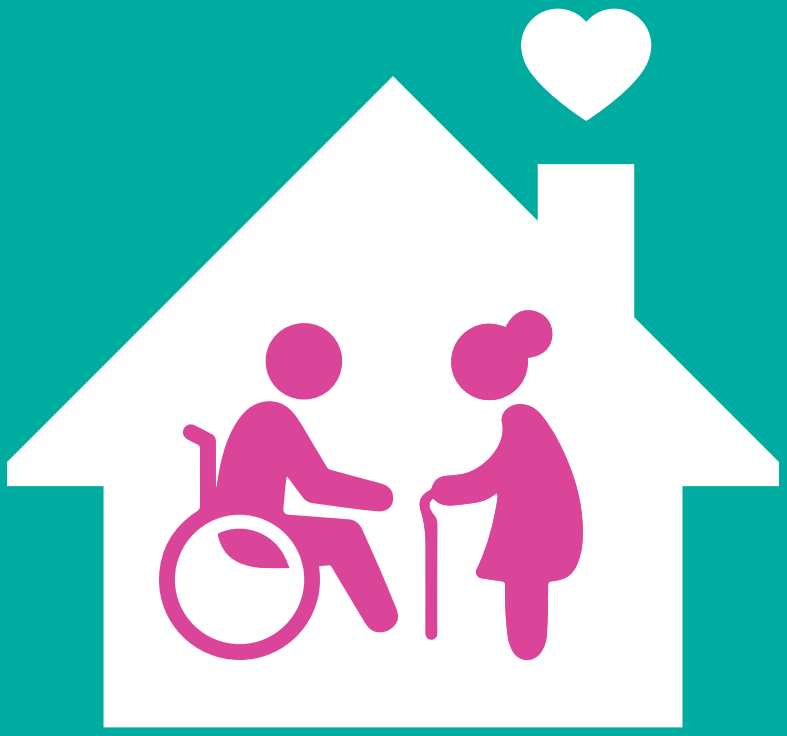


Home Care Report
January 2019

healthwatch
Sheffield

Contents

healthwatch Sheffield

About Healthwatch Sheffield

We are here to help adults, children and young people influence and improve how services are designed and run. We are completely independent and not part of the NHS or Sheffield City Council.
You can tell us about your experience of:

1. Health services

(GPs, dentists, opticians, pharmacies and hospitals etc.)

2. Social care services

(care at home, residential and nursing homes, personal budgets etc.)

We collate the feedback you give us so we can make evidence-based recommendations to the organisations that design, pay for, and run our local services.

Acknowledgements

Thank you to all the users of home care and family carers who shared their views and experiences with us; without you this report would not have been possible.

We would also like to thank the following organisations for their help and support:

- **Age UK Sheffield**
- **Sheffield Carers Centre**
- **Alzheimer's Society (Sheffield)**
- **Stroke Association (Sheffield)**
- **Disability Sheffield**
- **Shipshape**
- **Chinese Community Centre**
- **SHINDIG**
- **SOAR**
- **Manor and Castle Development Trust**
- **Sheffield Teaching Hospital's NHS Foundation Trust**

Executive summary

There is some evidence that a higher percentage of users of adult social care in Sheffield feel satisfied with their care and feel in control of their daily lives than in recent years and that social care-related quality of life has slightly improved.

However, Sheffield still performs worse than other local authority areas in South Yorkshire, and when compared to figures for Yorkshire and Humber and England.

In 2017, Sheffield City Council (SCC) changed their approach to contracting home care by increasing the number of providers they work with, in an attempt to create more capacity and improve the quality of home care services for local people.

Healthwatch Sheffield wanted to update and deepen its knowledge of the quality of home care in Sheffield by gathering the views and experiences of users of home care and family carers. To achieve this, we held focus groups and carried out semi-structured face-to-face and phone interviews.

In terms of accessing and planning care we found that in general people were satisfied with care needs assessments and the content of care plans. However, people told us that care plans can be too rigid, increased clarity and support are needed through the financial assessment process, and they would like to have more control and flexibility in how they can spend their financial support.

Our findings suggest that there was some general satisfaction with home care, with positive experiences involving home care workers going 'the extra mile' and people building good relationships with care workers. Nonetheless, poor communication was a theme that was present in several different aspects of people's experiences. We also heard many examples where home care did not match with people's priorities and preferences or promote their health and wellbeing, and these experiences were characterised by a lack of choice and control.

We identified the following key concerns which contrast with NICE guideline recommendations on planning and delivering person-centred home care:

- **Late, missed and inappropriate timing of care visits**
- **Rushed care visits**
- **Lack of continuity of care**
- **Care plans were not followed or reviewed regularly**
- **Lack of opportunities for family carers to give feedback and difficulty making complaints**
- **A perception that there is a lack of training, supervision and monitoring of home care workers and no experience or qualifications are needed to do the job**

We have summarised our findings in a model **(see page 21)** which shows what person-centred home care looks like to people locally. We have also made six recommendations, which aim to guide efforts to improve home care for the people of Sheffield, including work to address concerns raised in the Care Quality Commission's recent local system review of Sheffield [1].

[1] www.cqc.org.uk/files/local-system-review-sheffield

Overview of recommendations

Healthwatch Sheffield recommends that commissioners* and providers of home care work together and involve users of home care and family carers to make changes in the following areas:

1. **Improve experiences of accessing & spending financial support**
2. **Improve experience and reduce risk in relation to the timing & length of care visits**
3. **Address a lack of continuity of care**
4. **Encourage care plans to be read & a responsive approach to reviews**
5. **Improve the experience of making a complaint & create conditions where feedback about services is valued and used**
6. **Enable a more consistent, joined up approach to workforce training & improve the credibility of care workers & how they are recruited**

We have suggested specific ways to make improvements in relation to each of the recommendations shown above (see page 22 for full details).

***Commissioners** of home care decide who provides home care services to local people and how they are paid for with public money. Sheffield City Council and Sheffield Clinical Commissioning Group are both organisations that commission home care services.

Background

What is home care?

Home care (sometimes called domiciliary care) is a source of support for people who need help with things like personal care, essential tasks around the home and other daily living activities such as socialising outside the home. This support can help people remain in their own home rather than living in a care home. Paid home care is provided by local authorities, independent home care companies and personal assistants. It is estimated that 673,000 people use home care in England at a total cost of £3.3 billion [2].

673,000

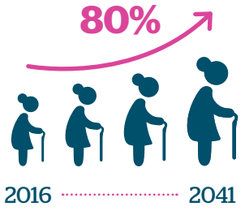
people use home care in England

National and local challenges

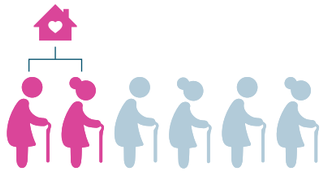
The demand for home care is increasing. In England, a growing ageing population is expected to lead to a 60% increase in the number of people with care needs [3] and the number of people with complex, chronic or multiple conditions is increasing. For example, it is predicted that there will be a million people with dementia in England by 2027, and this will continue rising, reaching 1.75 million by 2050 [4].

1 Million

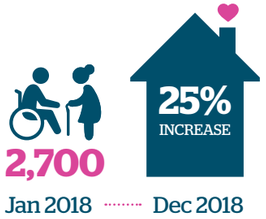
people could be living with dementia in England by 2027



By 2041, the number of people aged over 65 in Sheffield is predicted to grow by 37% , whilst the number of people aged 85 and over is expected to increase by 80% (based on 2016 population estimates) [5].



Over a third of people aged over 85 have difficulties carrying out five or more tasks of daily living without assistance, so are likely to need health and care services [6].

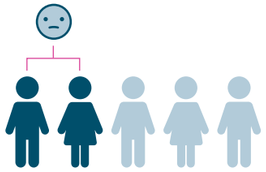


We were informed by Sheffield City Council (SCC) that in 2018 they had organised home care for around 2700 people, which represents an increase of around 25% within a year.

Difficulty attracting and retaining staff in adult social care is also a key concern, particularly in the context of growing demand.

National estimates for 2017/18 suggest that within adult social care, home care services had the highest job vacancy rate (9.9%) and staff turnover rate (36.8%) compared to other service types.

The job role with the highest staff turnover was care workers (37.5%) and the rate was even higher for home care workers (42.3%).



Around 2 in 5 leave their role within 12 months [7].

Staff leaving can have a negative impact on users of home care because they have to get to know someone new who isn't familiar with their needs and preferences, and care companies have to put resources into recruiting and training new staff.

In 2017/18, estimated staff vacancy rates for adult social care in Sheffield were at the lowest rate seen in the last 5 years (4%). However, they have consistently risen and fallen from year to year during that time. In contrast, estimated staff turnover rates have steadily increased and doubled in the same period, increasing from 17.8% to 35.7% [8].

The local picture

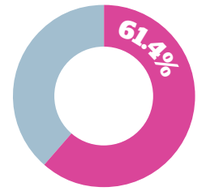
The Adult Social Care Framework (ASCOF) measures how well support and care services achieve the outcomes that matter most to people, through user and carer surveys. The results are published every year and inform us how well Sheffield is doing in comparison to other local authority (council) areas, and the regional (Yorkshire and Humber) and national picture.

According to the ASCOF data for 2017/18 [9]:

Quality of life score

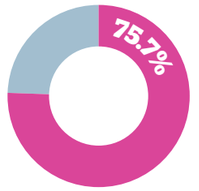
18.4 out of **24**

The social care-related quality of life score has increased to 18.4 out of a possible score of 24, but it is still lower than the regional and national score, and Sheffield has had the lowest score compared to other local authority areas in South Yorkshire for the last 3 years.



People reporting overall satisfaction with care

This has improved for the second year in a row but remains lower than the percentage regionally and nationally and is lower than other local authority areas in South Yorkshire.



Worst performing local authority in South Yorkshire

Sheffield remained the worst performing local authority area in South Yorkshire for the third consecutive year in terms of the percentage of people who felt they had control over their daily life (75.7%). Regional and national percentages are higher, but the gap is narrowing. The percentage in Sheffield has increased for the last two consecutive years.

[2] www.ukhca.co.uk/pdfs/DomiciliaryCareMarketOverview2015.pdf

[3] www.kingsfund.org.uk/projects/time-think-differently/trends-demography

[4] www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf

[5] www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

[6] www.cqc.org.uk/sites/default/files/20170703_ASC_end_of_programme_FINAL2.pdf

[7] www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf

[8] https://drive.google.com/file/d/10aJpm4ncjq91tQhV1SuE1Gs-nfhv1nie/view

[9] https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current

The Care Quality Commission (CQC) regulate, monitor and inspect home care providers. **Table 1** shows CQC inspection ratings of home care providers in Sheffield in September 2018. There was a lower percentage of home care providers in Sheffield rated as Good and Outstanding and a higher percentage of unrated providers compared to the national and comparator group. The comparator group is made up of 15 local authorities viewed as 'most similar' to Sheffield in terms of demographics and geography.

Table 1: CQC Inspection ratings of home care providers in Sheffield (based on CQC data accessed on 28/09/18) [10]

Key
*R.I. = Requires Improvement
Numbers in brackets show the number of home care provider sites

	Inadequate	R.I*	Good	Outstanding	Unrated
Sheffield Local Authority	**1%** (1)	**11%** (11)	**59%** (57)	**0%** (0)	**28%** (27)
Comparators	**0%**	**12%**	**61%**	**3%**	**24%**
Emgland	**1%**	**10%**	**63%**	**2%**	**24%**

[10] https://drive.google.com/file/d/10aJpm4ncjq9ltQhVlSuE1Gs-nfhvlnie/view

Why we investigated home care

In March 2017, we published a summary of our survey findings which provided a snapshot of local people's experiences of home care and was used to inform the service specification in Sheffield City Council's recommissioning of home care services.

We found that people wanted more consistent, flexible care and longer care visits.

In 2017, Sheffield City Council (SCC) increased the number of providers working with them to deliver home care and supported living across the city. Around 29 providers were contracted, and a formal home care framework was introduced in a move towards increasing capacity, quality, and more flexible and responsive services for individuals using home care [11]. Although we didn't expect to see significant changes in these areas in such a short space of time, we felt it was still important to find out more about people's experiences of home care because:

- **We want to ensure that people's views on home care are added to the evidence base available to local decision makers.**
- **Some people who use home care can be difficult to reach using usual feedback gathering methods because they spend little time outside of their home and we have received little feedback about home care in the last year. Additionally, home care is not usually visible at the point of delivery because it mainly takes place in people's homes.**
- **ASCOF data published in 2016/17, showed that Sheffield ranked poorly in terms of the social care-related quality of life score (ranked 154 out of 159 local authority areas) and remained lower than national and regional scores. Furthermore, a lower percentage of users of adult social care services in Sheffield felt in control of daily living and had overall satisfaction with their care in comparison to the regional and national figures [12].**
- **We were aware of the challenging climate in which home care is commissioned and delivered, with growing demand for home care services and difficulties around recruiting and retaining care workers potentially having a negative impact on people's experiences of home care.**

[11] www.sheffield.gov.uk/content/dam/sheffield/docs/social-care/social-care-policies-and-plans/Local%20account%20ASC17.pdf

[12] https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/archive/measures-from-the-adult-social-care-outcomes-framework-england--2016-17

How we investigated

Our approach

In contrast to our work in 2017, we wanted to have detailed semi-structured conversations with people and actively seek views from the family carers of people using home care.

When planning our investigation, we consulted with local organisations that work with people who have experiences of home care including the Sheffield branches of Age UK, Alzheimer's Society, and the Stroke Association, Sheffield Carers Centre and Disability Sheffield.

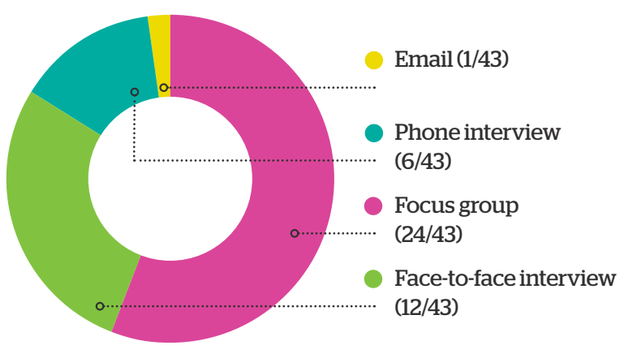
How we gathered evidence

Healthwatch Sheffield staff and volunteers gathered people's views and experiences of home care over eight weeks, between February and March 2018.

We held four focus groups and conducted semi-structured phone and face-to-face interviews (see **Appendix A** for interview questions). This allowed people to focus the conversation on the aspects of home care they thought were important.

Opportunities to take part were promoted in our newsletter, on our website and through social media, and leaflets were distributed by voluntary sector groups, home care providers and Community Services at Sheffield Teaching Hospital's NHS Foundation Trust.

Figure 1: How we gathered views and experiences



Focus Groups

5th March 2018
The Circle, Rockingham Lane, S1

8th March 2018
Quaker Meeting House (This focus group was arranged and facilitated in association with Sheffield Dementia Involvement Group (SHINDIG) and Alzheimer's Society Sheffield)

9th March 2018
Victoria Hall Methodist Church (This focus group was advertised through Sheffield Carers Centre)

27th March 2018
Parson Cross Library (This focus group was arranged and facilitated by Healthwatch Local)

Who spoke to us

We heard from 43 people about their experiences of home care. 10 people were users of home care and 33 were family carers who had a role in supporting their relative/s alongside paid home care.

People mainly told us about older people's experiences of home care. We didn't record the age or ethnicity of people who spoke to us but we are aware that there was a lack of representation from younger adults and people from Black Asian and Minority Ethic (BAME) communities. You can read what two BAME community workers told us about attitudes and experiences of BAME people using home care in **Appendix B.**

Most people said that the home care provided was arranged by Sheffield City Council (SCC) **(Figure 2)**. Some people said the care was completely self-funded whilst some was partly or fully funded by SCC **(Figure 3)**. There were also some people who didn't know or tell us how the home care provided was arranged or paid for. Almost everyone we spoke with used home care companies rather than Personal Assistants (PA's) to support them at home.

