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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 11 September 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 Cate McDonald (Chair), Steve Ayris (Deputy Chair), Sue Alston, Angela Argenzio, Vic Bowden, Mike Drabble, Jayne Dunn, Adam Hurst, Talib Hussain, Mark Jones, Martin Phipps, Jackie Satur, Gail Smith, Garry Weatherall and Vacancy

Healthwatch Sheffield
Lucy Davies (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
11 SEPTEMBER 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 24th July, 2019.

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

7. The Sheffield Mental Health Transformation Programme (Pages 11 - 46)
Joint report of Dawn Walton (Director – Commissioning, Inclusion and Learning, Sheffield City Council); Brian Hughes (Director of Commissioning and Performance, Sheffield Clinical Commissioning Group); Clive Clark, (Deputy Chief Executive, Sheffield Health and Social Care NHS Foundation Trust) and Dr Steve Thomas (Clinical Director for Mental Health, Learning Disabilities and Dementia, Sheffield Clinical Commissioning Group)

8. Update on the development of the joint dementia strategy commitments and the commissioning plan for dementia (Pages 47 - 62)
Joint report of Dawn Walton, Director: Commissioning, Inclusion and Learning and Brian Hughes, Director of Commissioning and Performance, Deputy Accountable Officer.

9. Urgent Care Review Update (Pages 63 - 102)

Report of Brian Hughes (Director of Commissioning, NHS Sheffield Clinical Commissioning Group (CCG).

10. Written Responses to Public Questions (Pages 103 - 106)

Report of the Policy and Improvement Officer.

11. Work Programme (Pages 107 - 116)

Report of the Policy and Improvement Officer.

12. Date of Next Meeting

The next meeting of the Committee will be held on Wednesday, 16th October, 2019 at 4.00 p.m., in the Town Hall.

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

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

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 24 July 2019

PRESENT: Councillors Cate McDonald (Chair), Steve Ayris (Deputy Chair), Sue Alston, Angela Argenzio, Vic Bowden, Mike Drabble, Jayne Dunn, Mark Jones, Martin Phipps, Jackie Satur, Gail Smith and Garry Weatherall

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Adam Hurst and Talib Hussain and from Lucy Davies (Healthwatch Sheffield).

1.2 Lucy Davies has been appointed as a Healthwatch observer on the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee, in place of Margaret Kilner and Clive Skelton, with effect from 15th July, 2019.

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 Councillor Mike Drabble declared a personal interest in Item 7 – NHS Sheffield Clinical Commissioning Group: Improvement Plan – due to his work as a self-employed Counsellor.

4. MINUTES OF PREVIOUS MEETINGS

4.1 The minutes of the meeting of the Committee held on 20th March, 2019 were approved as a correct record, subject to the alteration in Item 5.3 of the name “Ms. Hancock” to read “Ms. Manclark”.

4.2. The minutes of the meeting of the Committee held on 15th May, 2019 were approved as a correct record.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 Sheila Manclark asked that following the Clinical Commissioning Group’s 13 commitments to dementia in Sheffield, how will the revised Sheffield City Council dementia strategy support the elements of the CCG proposing personalised local support for people with dementia and support for families and carers?

5.2 Andy Shallice asked that now that dementia commissioning for day support services has been abandoned, after already running late, can we assume that the significant flaw of separate strands for supporting people with initial/mild dementia, and those with more advanced dementia, so emphasising continuity of care, will be addressed?

5.3 The Chair, Councillor Cate McDonald, stated that there is to be an update at the next meeting of the Committee to be held in September, on the Dementia Strategy and its impact in the City. Councillor McDonald also stated that she would request the Cabinet Member with responsibility for dementia care, to respond in writing to the questions raised. Officers in attendance from the Clinical Commissioning Group agreed to provide written answers to the questions raised where these related to the activities of the CCG.