Figure 2: How home care was arranged

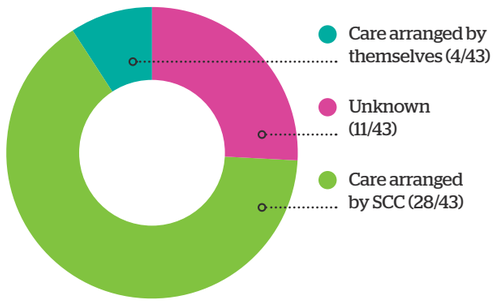
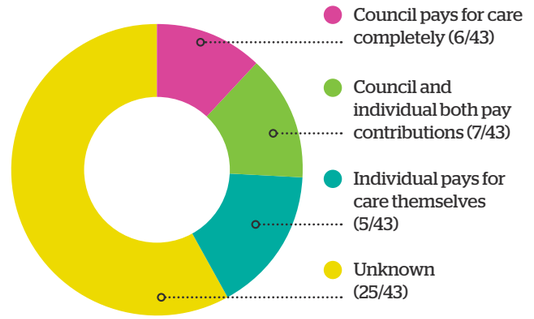


Figure 3: How home care was paid for



The number of daily care visits people had varied from one visit by one care worker to four visits by two care workers. Most people spoke of having two or three visits daily to help with tasks such as taking medication, getting washed and dressed, toileting, preparing meals and getting in and out of bed.

Please note that we changed the names of people who spoke to us in our findings to protect their identity.

How we analysed the evidence

We analysed and themed what people told us then explored how this compared with the best-practice recommendations in NICE guideline 21 'Home care: delivering personal care and practical support to older people living in their own homes' (2015) [13].

This allowed us to identify areas of contrast between people's reported experiences of home care and how person-centred home care should be planned and delivered according to NICE.

This helped in establishing key priority areas for improvement and informed our recommendations.

About NICE Guideline 21

NICE (National Institute for Health and Care Excellence) guidelines contain evidence-based recommendations on safe, effective and value-for-money practice. The guideline covers the planning and delivery of person-centred care for older people living in their own homes. It aims to promote older people's independence and to ensure safe and consistently high quality home care services. It can also be relevant to people under 65 with complex needs.

[13] https://www.nice.org.uk/guidance/ng21

Findings

We have displayed relevant points of NICE guideline 21 within our findings to illuminate the difference between people's views and experiences of home care and what people should be able to expect when accessing and using home care.

Accessing and planning home care

When people are identified as needing home care, they are given information about financial and practical support options, their care needs are assessed, and a care plan is generated which states how home care will satisfy their needs and priorities.

Care needs assessments are done well

In general, family carers were happy with how their relative's care needs assessment was carried out and with the subsequent content of care plans.

> "The assessment was done well. I felt they heard what I was saying, and they listened to me..."

Accessing financial support can be confusing & difficult

Accessing financial support was highlighted as being complicated and confusing by users of home care and family carers. They told us there was a lack of clear information and upfront advice about financial entitlements and the wider implications of care costs, and that filling in long forms could be a burden. It was suggested that people need more support through the financial assessment process.

> "We had no choice about what care company we had, and we weren't told upfront how much it was going to cost. I'd have liked this to happen."

Home care insights

John is a user of home care. He told us that the major issue with home care is the financial system around care.

He explained what he thought the problems are:

"I need supplements to help treat ME such as massages. The finance team through the council and NHS are pointing fingers at each other about who should be funding this, and the result is that no one is so my health is deteriorating.

The systems are too opaque, and information isn't always accessible. I can't read and fill in lengthy online forms etc, and people won't always tell you what you are eligible for, so you have to look it up yourself, and the guidance is difficult to follow.

I want some sort of independent officer who can provide support around finance and other terms relating to care."

Lack of choice and control

People wanted more choice and control in how financial entitlements can be spent. Users of home care told us that strict rules on spending financial support means that people can't always spend it on things that matter to them and satisfy their specific needs and priorities. Similarly, family carers felt that a lack of flexibility in their relative's care plan meant that care workers couldn't carry out tasks that were a priority for their relative as and when they mattered to people.

> "Care plans can be too rigid. They mean that the carer cannot use any initiative to do other things if that is needed."

Users of home care and family carers told us they were concerned that having too many different care workers was having an impact on the quality of care provided. This suggests that continuity of care may not have been prioritised when care was planned.

Difficulty finding the right information

When we used an internet search engine, we easily found useful factsheets on the SCC website, but struggled to find them when we started searching from the SCC website home page and using the search tool. Although we found an Easy Read version, it wasn't clear how to request information in other formats or how to begin the process of accessing home care.

NICE guidance

1.2.5 Tailor all information for different audiences and make sure it is accessible and understandable...

1.1.1 Ensure services support the aspirations, goals and priorities of each person, rather than providing a 'one-size fits all' service.

1.3.3 Ensure home care packages address social care-related quality of life and the person's wider wellbeing (for example home cleanliness and comfort) in addition to practical support. Recognise that people who use home care services often need support that goes beyond their personal care needs.

1.3.20 Ask people:which elements of home care are a priority for them, and whether they want some home care time used flexibly (that is, used for a variety of jobs according to what is needed).

1.1.4 Prioritise continuity of care by ensuring the person is supported by the same home care worker(s) so they can become familiar with them.

See recommendation 1 – page 22

Home care insights

Phil told us he was unable to use his financial allowance in a way that suited his needs and priorities.

He was unable to put some of his financial support money towards carpet cleaning that was needed due to disability-related incontinence. Yet he felt that access to cleaning was important for health and hygiene reasons.

Home care insights

June was a user of home care following a hospital stay. She told us how she stopped the care company coming because she didn't feel they were supporting her very much.

June explained that the care workers would make snacks rather than meals and would often say the things she asked them to do weren't in their remit, such as changing bed sheets. They often didn't come to get June out of bed until 11am so she started sleeping in a chair instead of her bed because it was easier.

Several weeks passed before she managed to cancel the care. She wasn't charged for care during that period, but she didn't want the care or find it useful.

Good experiences of home care

We found that home care was valued because it enables people to stay in their own home and maintain some independence. Several family carers told us they were happy with the care provided, appreciated the efforts of individual carers and understood the challenges care workers face. We heard examples of care workers going 'the extra mile' and some family carers suggested better pay for care workers and a 'carer awards' event to recognise the efforts of individual workers.

> "If home care didn't exist my parents would be in a home. I'm happy with the service they receive."

Users of home care and family carers described good experiences of care which involved care workers getting to know the person using home care and them getting on well together. Good communication and feeling listened to was characteristic of family carers' positive experiences.

> "One time a carer waited with my sister- in-law while she waited for an ambulance. This was really good and reassured my mum."

These findings suggest that building a good relationship between a person and their home care workers plays an important role in influencing how satisfied people are with their care. The right conditions are needed to enable these relationships to form (See NICE guidance below).

NICE guidance

1.1.4 Prioritise continuity of care by ensuring the person is supported by the same home care worker(s) so they can become familiar with them.

1.1.5 Ensure there is a transparent process for 'matching' care workers to people, taking into account:

- the person's care and support needs, and
- the care workers' skills, and
- if possible and appropriate, both parties' interests and preferences.

Home care insights

Emily explained how home care enables her to stay in her own home and keep enjoying the things that give her pleasure in life.

"Alzheimer's is a cruel thing. It is taking any sense I had. It has changed my outlook on life. I accepted that I was going to finish up in a home somewhere, I just hope it is a warm and caring place. With home care I'm able to stay at home and can see the gardens and stay near my neighbour who I like."

Home care insights

Linda told us how her mum is thriving since moving into an extra care scheme flat, and that she is happy knowing her mum is in safe hands.

"There is a café right below her flat where the staff know her and her condition, and this extra stimulation is really helping. She has two visits a day from carers but can increase this as soon as she feels the need to. The carers have got to know her really well and they know how to help."

Key concerns

Despite some people reporting good experiences of home care, they were not always satisfied with how well the care provided matched people's needs, priorities and preferences, or accounted for these changing over time. People's experiences highlighted a lack of person-centred care which contrasted with the best-practice recommended in the NICE guidance in six main areas.

Late, missed and inappropriate timing of care visits

Lateness and missed visits were key concerns. Users of home care said the times of visits were often inappropriate and didn't match their needs and preferences, for example with the timing of meals. Family carers were particularly concerned about the health implications of people being taken to bed too early and helped out of bed too late the next day.

> "They arrived today at 11am for one visit and 4pm for a second visit. They say that's the only visits they're making today, which means she either has to go to bed at 4pm or somehow manage herself."

Rushed care visits

There was a perception among family carers that care workers don't have enough time during visits which can lead to a rushed experience of care and tasks being missed or not done properly. This may mean that family have to do the missed tasks. People thought longer care visits were needed, however it was also acknowledged that workers' travel time isn't always used efficiently.

> "One time a new carer came, and she was really fast, she washed mum in 10 minutes. She was really proud of herself, but I don't feel it was a good experience for my mum."

See recommendation 2 – page 22

Home care insights

Carol told us how her GP spoke to her care provider about the timing of her visits.

Carol is diabetic and injects insulin at meal times. She said her meals should be regular to help control her blood glucose levels. Carol's carers would often come at 10am for breakfast, 11:30am for lunch and 4pm for her evening meal. She said this was very unhelpful for managing her diabetes.

Eventually her GP contacted the company to say that the visits were not at an appropriate time. Carol said the care company's response was that her diabetes was not their concern. They only had to make sure she had her meals and her medication, and because she could inject her insulin there was no need to change the visit times.

NICE guidance

1.1.3 Ensure people using home care services and their carers are treated with empathy, courtesy, respect and in a dignified way by providing a reliable service that people and their carers can trust.

1.4.10 Home care workers should avoid missing visits. They should be aware that missing visits can have serious implications for people's health or wellbeing.

1.4.13 Put contingency plans into action when visits are missed or late.

1.4.1 Ensure service contracts allow home care workers enough time to provide a good quality service, including enough time to talk to the person and their carer, and to have sufficient travel time between appointments. They should ensure that workers have time to do their job without being rushed or compromising the dignity or wellbeing of the person who uses services.

Lack of continuity of care

Users of home care and family carers said that there were too many care workers involved in delivering one person's care. They wanted fewer workers to provide an individual's care because they felt that having multiple workers meant that workers didn't get to know the person or their care plan.

Family carers said they disliked having lots of people they didn't know in their home and that users of home care found it distressing. They pointed to staff leaving and changing care companies as factors disrupting continuity of care.

> "One of the most distressing things for him was the fact that different carers would come every day. We once counted 17 different people across 14 days. None of them got to know his care plan very well, and he was distressed at strangers coming in every day."

See recommendation 3 – page 23

Care plans were not followed or reviewed regularly

Several family carers told us that care workers were unfamiliar with care plans and that care plans weren't reviewed regularly enough. Family carers stressed the importance of regular reviews taking place and said they would like care workers to read and follow care plans. It is not clear why care plans were not being read, but this could be due to care workers not having enough dedicated time in their work schedule to allow for this.

> "Carers don't read the care plan. Only one carer has ever asked for the care plan and they were on their second week so were still doing things by the book."

See recommendation 4 – page 23

NICE guidance

1.4.7 Ensure continuity of care so that the person knows the home care workers and the workers are familiar with how that person likes support to be given, and can readily identify and respond to risks or concerns by:

- introducing people to new home care workers, and
- building teams of workers around a person and their carer, and
- informing people in advance if staff will be changed and explaining why

1.3.24 Ensure all people involved in providing care and support have access to the home care plan and to the care diary. Encourage them to read and contribute to both documents as appropriate.

1.3.25 Undertake an initial review of the home care plan within 6 weeks, then review regularly, at least annually.

Home care insights

Marie has used home care for some time. She explained the issues she had encountered in relation care plan reviews.

"When they reviewed my care plan, they wanted to have a meeting with just me, the social worker and advocate from Disability Sheffield but I wanted [other professionals] included. I had to fight to get them involved.

The social worker then wanted to go away and write the care plan for me, but I wanted to be involved.

I have now not had a review for two and a half years. You're meant to have a yearly review..."

Lack of opportunities for family carers to give feedback and difficulty making complaints

Family carers would like to be asked for feedback and for this to be followed up, but there is a lack of consistency in care providers asking for regular feedback. This may mean that they feel making a complaint is the only way to give negative feedback and providers may be less aware of what is working well.

People told us that making a complaint or raising a concern with care providers can be difficult and frustrating because of a lack of information about how to complain, feeling scared about sharing concerns and difficulty contacting providers. Additionally, some family carers reported that providers had not responded to their attempts to complain and making a complaint didn't always lead to a satisfactory change. Improvements suggested by family carers were:

- being able to complain to an independent person who doesn't work for SCC or the home care provider
- having a forum where people can give feedback and check whether other people are having similar experiences

> "After I spoke to the CQC they told me to ask the care agency to send me their complaints procedure. I have done this three times now and they still haven't sent it to me. I'm not going to bother asking again."

Making complaints to SCC can be difficult by phone because it involves using the main enquiries number and there isn't a designated option in the main menu. Complaints via the SCC website involves several stages of entering personal details before feedback or complaints can be detailed, and there is no option to remain anonymous.

When we briefly checked the websites of 16 home care providers on SCC's Recommended Provider List, we couldn't find information about how to make a complaint on any of the websites. This suggests the information was not there or it is not easy to find.

See recommendation 5 – page 24

Home care insights

Home care user Beth told us how she didn't give up when her situation didn't change after making a complaint.

"Lots of people are scared about rocking the boat so won't say anything. Friends just go along with the system because they are scared they will lose their support.

My local complaint was upheld but nothing happened so I went to local government and adult social care ombudsman, as well as the parliamentary and health ombudsman. They were really concerned and helpful and they upheld my complaint.

I partially took out the case because of the others who can't communicate their concerns."

NICE guidance

1.1.3 Ensure people using home care services and their carers are treated with empathy, courtesy, respect and in a dignified way by...regularly seeking feedback (both positive and negative) about the quality and suitability of care from people using the service, including those who don't have a carer or advocate.

1.4.5 Ensure there is a complaints procedure in place. Tell people about how they can make a complaint either in writing or in person.

1.4.6. Make the complaints procedure available on your website and in other ways appropriate to people using the service and their carers. Give information about escalating complaints (to the commissioning body and Ombudsman) or ensure this information is readily available.

A perception that there is a lack of training, supervision and monitoring of home care workers, and no experience or qualifications are needed to do the job

Family carers reported having a lack of knowledge about how care workers had been recruited and trained, and it was perceived that no relevant experience or qualifications are needed to be a care worker. They expressed a need for more training and supervision of care workers and increased monitoring of the care provided, although it is unclear how much knowledge they had about what already happens in these areas.

It was also acknowledged that a lot of good practice already takes place and that care workers should come together to share their learning.

> "It needs to be clear how the providers are vetting and employing staff. It needs to be possible to find out who the carers are."

Family carers suggested that training was needed to improve care workers' communication skills during care, especially when caring for people with dementia. They also wanted to see more general dementia training and specialist training in other areas, for example, physical disabilities, mental health and long-term health conditions such as diabetes.

> "It is no good asking what they need from the shops because they don't know. My [relative] always says [they] want trifle, but this means the fridge is just full of trifle."

See recommendation 6 – page 24

NICE guidance

1.7.1 Have a transparent and fair and recruitment and selection process...

1.7.11 Supervise workers in a timely, accessible and flexible way, at least every 3 months and ensure an agreed written record of supervision is given to the worker.

1.7.12 Observe workers' practice regularly, at least every 3 months, and identify their strengths and development needs.

1.7.4 Ensure home care workers are able to recognise and respond to: common conditions, such as dementia, diabetes, mental health and neurological conditions, physical and learning disabilities and sensory loss (see also NICE guideline 1.3.8.)

Home care insights

Susan felt her relative would benefit if his care workers spoke to him differently.

"First one [carer] said 'Ey up chuff nut'. Think she was trying to be friendly, but not a good start....

Ian can't speak now and can't walk. Still treat him as intelligent. Don't treat him as very childlike, singing nursery rhymes to him!

Presume who you are looking after has had a life before. They see you at the worst time in your life. For training that is important; how to speak to people."

Spotlight on communication

Communication is a wide-ranging topic which isn't fully covered within NICE guideline 21. We decided to shine a light on communication because it was a consistent feature of negative experiences of home care and mattered to people in a variety of ways.

As stated earlier in this report, some family carers thought that care workers could improve on how they communicate with users of home care and found contacting providers difficult. Having no or little contact with home care providers other than through care workers could be problematic because people may need to discuss an aspect of organising care that care workers don't deal with, or they might want to report an issue with the conduct of a care worker.

Family carers were dissatisfied with communication in two other main ways:

Poor communication between services

In a discussion at a focus group, the vast majority of family carers agreed that the biggest issue with social care was communication between services. People said the system was very disjointed, especially between health and social care. They called for the system to be joined up more efficiently so they didn't have to repeat information to different services. This echoes what the CQC found when they reviewed the health and social care system in Sheffield, in that people reported 'a fragmented approach to service provision' which meant they had to tell their story multiple times [14].

Not being consulted or involved

Some family carers felt they should have been more involved in decisions about their relative's care which also affected them. For example, a family carer told us they had been asked to look after their relative in their home without being consulted, and another person was advised to take early retirement to care for their parents.

During a focus group we learnt that family carers didn't feel they had the chance to have any input during the process of applying for Personal Independence Payment (PIP), despite feeling they had more knowledge of their relative's needs than the decision-making panel. Furthermore, some family carers reported that home care providers and care workers were not pro-active in asking for and using their knowledge of their relative's needs. This mirrors findings at a national level; the CQC identified a lack of involvement of family or carers as a key concern in relation to the care and welfare of people using home care in their report published in 2013 [15].

> "When I tried to phone, they always say that the person I want to speak to is unavailable. There is no response to emails. Even if you go to the top no one responds."

> "One is so bouncy and full of life but talks to her as if she's a 90-year-old frail lady. I can see the look on her face. The girl is so nice I haven't got the heart to ask her to tone it down."

> "Carers don't always listen to family carers even though they know the needs of the person being cared for."

[14] www.cqc.org.uk/sites/default/files/20180522_local_system_review_sheffield.pdf

[15] www.cqc.org.uk/sites/default/files/documents/9331-cqc-home_care_report-web_0.pdf

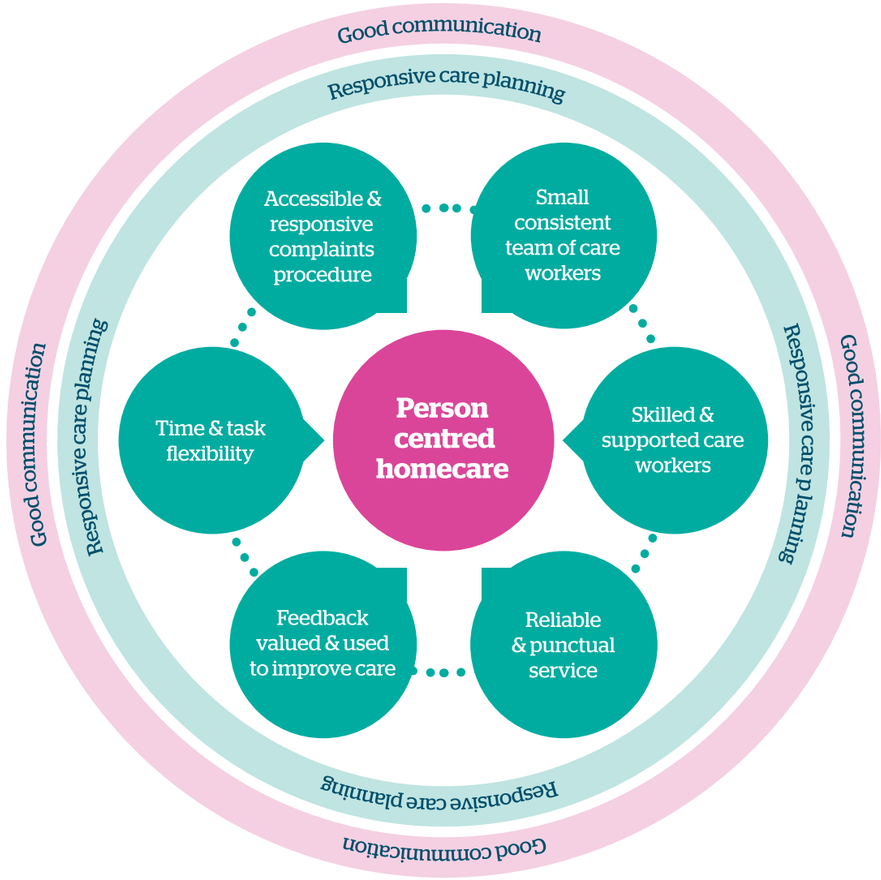
Conclusion

Home care aims to help people to live their life the way they want to and should go beyond addressing health and personal care needs. It should also help people to have a better quality of life. Care that centres around people's needs and wishes rather than those of services, is central to people's satisfaction with their own lives and with home care.

Person-centred care has the potential to be a game changer; when care is not person-centred people tend to be dissatisfied and their health and wellbeing may be adversely affected. People told us how important it is that care workers built good relationships with users of home care, and this facilitates person-centred care, but the right conditions are needed for this to happen.

We have summarised our findings to show what person-centred home care means to local people in Figure 4 below. This model accounts for the views and experiences of users of home care and family carers and reflects some of the findings from our survey in 2017.

Figure 4: Person-centred home care



NICE guideline 21 suggests that providing person-centred care helps to deliver a better quality of life for people using home care and family carers and can mean greater job satisfaction for the workforce as they can establish and develop relationships with people and support good outcomes for them.

Recommendations

Healthwatch Sheffield recommends that commissioners and providers of home care services consider the recommendations below, including the specific suggestions about how to make improvements.

1. Improve experiences of accessing & spending financial support

Sheffield City Council (SCC) to work with people who use home care and their family carers to:

a. Review the suitability and accessibility of information about the financial aspects of home care, how easily it can be found on the SCC website (following NICE guidance 1.2.5 and 1.2.6), and the timing of information giving.

b. Identify sources of good quality information from other organisations which people can be signposted to and consider adding links to this information on the SCC website.

c. Establish how financial assessment forms can be improved and what support people would find useful in terms of form filling and throughout the financial assessment process. Include a review of current support available and discussions around the possibility of a Financial Support Officer who is independent from SCC.

d. Explore ways of increasing flexibility in how financial support can be spent to better suit people's needs and priorities.

2. Improve experience and reduce risk in relation to the timing & length of care visits

Commissioners to consider the following changes in relation to home care service contracts and monitoring arrangements:

a. Ask home care providers to report how many people who live alone, or lack capacity have been affected by late and missed visits. Additionally, consider setting a limit for the percentage of late visits experienced by one person within a set period, with home care providers reporting the number of times this is breached.

b. Work with users of home care and family carers to generate clearer definitions within home care service contracts of the circumstances which allow care visits to last less than 30 minutes. The revised criteria should allow for increased consideration of someone's individual situation and needs. For example, considering whether someone is isolated and the visit also helps to addresses their social needs.

c. Work with a home care provider to trial offering people the option of using a set amount of time flexibly each week/month without the need for approval from commissioners. This should be offered when care is planned or reviewed and the impact on users and providers should be assessed.

d. At the care planning stage, home care providers to consult with users of home care, relevant health care professionals, and when appropriate their family carers, to identify acceptable personalised boundaries for the spacing out of visits which involve giving meals and assistance going to bed at night and getting up the next day.

e. Ask users of home care and their family carers about quality of care, including the occurrence and handling of late and missed visits before providers can be contracted to take on a significant number of new clients.

3. Address a lack of continuity of care

a. Commissioners and home care providers to agree to set a limit on the number of care workers to be involved in one person's care and for this to be monitored. The limit should account for the number of care visits people receive weekly, and the nature of their care needs.

b. Home care providers to introduce all care workers to people before their first care visit together. Introductory phone conversations should be attempted when it is not possible in person and this fits with the user of home care's communication needs. The use of a 'Meet your team' document should be considered as a way of familiarising people with care workers that are or might be involved in their care. This could include photos, names and brief profiles of care workers and should be kept up to date.

4. Encourage care plans to be read & a responsive approach to reviews

a. Commissioners to work with home care providers to devise a way to monitor how often care plans are read and reviewed.

b. Commissioners to consider specifying a set of triggers for a care plan review at any point in time. These are to be informed by clinical opinion and insight from users of home care, family carers and care workers.

5. Improve the experience of making a complaint & create conditions where feedback about services is valued and used

a. Home care service contracts to require home care providers to have a named complaints lead and target response times for formal and informal complaints within their complaints policy and procedure. Users of home care and family carers could also be asked about complaints satisfaction through the SCC 'Customer Voice' surveys.

b. SCC to work with users of services and family carers to review and improve the process of making a complaint and sharing feedback through the SCC website and main enquiries phone line.

c. Commissioners and home care providers to explore how to effectively gather and use feedback from users of home care and family carers and make the most of opportunities to address negative feedback so that complaints are avoided.

d. Home care providers to consider holding regular 'drop-in' days or open meetings for users of home care and family carers to give and discuss feedback in person.

6. Enable a more consistent, joined up approach to workforce training & improve the credibility of care workers & how they are recruited

a. Commissioners to support home care providers to embed the practice of involving users of home care and family carers in the recruitment and training of care workers.

b. To provide reassurance to users of home care and family carers, home care providers should inform people of their monitoring, observation, supervision and training practices through their welcome packs and websites. Details of the qualifications and experience of individual care workers should be made available to the people they care for and their family carers.

c. Sheffield Clinical Commissioning Group (CCG) to mirror the approach taken with care homes by holding a home care conference for care workers and managers, to promote sharing of best practice and allow sector-wide training needs to be identified and addressed. To encourage a joined-up approach to care, efforts should be made to include other professionals at the conference and at existing home care forums. For example, GPs, social workers and others involved in the care of people who use home care.

d. Sheffield CCG to consider inviting care workers to take part in free education sessions, such as Protected Learning Initiatives to help strengthen their knowledge and skills in specific areas.

Next steps

Healthwatch Sheffield invites Sheffield City Council and Sheffield Clinical Commissioning Group (CCG) to respond to our recommendations (see pages 22–23) and fill in the Recommendation Response Form **(See Appendix C)**. We will publish their responses and monitor progress.

In response to family carers telling us they would like to share experiences about home care with an independent body, have a forum where people can give feedback about providers and check other people's experiences, we will take the following action:

- **Make efforts to let more people know that they can share feedback about home care with us and that we can provide information about making a complaint and signpost them to further support.**
- **Actively promote our online feedback centre as a way of sharing feedback about home care providers and finding out other people's views of home care services.**
- **Continue to advertise opportunities for people to share their views about home care with commissioners and relevant local and national organisations.**

Our work does not tell us much about the views and experiences of younger people, those from BAME communities and people who use personal assistants to support daily living. We aim to address this in the future.

Listening to what people think about accessing and using home care will always be an important part of our work.

Appendices

Appendix A:
Interview and focus group questions

Q1: What sort of help with daily living do you receive?

Q2: What is your experience of help with daily living?

Q3: Can you describe the process of accessing home care?

Q4: To what extent do you feel your home care service helps to enable your independence at home?

Q5: What could be improved about the help with daily living you receive?

Q6: What are your expectations of help with daily living going forward?

Q7: Do you have any long-term health conditions?

Q8: Is there anything else you would like to tell us about?

Appendix B:
BAME experiences and views of home care

In August 2018 we spoke to two BAME workers who work for different community organisations that help people to improve their health and wellbeing. They gave us some insight into BAME experiences and views of home care. This is what they told us:

- There is a need for home care but there are language and cultural barriers preventing Chinese people from accessing care at home agencies. Someone that speaks Chinese is needed.
- My organisation signposts people to allowances but they don't get a lot and have to wait a long time before the council do an assessment. Often the council turn up to do an assessment but then realise there is a language barrier so have to return with an interpreter.
- If my organisation referred people for assessment, they may be able to provide an interpreter for the assessment.
- One person was having 4 – 6 visits per day from a care company but visits were too short (around 10 minutes) so they got very frustrated and stopped using the company.
- When people struggle to access appropriate home care they struggle or rely on family carers. There is no way for them to have a break and it affects their quality of life and wellbeing.
- People end up in care homes or in and out of hospital due to a lack of appropriate home care. Some people try but find it difficult. There can be different carers every day and they can't always communicate, and the lengths of the visits aren't appropriate. The home care company need to support communication and provide emotional support.
- Many people from Black African, Chinese and Asian communities don't know about care assessments and benefits. We refer them to the Carers Centre.
- Some people wouldn't access home care for cultural reasons, they would question why people from outside were coming in to help, but it does depend on the individual situation.
- Younger people are more likely to accept help, I had 4 weeks of daily help with cooking and cleaning, but the older generation could be more likely to say no to help or not ask.
- Home Instead have a diverse workforce and so some workers can speak other languages.
- Word of mouth and the Sheffield Carers Centre is how people would find out about home care and support.

Appendix C:
Recommendation Response Form

Name of organisation:

Date:

Recommendation	Response (including actions)	People leading on actions	Date of completion

healthwatch Sheffield

The Circle
33 Rockingham Lane
Sheffield S1 4FW

Telephone: (0114) 253 6688
Email: info@healthwatchsheffield.co.uk

Text: 0741 524 9657
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Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee 20 March 2019

Report of: Phil Holmes
Director of Adult Services

Subject: Update on Adult Social Care Performance

Author of Report: Phil Holmes (Director of Adult Services)
(Liz Tooke - Performance and Risk Officer, Business Strategy)

Summary:

This agenda item provides a summary for scrutiny members of adult social care performance in Sheffield. The last time this topic was covered by Scrutiny was January 2018.

The report sets out:

- How adult social care is performing in Sheffield across a number of key measures
- Further updates on improvement activity since the last report
- What we will be doing over the next year to improve.

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	**x**
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	

The Scrutiny Committee is being asked to:

The Scrutiny Committee is asked to review the information provided in the presentation and appended documents and provide comments on it and identify any priorities for improvement.

Background Papers:

- Adult Social Care Outcomes Framework Benchmarking overview (2017/18)
- Making our Conversations Count: Sheffield's Local Account for 2018 *(draft)* - ***Note – the appended is draft and will be considered by Cabinet on 20 March.***

Category of Report: OPEN

Report of the Director of Adult Services
Update on Adult Social Care Performance

1. Introduction

1.1 This agenda item provides a summary for the Scrutiny Committee of Adult Social Care performance in Sheffield. The last time this topic was covered by Scrutiny was January 2018.

1.2 Adult Social Care supports people over the age of 18 to remain independent, safe and well and to get on with living the kind of life they want to live. This includes care and support for adults, older people, adults with a learning disability, adults with autism and adults with a mental health condition. We also provide support for carers and for families with a disabled young person (as part of their journey into adulthood).

1.3 Adult Social Care sits within the People Portfolio, which is an integrated service supporting adults, children, young people, families, carers and communities with three key areas of focus:

- Early intervention and **prevention**, enabling the people we work with to live successfully and safely. Our strategy has been and continues to be delivery of the right level of support by the right people at the right time.
- **High-quality**, diverse and robust support for people, building better lives for them and making more equitable use of our limited resources.
- Developing our **workforce**, making sure we have the right-sized staff groups with the right values and behaviours, enabled by effective systems and support to develop their skills**.**

1.4 Our ambition is for an 'All Age' approach to disability related support across the portfolio which supports people from childhood through to older age in a consistent and seamless way, and without barriers or difficult transition points. We are ambitious for all children, young people, adults of working age and older adults with disabilities and will work with them, their families/ carers and their communities to help them achieve their full potential.

1.5 Our vision for Adult Social Care is underpinned by our 'Conversations Count' approach. Conversations Count is about listening to people and understanding what matters to them, and what a good life looks like to them and their family. Instead of assessing needs, ticking boxes on forms and putting in 'one-size fits all' services, it's about seeing people as individuals and as experts in their own lives, acknowledging their strengths and what they want to achieve, and working with them and others to organise the support they need to live the best life possible.

1.6 At the heart of the approach are the three distinct conversations we use to understand what really matters to people and families, what needs to happen next for them, and how we can be most useful.

- We start all our conversations by listening hard to people and their families and working with them to make connections and build relationships to help them get on with their life independently
- If people need some urgent help, we stick with them to make sure change happens quickly and help them regain stability and control in their life. We don't plan any long-term support until the immediate crisis is over, when we can all think more clearly about what support, if any, they'll need
- Where people do need longer-term support, we work with them to understand what a good life looks like to them and their families, and help them to organise the support they need to achieve this

1.7 We're continuing to develop our Conversations Count approach, and we're already hearing some extremely positive stories about the difference the approach has made. We've included a selection of our stories as Appendix 3.

1.8 While we're making some great progress, we're also aware of the challenges we face. The scale of the financial challenge facing adult social care nationally and locally is significant. As well as continuing Government cuts in funding, we have faced significant increases in demand for support. In Sheffield, the Council's financial pressures can broadly be defined in two categories:

- Rising provider costs, predominantly the costs associated with the crucial investment in staff wages to meet the National Minimum Wage
- An increasing demand for care and support services resulting from increasing numbers of people requiring higher levels of support in the community for longer. A significant element of these demand pressures is associated with progress in supporting increasing numbers of people out of hospital faster.

1.9 The strategic intention of Adult Social Care in Sheffield is to support a shift into prevention and well-being. This means moving away from a crisis intervention model and instead increasing focus on access to universal services and early help and preventative support. This will improve outcomes for local people and promote better usage of adult social care resources. The Conversations Count approach supports this shift whilst reducing the time spent on processes and systems in order that staff are able to respond more quickly to more people.

1.10 In the context of the situation described above, this report sets out:

- How adult social care is performing in Sheffield across a number of key measures
- Further updates on improvement activity since the last report
- What we will be doing over the next year to improve.

2 Adult Social Care Performance in Sheffield (key measures)

2.1 Headlines from our 2017/18 Adult Social Care Outcomes Framework (ASCOF) results are set out below. ASCOF measures how well care and support services achieve the outcomes that matter most to people. Some of the measures are based on a survey of people accessing adult

social care services in Sheffield. The measures are grouped into four domains which are typically reviewed in terms of movement over time. Data is provided at council, regional and national level. For some measures high scores signify good performance, and for others low scores signify good performance.

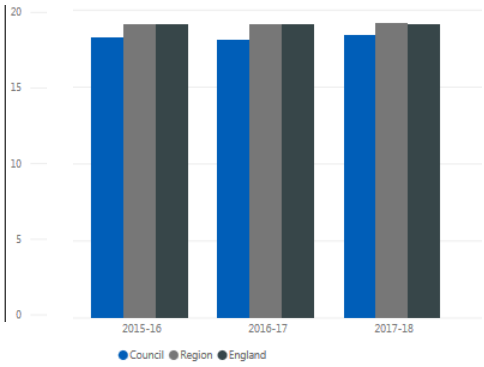
2.2 *Theme 1: ensuring quality of life for people with care and support needs* - **Social care quality of life score**

- This measure is an average quality of life score based on responses to the Adult Social Care Survey. It gives an overarching view of the quality of life of service users of social care. Scores are out of a maximum score of 24.

1A: Social care-related quality of life score

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	18.4	19.2	19.1
2016-17	18.1	19.1	19.1
2015-16	18.2	19.1	19.1



- There has been an increase in self-reported quality of life over 2017-18. This brings the Council closer to both the regional and national score but there is still more to be done.

- In 2017/18, the working age quality of life score in Sheffield (score: 18.6) was higher than the score for people aged 65+ (score: 18.1). This trend is reflected in other local authorities as well.

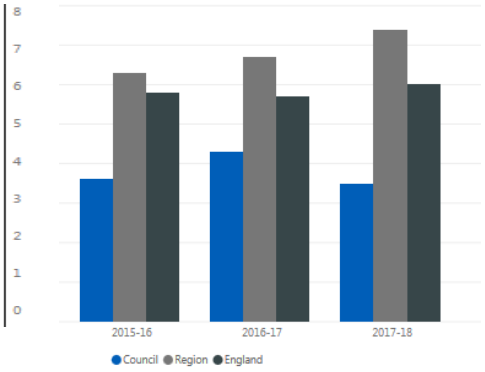
- We expect that the roll out of our "Conversations Count" approach across teams will form the basis for further improvement.

2.3 *Theme 1: ensuring quality of life for people with care and support needs* - **Proportion of adults with learning disabilities in paid employment**

1E: The proportion of adults with a learning disability in paid employment

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	3.5	7.4	6.0
2016-17	4.3	6.7	5.7
2015-16	3.6	6.3	5.8



- The percentage of adults with a learning disability in paid employment rose in 2016-17 but dropped back again in 2017-18. We have seen an improvement during 2018/19 and present performance is at 4.3%.

- Some caution needs to be exercised about regional and national comparison because Sheffield is one of the only places still to maintain a Case Register for people with a Learning Disability and supports a comparatively larger population than most other areas.

- Nevertheless there is much more that can be done to help people with a learning disability access employment. For example, in June 2018, we brought prevention work and occupational therapy together to provide time-limited support to help people to gain/regain confidence and skills, to build on strengths and to connect with community assets. One of the benefits of this project is that it will support people to actively contribute to their local community, through volunteering, paid employment, and sharing their skills and knowledge with others.

- We are also seeking to increase opportunities through work with Learning and Skills colleagues, in particular to develop opportunities for young people with disabilities preparing for adulthood.

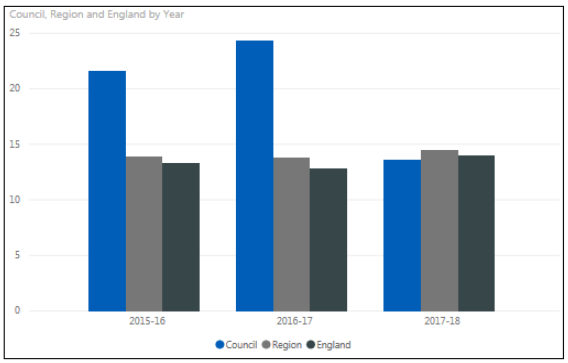
2.4 *Theme 2: Delaying and reducing the need for care and support:* **Permanent admissions to residential and nursing care homes, per 100,000 population - younger adults (aged 18-64)**

- 2017/18 showed a significant improvement from the previous two years.

2A1: Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population | Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	13.6	14.5	14.0
2016-17	24.3	13.8	12.8
2015-16	21.6	13.9	13.3



- The main area of improvement between 2016/17 and 2017/18 for this age group was in Mental Health admissions - one of the reasons for the higher admission rate in 2016/17 was due to a cohort of people moving from long stay hospital to residential care during 2016/17. However, the downward trend for Mental Health has continued in 2018/19. In quarter 3 2018/19 Mental Health admissions make up about a quarter of all admissions. The ongoing reduction in admissions is due to more rigorous authorisation procedures and a strategic direction which is about offering more accessible alternatives to residential care that increase both inclusion and independence for adults aged 16-64.

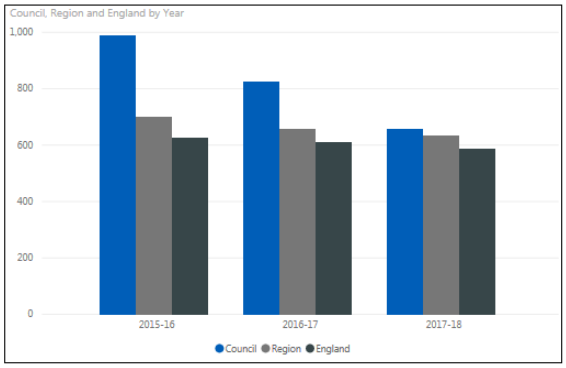
2.5 **Theme 2: Delaying and reducing the need for care and support:** *Permanent admissions to residential and nursing care homes, per 100,000 population - older adults (aged 65+)*

- Year end data shows a significant improvement from 2015/16 to 2017/18.

2A2: Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	657.4	632.6	585.6
2016-17	824.1	658.4	610.7
2015-16	987.9	699.5	628.2



- A key factor in this improvement is that we now have less admission direct from hospital to care homes as we have improved access to community support. This enables a greater proportion of older people to return home from hospital in line with their wishes.

- Care home admissions for older people are currently lower than the same time last year. Comparison with regional neighbours suggests the potential for further improvement, and reducing care home admissions continues to be an area of focus for the service.

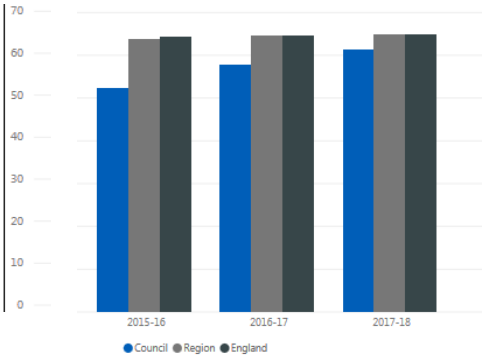
2.6 **Theme 3: ensuring that people have a positive experience of care and support**: *Overall satisfaction of people who use services with their care and support*

- Our scores have significantly improved since 2016 (the trend for 2017 regionally/all England was to stay the same). Therefore we are now closer to the regional and national average but have more work to do to achieve this.

3A: Overall satisfaction of people who use services with their care and support

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	61.4	65.0	65.0
2016-17	57.9	64.6	64.7
2015-16	52.3	63.8	64.4

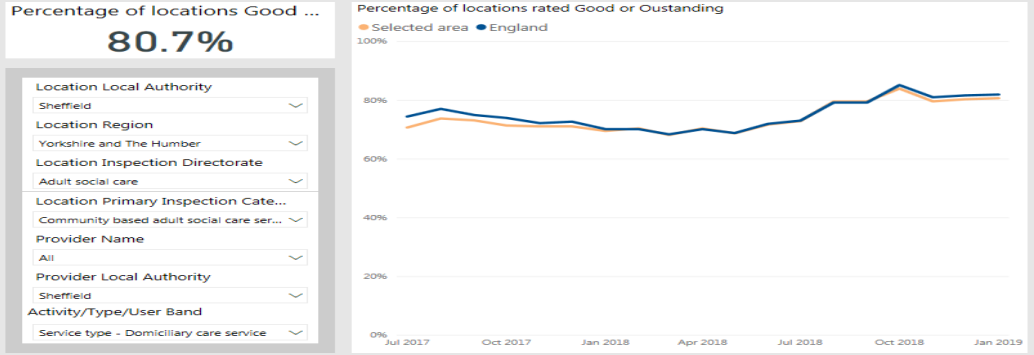


- Working age people in Sheffield (66.6% satisfied) are more likely to express satisfaction than people aged 65+ (57.2% satisfied). This trend is reflected in other local authorities as well.

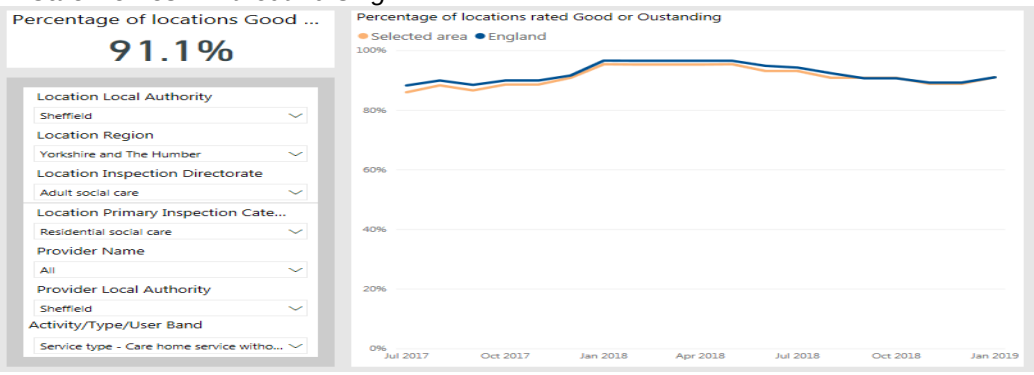
- The Council has significantly invested in Home Care, Supported Living and Care Home provision over the last three years and this is likely to be the biggest factor in our improvement.

- The graphs below show the percentage of care locations which were rated 'good' or 'outstanding' by CQC in Sheffield compared to All England rates.

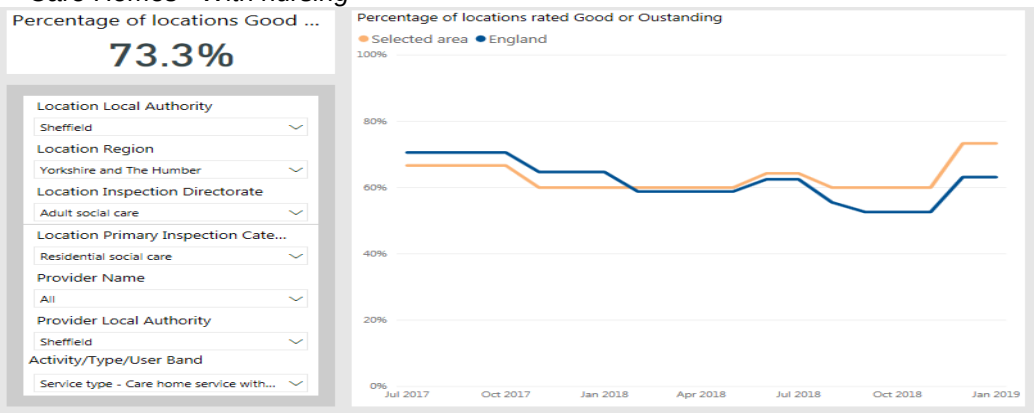
Home care



Care Homes - *Without nursing*



Care Homes - *With nursing*



- Ratings for home care and care homes (without nursing) are now close to national averages. Ratings for care homes with nursing are above the national average.

- Council staff working on Contracting and Quality Assurance have focussed their efforts on improving the quality of commissioned home support in the city, including regular supportive monitoring visits, contract compliance, CQC focussed workshops, sharing best practice, etc. This work has delivered positive change, including in an improvement in ratings for commissioned support.

- Staff have also strengthened relationships since 2017 with residential and nursing care homes, through scheduling more frequent monitoring visits. This has resulted in Care Homes being more likely to respond

positively to the team's recommendations, and to contact the team if they are experiencing difficulties. Feedback from Care Home managers has shown that the Council's support has been valued and has helped CQC ratings (for example through early identification of issues, sharing good practice, and support to make improvements).

- Latest data on complaints (quarter 3 2018/19) shows a 15% reduction in the number of complaint investigations compared with numbers seen in the previous year.

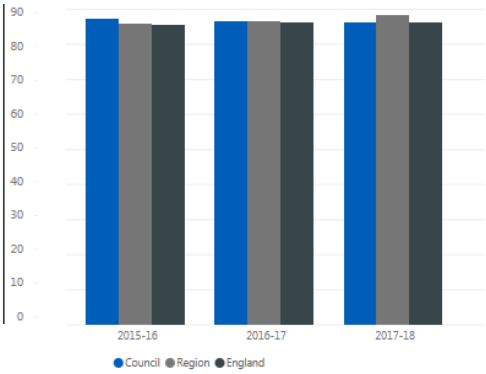
2.7 *Theme 4: Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm* - **The proportion of people who use services who say that services have made them feel safe and secure**

- We are slightly better than the average for England, but slightly below the regional average. Our score has remained similar over the last 3 years.

4B: The proportion of people who use services who say that those services have made them feel safe

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	86.4	88.3	86.3
2016-17	86.6	86.6	86.4
2015-16	87.2	85.9	85.4



2.8 Full details of how we scored against the Adult Social Care Outcomes Framework in 2017/18, and how we benchmark with others, are included in **appendix 2**.

3. Further updates on improvement actions since last report

3.1 We have arranged home care services for many more people. We know we provide home care for more people compared to most other councils in the area, helping people to stay in their own home so they don't have to move into a care home.

3.2 We have helped more people return home quickly after a stay in hospital. We work closely with hospitals to make sure people can return home as soon as they are well enough. 'Delayed Transfers of Care' (DTOC) performance has shown month-on-month improvement since October 2017 and in early February 2018 continues to show significant improvement in terms of delayed patient and delayed day volumes, maintaining improvement over the last 12 months. Slight increases have continued to be effectively managed to ensure lower numbers than the same period last year overall. However there is still more to be done to work with NHS colleagues and improve performance.

3.3 Our new Conversations Count approach has started to improve the time taken to understand the support people need and then plan and arrange the support. Our processes and the way our services worked needed to

change to allow us to have better conversations at an earlier point in time. On average it is now taking us:

- 14 days to understand what Adult Social Care support is required.
- 13 days to then put in place ongoing Adult Social Care support once it has been determined that the person needs it.

3.4 These changes are making a real difference, for our staff and the people we support. Staff have been telling us they feel free to listen to people, and to work together on building a good life. People we support say it makes such a difference to be able to talk to a social care worker about their life, rather than answering questions as staff fill-in each box on a form.

3.5 Over the last year we have improved our performance regarding the percentage *% of people who have had an annual Conversation reviewing their longer-term Adult Social Care support* (currently at 43%, from 37% this time last year). However there is still significant improvement required, as we move more towards timely and planned (as opposed to unplanned or reactive) reviews. We benchmark poorly for reviews compared to regional counterparts, but we are not alone in finding this challenging - our performance is very similar to Leeds, North Yorkshire, and Wakefield. Going forward, performance monitoring information on this measure will be available for teams at locality level, to help teams manage performance and any variation between teams.

3.6 Appended to the report is ***Making our Conversations Count: Sheffield's Local Account for 2018 (draft)*****.** Sheffield's 2018 Local Account is a public document which provides an overview on Adult Social Care performance. It provides background information on the service, highlights activity over the last year, and what we plan in the year ahead. ***Note – the appended version is draft and will be considered by Cabinet on 20 March.***

4 What we will be doing over the next year to improve

4.1 For the 2018-2020 improvement plan the focus of our work will be structured under five themes:

- Increasing the shift to prevention. The strategic intention of Adult Social Care in Sheffield is to support a shift into prevention and well-being. This means that we are increasingly moving our focus to early help and preventative support. This approach is improving outcomes for local people and promoting better usage of adult social care resources.
- Increasing the independence and inclusion of adults of working age including helping adults and young people as they transition to adulthood to access social and community activities, employment and universal services, providing better outcomes for individuals and for their communities.
- Developing a sustainable provider market. 2019/20 will see a renewed focus on the Council's relationship with external contractors as well as a strong emphasis upon helping our in-house services achieve their full potential.

- Increasing the proportion of adults who are able to live at home. Better preventative support means that people are able to live in their own homes and remain active in their communities for longer. We continue to improve our joint working with NHS colleagues to ensure people are able to able to return home from hospital in a timely way, and we continue to ensure best practice is in place to avoid care home admissions as a default option.
- Fairer charging. A range of initiatives aimed at supporting people to pay their contributions for care and avoid accruing debt to the Council will continue into 2019/20. In 2019/20 the Council will also introduce an in-house Deputyship Service which will be able to provide vulnerable people with quicker access to Deputies at a lower cost than is available currently.

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

5.1 Social care affects the lives of many Sheffield citizens and their families. In the year 1 April 2017 to 31 March 2018:

- More than 11,000 adults received an adult social care service.
- We spent over £187 million on providing adult social care services.

5.2 Clearly, therefore, adult social care's performance is absolutely critical for a significant number of Sheffield people and their family, friends, carers and wider community.

5.3 In addition, adult social care is facing a significant increase in demand for support, anticipating a 10% rise between 2012 and 2020 in people aged over 65 with long-term limiting health needs. Viewed in the context of significant budgetary restraints, adult social care needs to be as effective and efficient as possible to ensure that those Sheffield people who need support receive it as appropriate and to a high quality.

6 Equality of Opportunities

6.1 The Council has a duty under section 149 of the Equality Act 2010 (the public sector equality duty) in the exercise of its functions to have regard to the need to:

a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

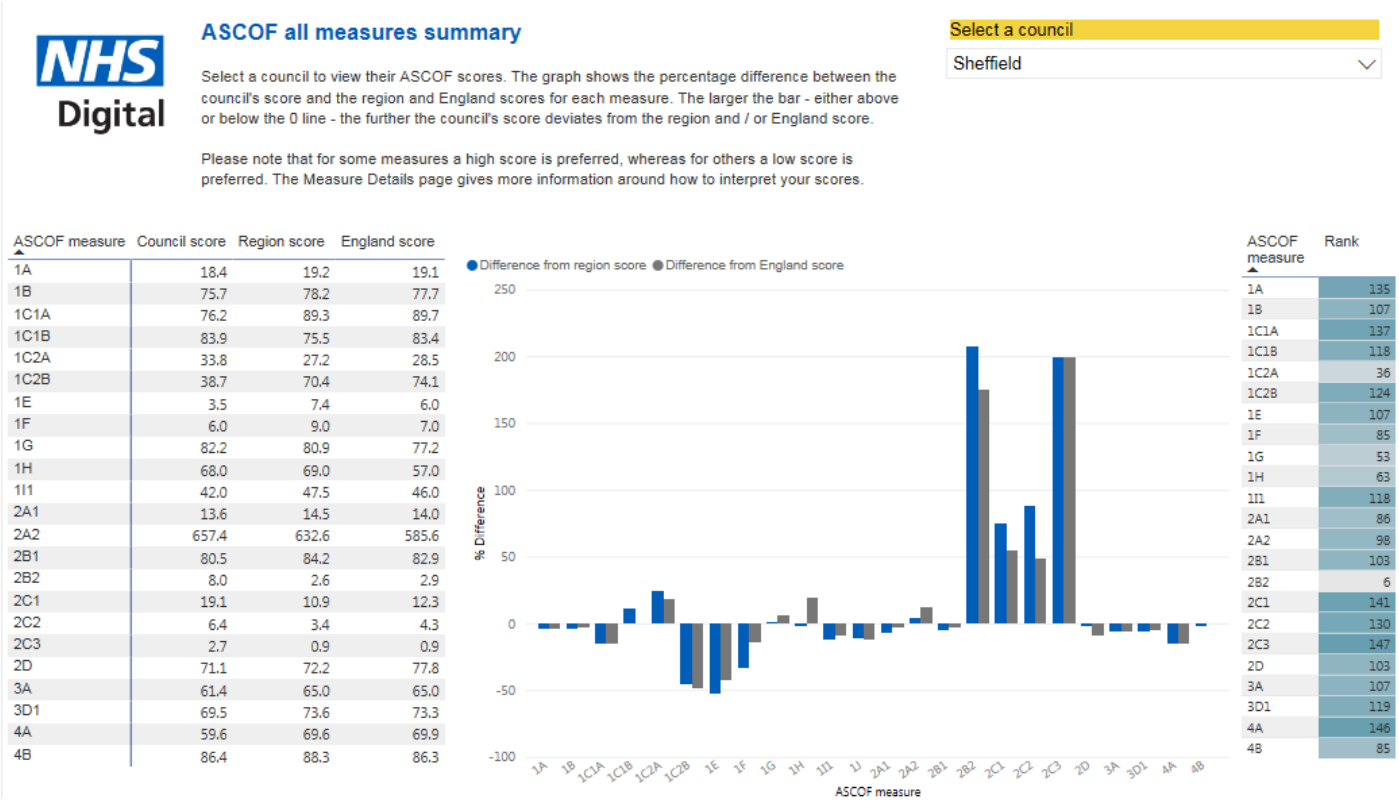
6.2 Although an Equality Impact Assessment (EIA) has not been undertaken for the production of the report, this duty has been taken into account during consideration of key change activities detailed in the report. Planned activity 2018/19 will also be subject to EIA.

7 Recommendation

7.1 The Scrutiny Committee is asked to review the information provided in the presentation and appended documents and provide comments on it and identify any priorities for improvement.

Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

Full data set can be found online.



NHS Digital

ASCOF all measures summary

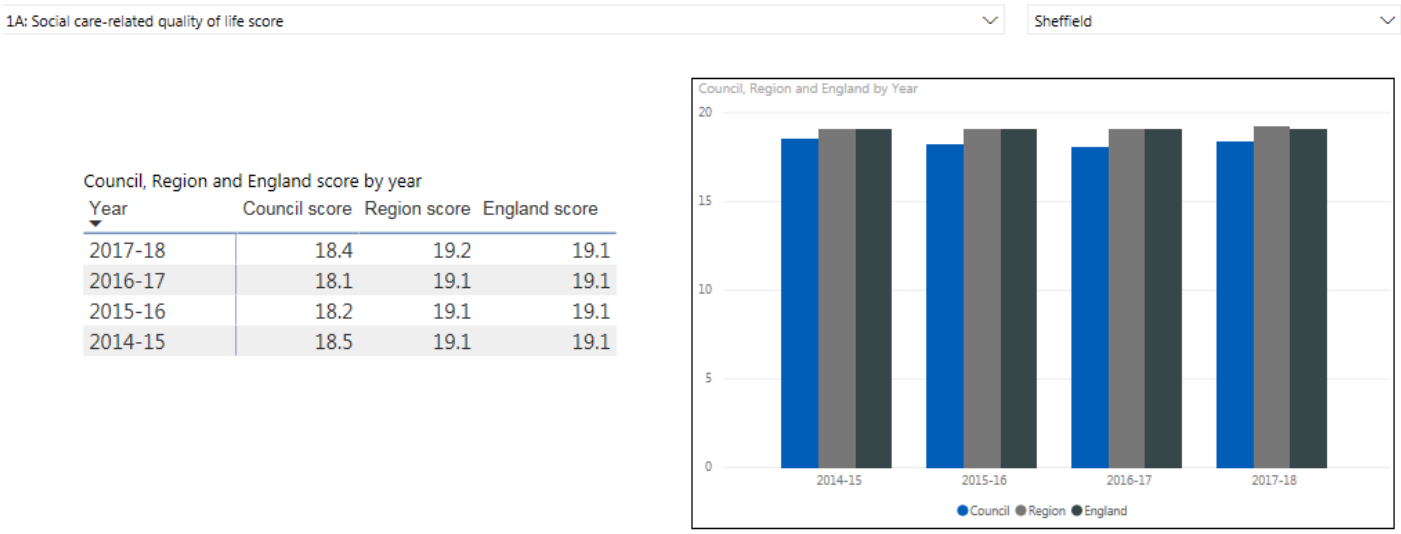
Select a council to view their ASCOF scores. The graph shows the percentage difference between the council's score and the region and England scores for each measure. The larger the bar - either above or below the 0 line - the further the council's score deviates from the region and / or England score.

Please note that for some measures a high score is preferred, whereas for others a low score is preferred. The Measure Details page gives more information around how to interpret your scores.

Select a council: Sheffield

ASCOF measure	Council score	Region score	England score
1A	18.4	19.2	19.1
1B	75.7	78.2	77.7
1C1A	76.2	89.3	89.7
1C1B	83.9	75.5	83.4
1C2A	33.8	27.2	28.5
1C2B	38.7	70.4	74.1
1E	3.5	7.4	6.0
1F	6.0	9.0	7.0
1G	82.2	80.9	77.2
1H	68.0	69.0	57.0
1I1	42.0	47.5	46.0
2A1	13.6	14.5	14.0
2A2	657.4	632.6	585.6
2B1	80.5	84.2	82.9
2B2	8.0	2.6	2.9
2C1	19.1	10.9	12.3
2C2	6.4	3.4	4.3
2C3	2.7	0.9	0.9
2D	71.1	72.2	77.8
3A	61.4	65.0	65.0
3D1	69.5	73.6	73.3
4A	59.6	69.6	69.9
4B	86.4	88.3	86.3

ASCOF measure	Rank
1A	135
1B	107
1C1A	137
1C1B	118
1C2A	36
1C2B	124
1E	107
1F	85
1G	53
1H	63
1I1	118
2A1	86
2A2	98
2B1	103
2B2	6
2C1	141
2C2	130
2C3	147
2D	103
3A	107
3D1	119
4A	146
4B	85



1A: Social care-related quality of life score

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	18.4	19.2	19.1
2016-17	18.1	19.1	19.1
2015-16	18.2	19.1	19.1
2014-15	18.5	19.1	19.1

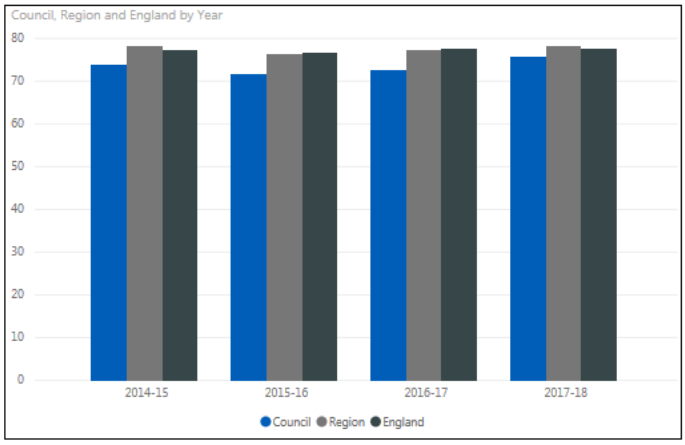
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

1B: The proportion of people who use services who have control over their daily life

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	75.7	78.2	77.7
2016-17	72.6	77.4	77.7
2015-16	71.7	76.2	76.6
2014-15	73.9	78.1	77.3

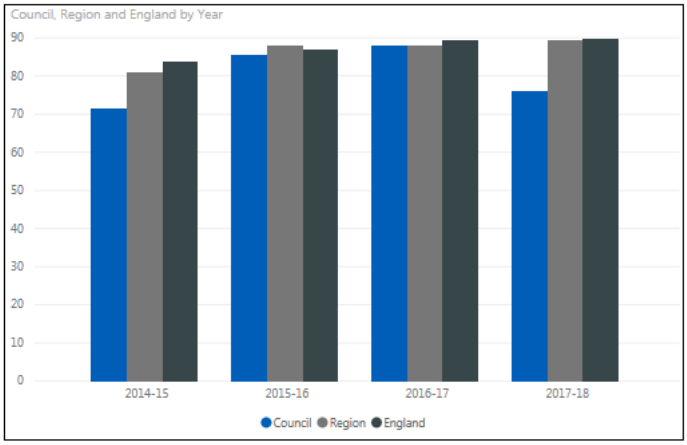


1C1A: The proportion of people who use services who receive self-directed support

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	76.2	89.3	89.7
2016-17	88.0	88.1	89.4
2015-16	85.4	87.9	86.9
2014-15	71.6	81.1	83.7

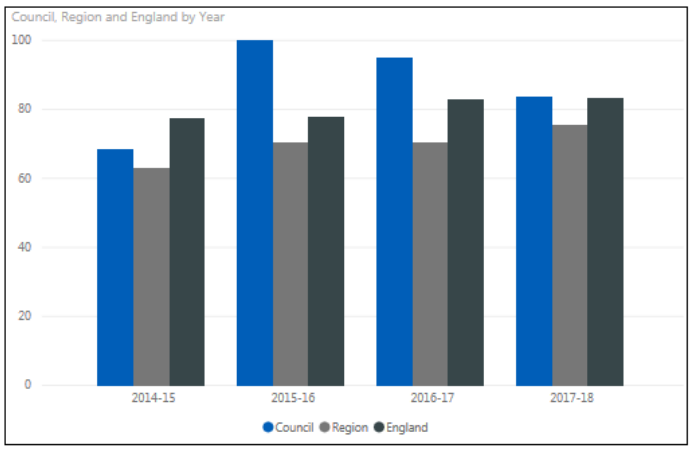


1C1B: The proportion of carers who receive self-directed support

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	83.9	75.5	83.4
2016-17	95.0	70.4	83.1
2015-16	100.0	70.3	77.7
2014-15	68.5	63.1	77.4



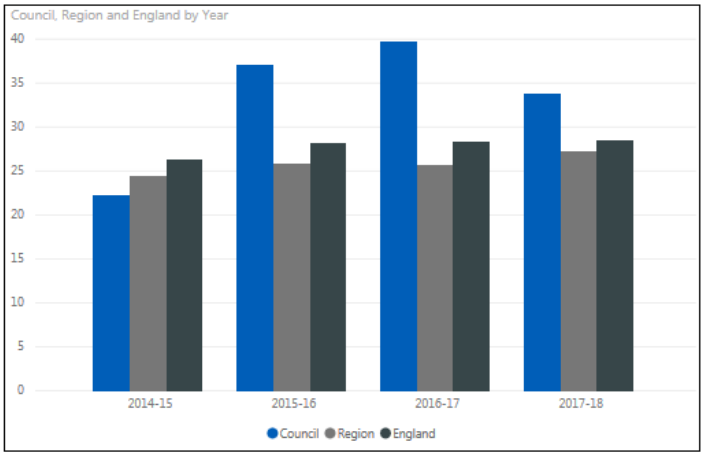
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

1C2A: The proportion of people who use services who receive direct payments

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	33.8	27.2	28.5
2016-17	39.8	25.7	28.3
2015-16	37.1	25.8	28.1
2014-15	22.3	24.4	26.3

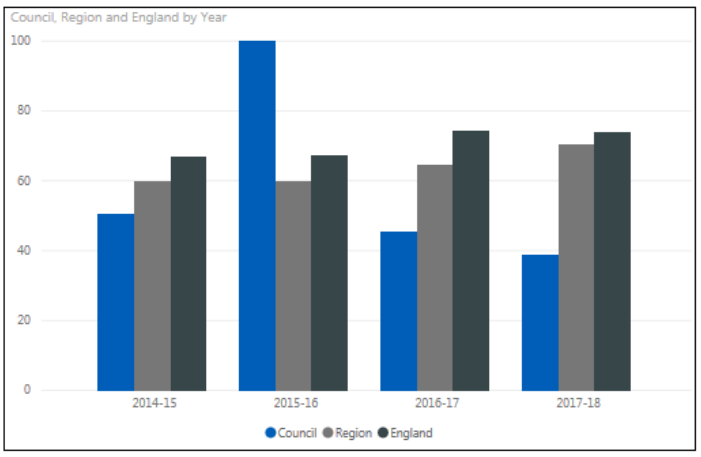


1C2B: The proportion of carers who receive direct payments

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	38.7	70.4	74.1
2016-17	45.6	64.5	74.3
2015-16	100.0	59.8	67.4
2014-15	50.5	59.9	66.9

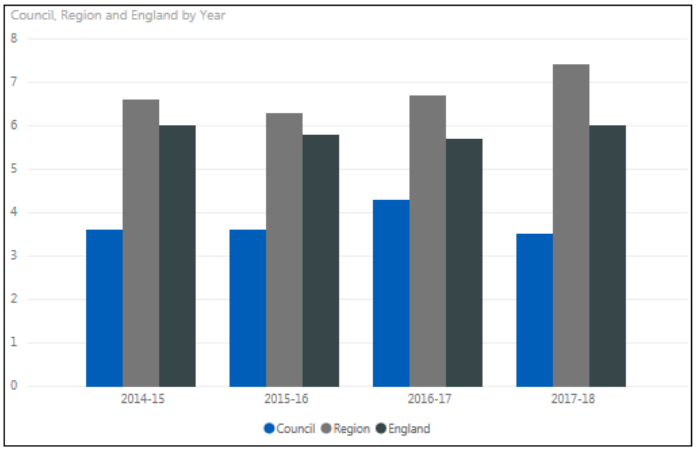


1E: The proportion of adults with a learning disability in paid employment

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	3.5	7.4	6.0
2016-17	4.3	6.7	5.7
2015-16	3.6	6.3	5.8
2014-15	3.6	6.6	6.0



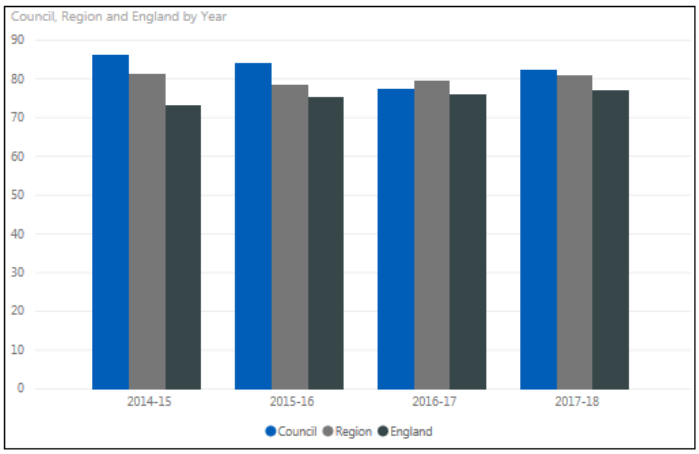
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

1G: The proportion of adults with a learning disability who live in their own home or with their family

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	82.2	80.9	77.2
2016-17	77.3	79.4	76.2
2015-16	84.1	78.6	75.4
2014-15	86.3	81.4	73.3

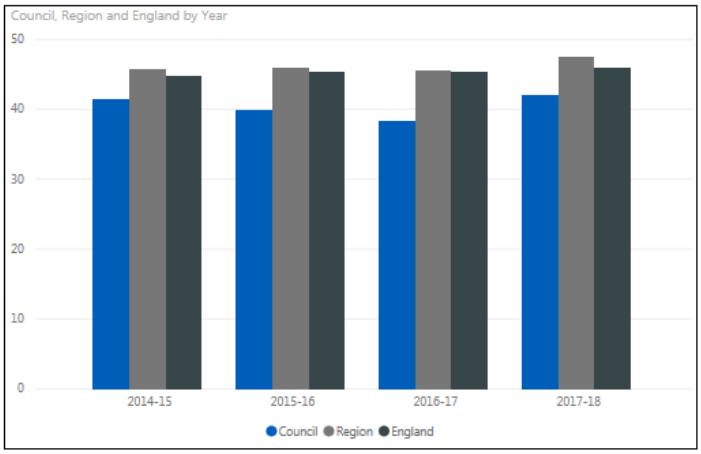


1I1: The proportion of people who use services who reported that they had as much social contact as they would like

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	42.0	47.5	46.0
2016-17	38.3	45.6	45.4
2015-16	40.0	46.0	45.4
2014-15	41.5	45.7	44.8

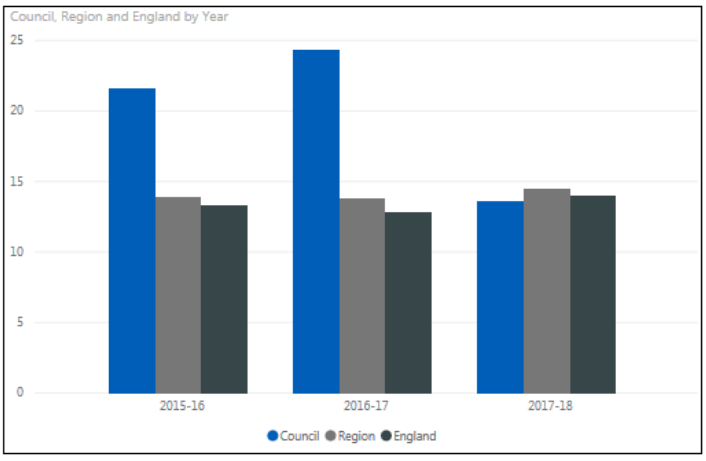


2A1: Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	13.6	14.5	14.0
2016-17	24.3	13.8	12.8
2015-16	21.6	13.9	13.3



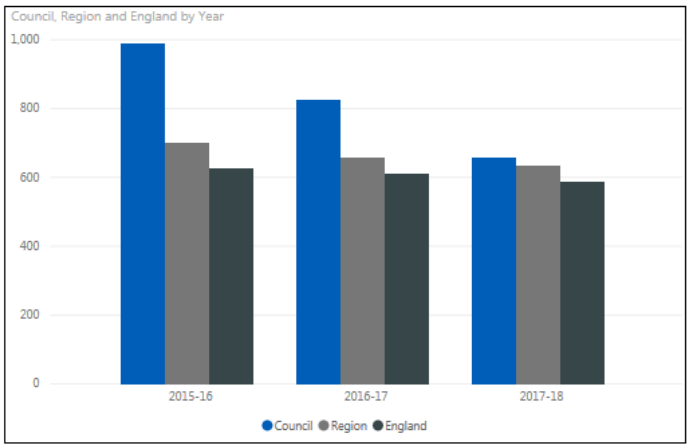
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

2A2: Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	657.4	632.6	585.6
2016-17	824.1	658.4	610.7
2015-16	987.9	699.5	628.2

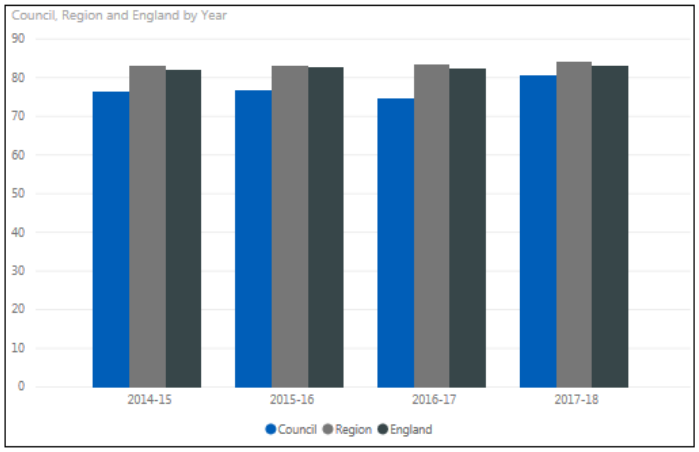


2B1: The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitati...

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	80.5	84.2	82.9
2016-17	74.7	83.4	82.5
2015-16	76.7	82.9	82.7
2014-15	76.5	83.2	82.1

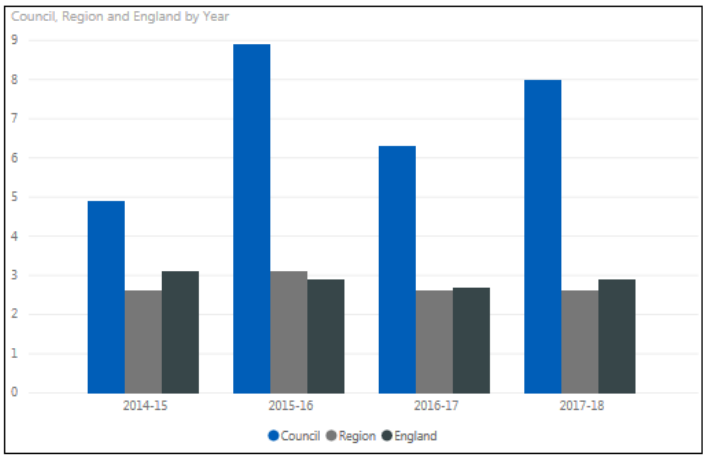


2B2: The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	8.0	2.6	2.9
2016-17	6.3	2.6	2.7
2015-16	8.9	3.1	2.9
2014-15	4.9	2.6	3.1



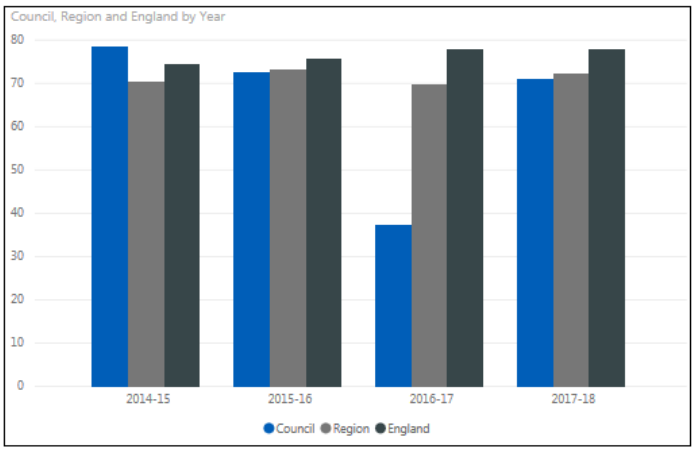
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

2D: The outcome of short-term services: sequel to service

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	71.1	72.2	77.8
2016-17	37.2	69.7	77.8
2015-16	72.7	73.1	75.8
2014-15	78.5	70.5	74.6

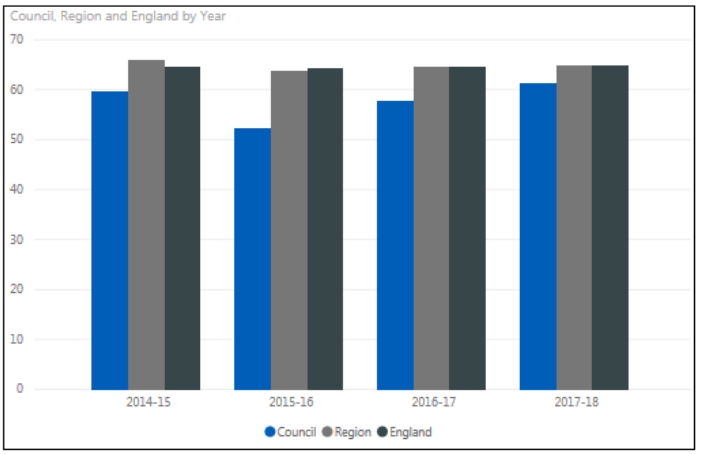


3A: Overall satisfaction of people who use services with their care and support

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	61.4	65.0	65.0
2016-17	57.9	64.6	64.7
2015-16	52.3	63.8	64.4
2014-15	59.8	65.9	64.7

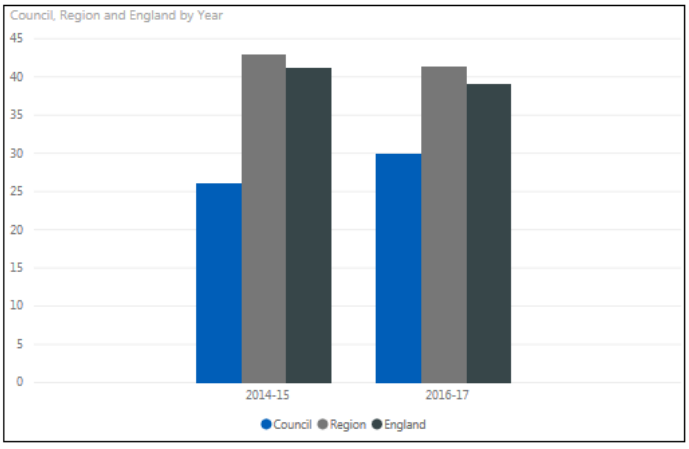


3B: Overall satisfaction of carers with social services

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2016-17	30.0	41.3	39.0
2014-15	26.0	43.0	41.2



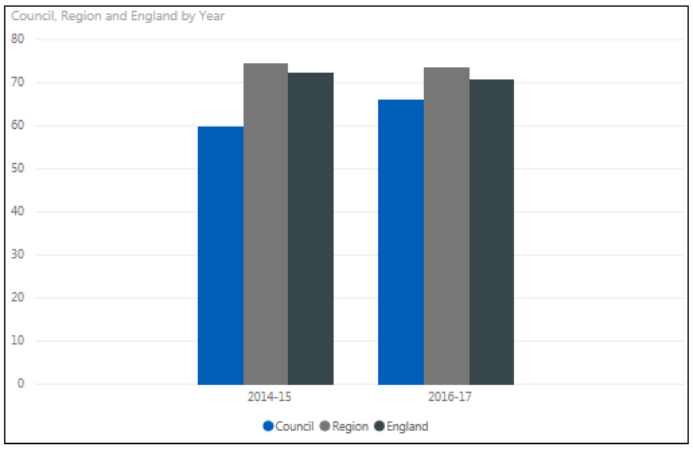
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2016-17	66.0	73.6	70.6
2014-15	59.9	74.6	72.3

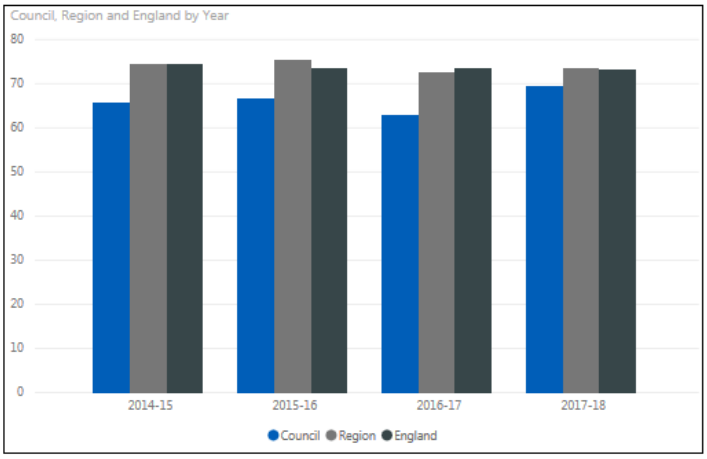


3D1: The proportion of people who use services who find it easy to find information about support

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	69.5	73.6	73.3
2016-17	63.0	72.6	73.5
2015-16	66.7	75.3	73.5
2014-15	65.7	74.4	74.5

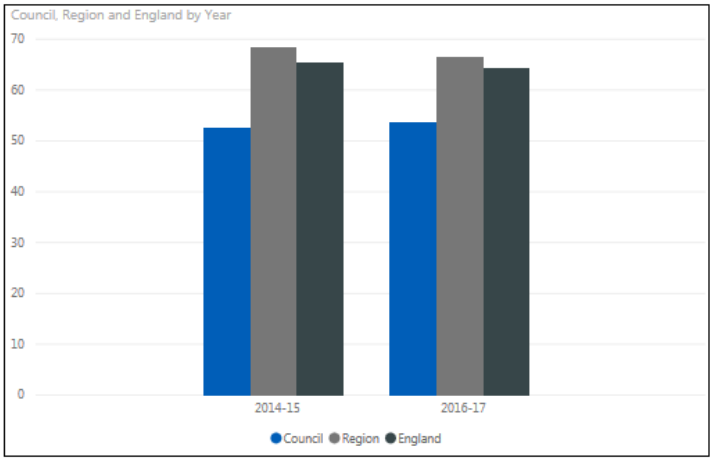


3D2: The proportion of carers who find it easy to find information about services

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2016-17	53.8	66.4	64.2
2014-15	52.5	68.3	65.5



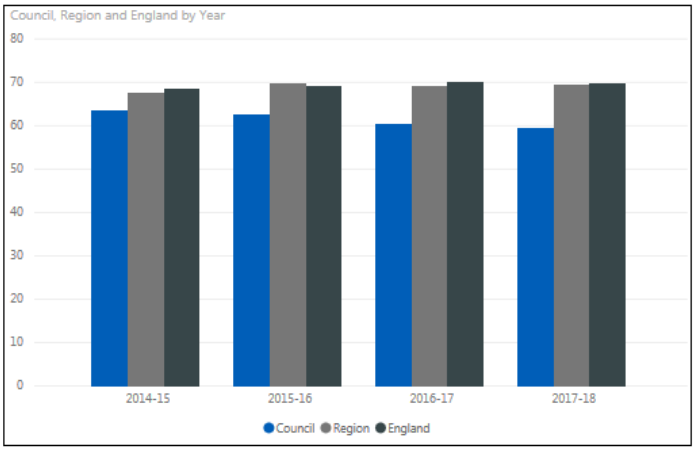
Appendix 1 - Adult Social Care Outcomes Framework Benchmarking overview (2017/18)

4A: The proportion of people who use services who feel safe

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	59.6	69.6	69.9
2016-17	60.3	69.1	70.1
2015-16	62.5	69.9	69.2
2014-15	63.6	67.7	68.5

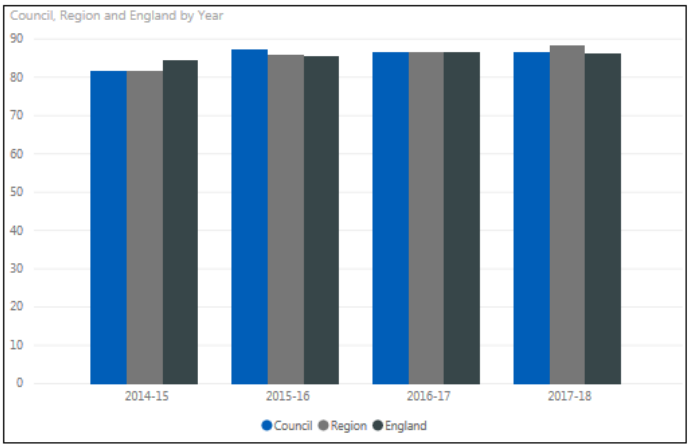


4B: The proportion of people who use services who say that those services have made them feel safe and secure

Sheffield

Council, Region and England score by year

Year	Council score	Region score	England score
2017-18	86.4	88.3	86.3
2016-17	86.6	86.6	86.4
2015-16	87.2	85.9	85.4
2014-15	81.5	81.8	84.5



Sheffield

Sheffield City Council

Making our Conversations Count

This report explains how we help people in Sheffield stay independent, safe and well. It explains our achievements, priorities and challenges in 2018, and our plans for the next year.

Sheffield City Council

2018 Adult Social Care Local Account

welcome

This has been another challenging year for the Council, and the city.

As well as continuing Government cuts in funding, we have faced significant increases in demand for health and social care support, for adults and for children and young people.

Sheffield is now recognised as a leading city for the way in which organisations are working together to face these challenges.

For example, the Local Government Association recently shared details of our work to reduce the number of people remaining in hospital when they didn't need to be there with other councils, to help them to learn how to tackle issues of disjointed systems, processes and decision-making. You can read more about our work in this area so far, and our next steps, later in the account.

We think we now need to bring together all the services that support children, young people and adults with a disability, to make sure all our citizens can access all areas of the city and all parts of city life. We want everyone to be independent and equal in society, and have choice and control over their own lives.

We know it's often the way services are organised that creates barriers for people, not a person's physical or mental impairment, illness or difficulty. And many times people face problems because of the way services are provided at key points in their lives, such as when they move from being a young person to an adult, and in later years as they become an older person.

So a key part of this work will be to make sure services are provided 'seamlessly', and help people as early as possible to grow and develop, and build a good life. As with all the different topics in this account you can get more information about this work from our Information Service (details on page 12).

Councillor Christine Peace,
Cabinet Member for Health and Social Care

Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families
Health and Social Care, and all age disability

What does ADULT SOCIAL CARE do?

Adult Social Care helps people over the age of 18 to get the care and support they need to remain independent, safe and well. This includes care and support for adults, older people, adults with a learning disability, adults with autism and adults with a mental health condition. We also provide support for carers and for families with a disabled young person (as part of their journey into adulthood).

'Care and support' is the help some people need to live as well as possible with any illness, disability or impairment they may have. It can include help with things like washing and dressing yourself, preparing and eating meals, getting out and about and keeping in touch with friends and family.

Social care affects the lives of many Sheffield citizens and their families. In the year 1 April 2017 to 31 March 2018:

- more than 11,000 adults received an adult social care service.
- we spent over £187 million pounds on providing adult social care services.

Adult Social Care works with many other organisations and services in the city, to:

- improve the health and wellbeing of all our citizens.
- help patients in hospital return home as quickly as possible.
- protect people from harm (also called safeguarding).

There's more detail about this work later.

For the 2018-2020 improvement plan the focus of our work will be:

- increasing independence and inclusion.
- increasing the shift to prevention.
- increasing adults able to live at home.
- developing a sustainable provider market.
- ensuring fairer charging.

Find out more

For a copy of our improvement plan contact our Information Service (details on page 12).

So... how did we do?

Every year we collect information about how many people we help, what services we provide, and how people feel about the support they get. We compare our performance to 14 other councils in the Yorkshire and Humber area, like Barnsley, Doncaster, Leeds and Rotherham.

You can download all of the details from NHS Digital (see below). Comparing our scores over the year April 2017 to March 2018, we:

● **supported more people in their own home,** so they didn't have to go into a care home. We know people prefer to stay independent in their own home for as long as possible, so we continue to work to help even more people stay in their community. The number of people moving to a care home each year in Sheffield is similar to that of other councils in the area, but we're working to reduce this further.

● **arranged home care services for many more people.** We know we provide home care for more people compared to most other councils in the area, helping people to stay in their own home so they don't have to move into a care home.

● **helped more people with a learning disability find employment.** We know employment can make a huge difference to a person's health and well-being. While we have improved this year, we know there's a lot more we can do to help even more people into employment.

● **helped more people return home quickly after a stay in hospital.** We work closely with hospitals to make sure people can return home as soon as they are well enough.

This year the number of people who were well enough to return home, but remained in hospital, reduced from 24 each day, to 19 each day. While this is good progress we continue to focus on reducing this with our NHS partners.

You can read more about this work on page 10.

So... how did we do?

We continue to work to improve things where we compare poorly to other councils in the area, including:

● **the quality of home care services.** The Care Quality Commission inspects the quality of all the companies that provide home care services. While the quality of Sheffield services improved this year, we're committed to helping home care providers raise the quality of their services even further.

We're working closely with NHS Sheffield services to help home care companies improve their services. Similar work on improving the quality of local care homes has significantly increased the Care Quality Commission rating of care homes in Sheffield. We continue to work with local nursing homes to improve their services.

● **the time taken to assess people's needs, and arrange their support.** Our processes and the way our services worked needed to change to allow us to have better conversations at an earlier point in time.

As part of a major improvement programme we began last year, we've made significant changes in our working practices, and replaced our IT system.

We now have a specialist team that talks to new people asking for help for the first time, often providing advice and help immediately, without having to wait for an assessment.

We also have 7 teams that work in specific areas of the city. These new locality teams have detailed knowledge about community support in the local area, and can respond quickly to help people work out what matters to them about their life, what's working and what isn't. We call this new way of working 'Conversations Count'.

Find out more

Read more about the impact of Conversations Count on page 8. To compare Sheffield's performance to other councils in the area visit NHS Digital: https://digital.nhs.uk.

Keeping people safe

Adult Safeguarding Partnership

Lots of different organisations in Sheffield help to keep people safe, from the Police, the Council and the Fire Service, to small organisations like home care providers. Many of these organisations work together as part of the Sheffield Adult Safeguarding Partnership.

The partnership makes sure these organisations work well together to prevent abuse and neglect (also called safeguarding), promote safety and wellbeing, and support people who have been abused. A Customer Forum makes sure local people (including those with a learning disability) are fully involved, including representation on the Executive Board.

This year we received 3,156 safeguarding concerns, 35% fewer than last year. Of these 973 we resolved quickly, with 2,183 needing further investigation before being resolved.

The partnership reviews their work every year, identifying new ways to further reduce abuse and neglect, and opportunities to improve practice across the city.

The four current priorities are:

- Prevent abuse and neglect of people at risk taking place – people at risk suffer less abuse and feel safe.
- Make safeguarding personal – people experiencing harm are supported to achieve the outcomes they want.
- Make sure safeguarding works well.
- Protect adults who have care and support needs from abuse and neglect.

The partnership website has advice for carers, plus advice and support to make your home safe (like escape plans and fitting smoke alarms). There's also advice about support across the city when you're out and about. The Safe Places scheme provides temporary safe refuges where adults who find themselves in difficult situations can get assistance.

Find out more

For more information about the partnership contact our Information Service (details on page 12), or visit the partnership website: www.sheffieldasp.org.uk.

Our plans and priorities

Better city-wide working together

There are many organisations in Sheffield all working to keep people healthy, independent, safe and well. How these organisations work together must improve if Sheffield is to meet the challenges and pressures on health and social care.

In March the Care Quality Commission looked at how Sheffield's NHS services and adult social care work together (or don't) to keep older people healthy and well. They found we hadn't got it right, but there was "a strong commitment to achieve the best outcomes for the people of Sheffield".

We have now begun to work in a radically new way with partners like the NHS Sheffield Clinical Commissioning Group, to find more ways we can support each other, and better deliver services that prevent people from becoming ill, needing hospital or needing support. We've agreed new rules that will make us work better together. We call this our Joint Commissioning Approach, and it's a significant commitment by all of us.

Through this approach we will make decisions together, agree joint aims, share our resources and funding, and share the risks and pressures on the city (like winter pressures, when many more people are admitted to hospital). A key focus of our work will make sure we can get support to people as early as possible, to prevent their illness, impairment or problems getting worse.

Through the approach we will make sure:

- people get health and social care support closer to home, without a stay in hospital.
- health and social care support is provided in a much more coordinated way, so people feel support is provided 'seamlessly'.
- we improve the lives of all our citizens. We know people living in some wards have poorer health and need greater support. We are committed to ending health inequality.

Find out more

For more information about our Joint Commissioning Approach please contact our Information Service (details on page 12).

Our plans and priorities

Conversations Count

We've been changing the way we support people since 2017. Instead of a focus on forms and processes like assessments and reviews, we now:

- listen to people – what matters to them about their life, what's working and what isn't.

- recognise people's skills and strengths, and their experience in managing their support, their family and their whole life.

- focus on wellbeing, prevention and independence, to help the person build a good life.

- help people to get support from their community and neighbourhood. Often these are creative solutions that are far better than our traditional support services like home care and care homes.

- make sure support fixes the things that aren't working now, and helps people to plan for the future.

Many of our teams now work in this way, and we expect the whole service will have changed to this way of working in 2019.

As part of planning this change we've involved people and carers, to help us develop our approach and involve our local experts by experience. This includes regular briefings at Service Improvement Forums and the Learning Disability Partnership Board.

'Stories of difference'

These changes are making a real difference, for our staff and the people we support.

Staff tell us they feel free to listen to people, and to work together on building a good life.

People we support say it makes such a difference to be able to talk to a social care worker about their life, rather than answering questions as staff fill-in each box on a form.

Our plans and priorities

Feedback

> I've been able to work with Joy longer to get a better picture of her needs.

> The freedom to talk more and write less really worked for Justin and his aunt.

> I was able to focus on exploring activities for Violet instead of completing forms. I found many resources within the community, which I can offer to other people.

> Family was anxious at first but relaxed as the conversation flowed.

> I feel like I am important – my life is important. I didn't expect that.

Carers and families tell us they feel much more included, respected and listened to.

People say they feel more in control of their own lives, with a plan they helped to create (rather than having support 'done to them').

We're finding the support people need is often less than we would have provided previously, and more creative solutions often cost less for the person and the Council.

Conversations Count is making a difference to the lives of the people we support, for younger adults, people with a physical or learning disability and for older people. Here's a quote on the difference our new approach is making:

> I have had input from a wide range of professionals over the last few years, since my injury/illness, a few have been excellent in what they do, fewer still have really inspired my confidence and made me feel like I am in the presence of a caring friend (which is exactly what I need) and I count Jennifer amongst them.

Find out more

For more stories of difference, and websites and resources about this approach, please contact our Information Service (details on page 12).

Our plans and priorities

Why not home, why not today?

Adult Social Care works closely with Sheffield NHS services to make sure patients can return home from hospital as soon as possible.

This is much better for the patient, and makes sure our hospitals can help as many people as possible.

While work with Sheffield Teaching Hospitals and the Clinical Commissioning Group in 2016/17 lead to significant improvements, we knew there was more we could do.

So we worked with a company that helps services improve (called Newton Europe) to find new ways to work better together. They looked at financial and performance data, read hundreds of patient stories, and talked to about 100 staff. They found we had some outstanding best practice, and a high desire to improve.

From this work we developed a new plan to reduce the amount we spend on high intensity and emergency care, to less costly, earlier support, like services from your doctor and community services like district nursing. We also agreed changes so that NHS staff and Adult Social Care staff work together in new 'multi-agency' teams.

This has improved the way we support people to return home, and made sure care is arranged quickly to help the person recover at home.

A report on the changes we made in Sheffield was shared with other councils looking to improve (see links below).

Find out more

For a copy of the report Why not home, why not today visit: https://reducedtoc.com, or visit the Fab Stuff website: https://fabnhsstuff.net, or read the Local Government Association report from their website: www.lga.gov.uk.

For more detail about the work we're doing to reduce hospital discharge in Sheffield contact our Information Service (details on page 12).

What do local people tell us?

Complaints

We deal with every complaint carefully. Most of the time we identify ways to improve things for the person, and improvements we can make to the way we provide our services.

We received 152 complaints about adult social care services in the year April 2017 to March 2018. This is 7 fewer than the previous year, and compares well to other councils in the area.

We regularly check how long it takes us to respond to complaints. Often we can respond quickly to sort out a minor problem, but it can take longer when a complaint is complicated.

This year on average we took 85 days to respond fully to adult social care complaints, 5 days longer than last year.

We're changing the way complaints are managed and working to speed-up the time to respond to complaints, so we can improve the time it takes in future.

Service User and Carer Surveys

We regularly contact people who get support from us (also called service users and carers) to ask them for their views. We use government advice on what questions to ask, how to contact people and so on. Most councils in England also take part in these surveys.

This year service users told us:

- 6 out 10 people are satisfied with the support they get. This is better than last year, but we know there's more we can do to increase this.

Similarly, we're looking at how we can improve people's views about:

- their quality of life
- how safe they feel
- how much control they have over their daily life.

Find out more

For a copy of our complaints report for this year, contact our Information Service (details on page 12), or visit the council website: www.sheffield.gov.uk/tellus.

Your questions, ideas and comments

For many of the sections in this account we have told you how you can get more information, either from our website or by contacting our information service:

- telephone: (0114) 273 4119.

- email: information@sheffield.gov.uk.

- in writing: Information Service.
Sheffield City Council People Portfolio.
Floor 9 East, Moorfoot building,
Cumberland Street, The Moor, Sheffield S1 4PL.

We've also produced an email that gives more information and sources of data for many of the topics in this account. To receive this email please email: information@sheffield.gov.uk.

If you have any questions or comments about this report please get in touch. You can also contact us with ideas on how we can improve the report, or what you would like to read about next year.

Sheffield City Council.
Adult Social Care Services.
2018 Local Account.

This document can be supplied in alternative formats. Please contact (0114) 273 4119.

Appendix 3 - Adult Social Care 'Stories of Difference' (March 2019)

Please find below several stories of difference (collated by the Practice Development team) which represent a great cross-section of the service and the support we've provided to a range of different people using the new approach.

The stories are from

- Focused Reablement (David)
- Localities (Joseph, locality 6, and Ella, locality 5)
- Preparation for Adulthood (Stephen and Oliver)
- HomeFirst (Nigel)
- Future Options (Mandy)

All names and other identifying details have been changed in all stories except David's as he is happy for his story to be shared.

Story of difference: David

Worker	Jennifer	Team	Focused Reablement	Date	September 2018

Reason for contact

David is 53 years old and lives independently in his own home. He has cerebral palsy that primarily affects his right side and is registered blind, with some vision remaining (40%). He is able to walk independently but struggles to fully extend his fingers and has reduced sensation in his fingers, and this impacts greatly on his fine motor skills. We contacted David as he was one of the group of people we'd identified to work with in the Focussed reablement team.

What would have happened (old world)

In the old world David would probably have waited a long time for a review by a worker in a Locality team. When they did visit him they would have reviewed at his care package and it would probably have continued with no change until his next review.

The conversation(s)

When I first visited David he was fairly hostile and reluctant to engage. He raised his voice several times and expressed clear views about his reluctance to attend activities associated with people with learning disabilities. As we talked I found out that his mum lives locally and visits often, and David and his dad go for a walk around Hillsborough Park every week and they also have season tickets for Sheffield Wednesday. Other than these outings, David rarely left the house.

David's family support him with shopping, washing and household/financial matters. A carer comes in for 40 mins each day at approximately 5pm to provide a hot meal and put out cereal and a sandwich for the following day. Any remaining time is used to support David with domestic tasks.

Through the conversation, it became apparent that David's care agency had changed hands a couple of times over the past two years, which had caused him considerably uncertainty and anxiety. He had also recently lost his two favourite carers to another agency and was very angry about how he perceived they had been treated. David's frustration and anger was causing tension between him and his mum, and was hindering him in his relationship with his new carers. David relaxed through the conversation. It became apparent that he relied quite heavily on his carer calls for social contact. We talked about ways of increasing social contact and activities he could try.

What happened next?

David was interested in finding out more about the Cycling 4 All group in Hillsborough Park, so I arranged to go there with David and we both had a go at cycling. David was keen to go again, he got to know a few people, 'got the bug' and is now attending twice a week, every week and has become a volunteer.

I helped David compose a letter of apology to one of the carers which helped him to accept the situation and move on, so he can engage with his current carers with an open mind. This is no longer causing tension between him and his mum.

I also went with David to the Zest Centre in Upperthorpe and he signed up for a gym induction.

The experience

I have loved working with David. He is now healthier and happier and is going out on a daily basis. His attitude to the Council is a lot less hostile and now, and instead of talking about his carers he talks about his friends. Although his care is unchanged, we have greatly influenced David's access to his community, his mental and physical wellbeing and his friendships.

Story of difference: Joseph

Worker	Samantha	Team	Locality 6	Date	February 2018

Reason for contact

Joseph is an alcoholic who had broken his hip and was in hospital for some time before being discharged to a 5Q bed. It was believed that he also had dementia but they could not tell how advanced this was due to his alcoholism. His wife who also had mental health issues was very worried that if he came back home she could not cope. He was referred to us through the 5Q hospital discharge process.

What would have happened (old world)

Joseph would have been placed in residential care.

The conversation(s)

I spoke at length with the family and asked that we take it day by day before they make a decision about him going into permanent care. I listened to Joseph's wife's fears of how she could not cope with how he was and I listened to his daughters and how they felt this impacted on their mother but they did fear for their father going into permanent care. I spent time meeting with the family at the care home and I spent time with Joseph. On my first visit he did not have capacity and he did not know where he was or why. On the second visit I noticed he was slightly more aware and able to have short conversations that made more sense. He had been detoxed in hospital and that had been some weeks prior but he was still asking for alcohol and he was still confused.

When we noticed that Joseph was gaining an understanding of where he was and was able to communicate better we discussed the possibility that he was improving and that the dementia was not as advanced and that he was still adjusting to living without alcohol. We moved onto talking about home support. I made it clear that I would be with the family throughout the process and I wouldn't hand them over to a new worker, as they feared they would be abandoned once Joseph came home. I made them a promise that I would see it through with them so that if he came home and it was going badly I would come out immediately and see them.

By my third visit Joseph was lucid and he knew where he was and what was happening and he was asking to go home. His daughters and wife were able to speak to him about their concerns about him demanding drink or hurting himself to get alcohol. He tried to assure them that he would behave. His eldest daughter was giving him drinks of Ribena at the home and telling him it was his alcohol and he seemed satisfied with this so the daughter kept doing it and assuring him it was his favourite alcoholic drink and that he was only allowed a little a couple of times a day. This actually worked and he went home with 4 calls a day.

What happened next?

Every couple of months the times and frequency of the care calls have been reduced. The eldest daughter would call and tell me how well he is doing and that he does not need the calls and reduce them down. We also put a key safe in so that carers could go in when the wife was out so it did not make her feel she needed to sit in all day waiting for care calls. Joseph is now only having 3 calls of 30 minutes in a week just to give him a wash and shave. He is learning to care for himself and the wife is coping well with the support that she does provide.

Joseph does not pester for alcohol or put himself at risk trying to get it as he believes the Ribena he drinks a couple of times a day is his alcohol and due to the dementia he can't remember what alcohol really is. I did discuss this with the daughter when she attempted this substitution; that it is well known that alcoholics when in recovery substitute alcohol for sugary drinks, hence why the daughter attempted it to see if it would work.

The experience

I was relieved that Joseph was able to go home and live with his wife as were his daughters. They were also pleased that I kept to my word of sticking with them and seeing it through so that they knew who to call and what was agreed before he went home. It made everyone feel safe that there was support that was constant and an agreed back up plan that could be utilised.

Most importantly it is about listening to the person and family members so that you get to know who they all are and understand them and their strengths and limitations and when they know that you have a thorough understanding and that you will commit to them not just the client, because it affects the family as a whole, in knowing their fears and limitations and taking that on board allows them to trust you, which allows them to try something that they would of said no to such as Joseph going home.

Story of difference: Ella

Worker	Andy	Team	L5	Date	March 2019

Reason for contact

Ella is an 85-year-old woman who has lived in Apple Tree retirement apartments for many years but recently the care provided by Apple Tree had broken down. Concerns had been raised about Ella's medication as her friends (one of whom is a retired GP) felt some of it was unnecessary. Ella's friend (who is also her Power of Attorney) contacted us as Ella had said she wished to move into a nursing home.

What would have happened (old world)

Under our old allocation system Ella would have had a lengthy wait as she would have been seen as a 'low priority'. This would have led to a significant depletion in Ella's savings and a distressing situation for her friends. Most of the questions in the old assessment questionnaire would not have been relevant to Ella, and would feel intrusive to an 85 year old. We wouldn't have been able to explore Ella's options in the same way, so there's a good chance she would have moved into a nursing home as she already had places in mind.

The conversation(s)

On meeting Ella, I found her to be very upbeat, friendly and chatty. We had an interesting and lengthy discussion about her life, how she'd travelled extensively, is still an active part of the church and how at the age of 85 still leads an independent and active life.

I met with two of Ella's friends, and the staff at the retirement apartments, who all felt that moving to a nursing home would limit Ella's independence, and that she didn't need that level of care. Her friends and I talked to Ella together to sensitively raise the subject of the move and discuss the pros and cons. Ella was open to this discussion, in which she decided to remain in her current home at least for the time being.

Ella is paying privately for her current care that had been sourced in haste by her friends after the breakdown in support from Apple Tree. Ella's friends said they had no knowledge of care companies or the cost of care. I calculated how much Ella is currently paying, and explained to her that if she changed care company the cost of her care would be reduced by almost £20,000 a year. Although she has a good relationship with her current carers, through our conversations she felt assured about being able to build an equally good relationship with new care staff, and appreciated that her savings would not last very much longer if she continued to pay the current rate.

I also talked to Ella's GP about her medication, which he said could be reduced with no detriment.

What happened next?

Ella's friends and I met with Apple View to discuss the possibility of reinstating their care if necessary. The manager assured us they would be happy to review the situation, and will continue to provide social and emotional support. Ella has also agreed to change to a less financially restrictive company. This will allow for extra care calls if required and still allow huge savings to be made. Ella's friends appreciated the information, advice and support I provided and feel this has taken a lot of burden from them.

The experience

For me as a worker, it has been a good and enjoyable piece of work to have been involved with. I have met and supported three people who previously had no knowledge of services or how the process works and therefore what pitfalls there can be especially in regard to finance. I have enjoyed acting a conduit into accessing appropriate and cost-effective services. Ella felt supported and listened to, and both she and her friends appreciate the rapid response and the positive outcome for Ella's physical and emotional self, and for her financial well-being. I have received verbal and written feedback as to how pleased everybody is with this outcome and Ella and her friends know they can call for further advice or information if required.

Story of difference: Stephen

Worker	Avi	Team	Preparation for Adulthood	Date	October 2018

Reason for contact

Stephen is a 19 year old young man who lives at home with his parents and brother. Stephen has been attending a specialist college for two years and has now progressed on to the supported internship course. The referral came to us as Stephen's carers expressed that college is moving to 3 days per week from 5 and that Stephen would be getting bored at home and would like to be carrying out further activities.

What would have happened (old world)

In the old world we would have assessed Stephen's needs and as the family had found day services already we would have gone forwards with a package of support that included day services for 2 days a week.

The conversation(s)

I got to know Stephen through speaking to him, his carers and his college tutor, and explored with him how he thinks his future could look like. We discussed his aspirations and found that he had a particular interest in metal work. Speaking to his college tutor and seeing examples of his work it was clear that he had both an interest and a talent for this. Stephen spoke about his ideal job within the metal work or jewellery industry.

I carried out some research and found a work based activity making glockenspiel which involved both metal work and wood work. We discussed the workload there and it was agreed that Stephen would attend two half days.

I did further research and found out about evening groups for adults that carried out activities that were of interest to Stephen.

What happened next?

Stephen will be able to further his training around wood and metal work, and gain transferable skills towards an employment area he would like to be working in the future, rather than a long term reliance on social care. He will be able to experience a workshop work style environment and engage in an activity independent from his carers. Stephen will attend two half days at a day service that costs £65 per day rather than two days that will cost £45-£55 per day.

The experience

Stephen expressed that he was happy to be able to progress his skills especially around metalwork. Stephen was happy he would be able to carry out an activity on the two days he was not in college. Stephen was happy he got to travel on public transport from his home to the workshop.

I felt that rather than an assessment questionnaire tick box exercise to document all Stephen's needs we were able to focus on the initial reason for the referral.

I was able to focus on a lot more practical support and set defined outcomes for support rather than involving someone in an open ended relationship with social care and day opportunities.

The conversation felt more natural rather than imposed and process driven.

Being able to practically support somebody to work towards a goal they would like to achieve was fulfilling.

Story of difference: Oliver

Worker	Manos	Team	Preparation for Adulthood	Date	February 2018

Reason for contact

We started working with Oliver (18) after his respite placement broke down when he assaulted staff and produced a knife. Oliver was drinking heavily, being abusive and regularly urinating in this room. His mum could not cope with his behaviour at home and was desperate for the respite to continue, but other respite providers would not accommodate Oliver due to his behaviour.

What would have happened (old world)

In the old world we would have referred Oliver to alcohol services and pursued other respite options.

The conversation(s)

I had a number of conversations with Oliver, his mum and his grandad. Speaking to Oliver's grandad proved very important. Oliver had previously lived with him so I asked about that happening again- thus providing the respite mum needed. Oliver was happy with that idea. Grandad was happy to do this but explained that his daughter had moved back in so there were not enough rooms. Grandad was willing to have the room partitioned so I spoke to Equipment and Adaptations and they are going to do this.

I was quickly able to build up a relationship with Oliver by speaking to him alone in his room, allowing him to be more comfortable with me. I don't believe that many people went into his room, certainly not professionals. I think this made a big difference to how he felt about me. I showed him a great deal of respect listening to his own views. This way I was able to really tackle his drinking personally. We talked about hangovers, his family, his behaviour and the physical concerns. He was able to think about the personal effect of his own drinking and was more motivated to change. I also spoke to his mum about how she could support this change and she was more positive working with him to do this.

Through speaking to Oliver I also learnt how he was enjoying the gardening group (day service) he attended.

What happened next?

Oliver is now hardly drinking any alcohol. I arranged a deep clean of his bedroom and since the clean Oliver has made more effort to clean up for himself. Oliver has increased the time he spends with his gardening group, which has increased his confidence and improved his well-being. The group leaders say Oliver has developed socially and is participating in all activities more. He is now eating openly with everyone and is clearly much happier.

The experience

Oliver is more positive and confident. His behaviour has improved in tandem with his wellbeing. He has much more positive relationships with all members of his family, and they are all happier too.

As a student social worker I was happy to see that my work contributed to a positive change to this family.

In the long run we have also saved money as the family are providing respite.

Story of difference: Nigel

Worker	Sean/Claire	Team	Home First	Date	February 2019

Reason for contact

Nigel was presented with a notice to quit his tenancy due to flammable substances being stored in his flat. He was not attending dialysis appointments and as a result of this his health had deteriorated so much that medical professionals were preparing to provide end of life care.

What would have happened (old world)

We would have requested that Nigel be taken to hospital where he could be looked after and made as comfortable as possible. We would have supported Nigel to apply to court for a stay hearing to prevent him from being evicted due to the current situation regarding health deterioration.

The conversation(s)

When we first met Nigel he had not been well for some time and had not been attending his dialysis appointments due to poor health. He was in bed and could not get up due to the deterioration of his mobility and his health. We thought it would benefit Nigel if he could be supported to get out of bed for a while, and with support he managed to get out of bed, get dressed and sit in a chair. We realised that he just needed a little prompting and support.

We met with the staff where he lived and explained the situation and they said if Nigel stopped storing fire lighters in the flat and kept to the standards required under the tenancy agreement they would consider removing the notice to quit. We cleaned and tidied the property to prevent any further issues with the landlord and to prevent Nigel becoming ill due to poor home hygiene.

Over the next couple of days Nigel began to improve in health and started to eat. We decided that we would go food shopping on the days he got paid to ensure that he had fresh food to eat. Nigel soon felt well enough to start his dialysis treatment and within a week was back to his normal self. The end of life plan is no longer relevant at this moment in time.

What happened next?

The Notice to quit has been put on hold without having to go to court and putting Nigel through unnecessary anxiety/stress. Nigel has an excellent relationship with us and agreed that we should look for a care provider to support him on a permanent basis. He was upset that we would be pulling out but understood that he needed more support. We liaised with a care company and social worker and introduced the care provider to Nigel. They really got on and it was agreed that Nigel would be provided with support.

The experience

Nigel is able to go out in the community and have the support he needs. This will enable him to do things he said he would never do again such as trips to Derbyshire and even a food shop in a supermarket rather than just the small shops which he used to use because they were the closest. Nigel will have support to attend dialysis and see his GP and other health professionals. He is happy and looking forward to the future and planning activities. Nigel's parents can relax more in the knowledge that he is being looked after.

This has been complex work and has taken a lot of hours, but to see Nigel now from where he was just a few weeks ago is truly heart-warming and rewarding. We really thought that Nigel would not be here today but with a bit of hard work, compassion and empathy, we managed to prevent him losing his life, and improve his outlook on his life. It makes us feel so proud.

Story of difference: Mandy

Worker	Julie	Team	Future Options	Date	September 2018

Reason for contact

Mandy is in her early 50s and had previously been discharged from hospital into a nursing home following two significant strokes, so was living with much older people who were mainly in their 80s and 90s. The Deprivation of Liberty (DoLS) team referred Mandy to us following a DoLS assessment.

What would have happened (old world)

In the old world Mandy's support in the nursing home would have been reviewed and the boxes ticked as the home appeared to be meeting her needs. This had actually happened not that long before I was asked to visit by the DoLS Team. The lady had funded nursing care and place as this was a Nursing Home. In the old world it would have been a standard review to check that FNC was still eligible (this had actually happened and the nurse assessor worked jointly with the care manager to agree this was still appropriate). Although this lady didn't have nursing needs any longer, she wasn't being hoisted in /out of bed any longer and didn't require any specialist support or nursing involvement.

The conversation(s)

By having several conversations with Mandy I was able to understand a lot more about her and her circumstances. Mandy didn't want to continue living in the nursing home so we talked about her moving into supported living. I engaged very closely with Mandy and her advocate, who was advocating for a move from the nursing home asap otherwise a S21a challenge to the Court of Protection was going to be made. It was only the relationship with the advocate and the promise that I would get this lady moved asap that held off the court application. Due to being involved with a supported living scheme, merely 100 yards up the road from the care home, which was used for our team's innovation site, I was able to identify a placement for Mandy. Obviously, other places were considered but these were across City and Mandy had lived in the nearby vicinity for many years, prior to moving into the nursing home, so it was felt appropriate to keep her in the area she was used to. Due to the nursing home not taking Mandy out, she had not been able to purchase shoes or essential items for herself and her money had significantly increased. By working closely with Mandy and her advocate, I was able to identify a private provider that would start to take Mandy out and about in the community. This commenced within a couple of weeks and Mandy was able to go out 3 times per week to wherever she wanted. She purchased new items of clothes, did her own shopping and had her hair done! She absolutely loved going out and still does. She has been able to buy all her own furniture and items that she needed for her new home. Mandy has built up a very good relationship with the private support worker, who also spends time with Mandy using her new communication Ipad, which the Specialist Speech and Language Nurse supplied her with.

Since moving into her new home, Mandy has come on immensely, she is so much more independent and

speaking more. She sings with her support workers, joins in with the baking session in the flat next door and she has been to Blackpool with others from the scheme. Another holiday is being planned for later this year! Prior to this, Mandy was living in a nursing home for 5 years and only went out for short periods of time approximately once per month. She now has more control of her life and making choices for herself.

What happened next?

Mandy has moved into supported living. She has been out to buy wallpaper and paint to decorate her new home, and has been on holiday to Blackpool with the other people she's living with. She has learnt to use an iPad, she goes shopping with staff so she can pick what she wants and she is being encouraged to become more independent and improve her speech. Her life is transformed. She actually made the hot drinks for us all at her last meeting!

The experience

Anyone wanting to know how this experience has transformed Mandy's life only needs to see huge smile on her face. She was sad and lonely in the nursing home, whereas now she is fully involved in all goings on at the scheme and has lots of new people to mix with and to go new places with. The plan is for her to go to the cinema and theatre with the lady in the next flat.

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