6. NHS SHEFFIELD CCG: IMPROVEMENT PLAN

6.1 The Committee received a report from Nicki Doherty, Director of Delivery, Care Out of Hospital, NHS Sheffield Clinical Commissioning Group (CCG) which set out the improvement plan which had been agreed by NHS Sheffield CCG's Governing Body and was now being implemented.

6.2 Also present for this item were Lucy Ettridge (CCG Deputy Director of Communications), Dr. Marion Sloan (CCG Governing Body Member) and Mike Potts (Independent Improvement Director).

6.3 Nicki Doherty outlined the reasons for the improvement plan which had been commissioned by NHS England as part of their role as an independent regulator. She stated that the CCG had recognised a great number of strengths but had also identified areas for improvement. She added that staff had continued to work well and the CCG was classed as a "good" organisation, which reflected the hard work of the staff. Feedback from staff had been taken into account when developing the improvement plan and it had found that generally they enjoyed working for the CCG but there were a number of areas where things could be done better and these were being addressed. Key areas were identified to be strengthened and developed and assessment of the impact and success of the plan will be monitored through regular staff and stakeholder surveys.

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

- In response to a question around ensuring that the rationale of CCG decision making is clear, the CCG stated that their aim was to be open and transparent. They recognise that there was a need to be clearer about strategy – what they plan to achieve and how they plan to do it – and then all decisions should clearly link back to CCG strategies. The CCG was also looking to work more proactively with the Scrutiny Committee.

- As part of the improvement plan, the CCG has revisited its Whistleblowing Policy, and has tried to provide staff with a wider range of opportunities and support to identify where things aren't right, including 'Freedom to Speak Up

Guardians and Executive Director Surgeries, where staff are able to drop in and see any Director to discuss any thoughts, feedback and ask questions. The improvement plan also recognises the need to continuously update policies, and to strengthen HR to ensure that policies are followed.

- The CCG has 330 members of staff, made up of communications teams, contracting staff, finance officers, nursing staff, all with a different role to play. There are different tiers of staffing from junior clerical staff up to executive directors. The improvement plan recognises that the CCG needs to be more proactive with its internal communications, and consider that a different approach may be required for its front line staff, e.g. Continuing Health Care teams, or commissioning staff. The CCG also needs to ensure that its membership, GP practices across the city, are influencing direction and needs to engage better with them.

- In response to a question about issues related to Joint Commissioning, the CCG stated that it has worked with partners to develop the improvement plan, and changes to the Executive Team will help to alleviate some of the frustrations that the Local Authority has been experiencing. There has been lots of work on shared principles, and the results from recent CQC and OfSTED inspections have heavily influenced joint commissioning priorities.

- In response to a question about how the CCG will continuously improve and learn from experience, the CCG confirmed that they will be asking whether existing strategies are fit for purpose, and continuous improvement will be a factor in robust business planning and programme management. The CCG recognises that there was a need to better demonstrate where improvements have been made through the commissioning cycle. They also recognise the need to make sure strategies are targeting resource where it is needed and draw on public health data to do this.

- An Improvement Plan Steering Group was established, chaired by a Governing Body Lay Member and made up with staff forum representatives a Governing Body GP, the Independent Development Director and the Executive Director who was co-ordinating the improvement plan, all of whom brought a great deal of experience to the Group.

- The CCG recognised that engagement with clinicians had been a barrier to progress in the past, however they are optimistic about the future with the development of Primary Care Networks (PCN). Each PCN will have a Clinical Director which will enable far more clinical input from the networks, a bigger clinician voice from primary care. The improvement plan recognises the importance of ensuring that the CCG is clinically led, and should reinforce that clinicians are in the driving seat, with staff supporting them. Stronger clinical leadership and PCNs will put GPs in a better position to strengthen and develop collective skills in Primary Care, and target resources where they are needed.

- Differential investment could be given and more could be put into areas where greater support was required to achieve the same outcomes in other

areas or populations.

- The Accountable Officer being appointed for both Barnsley and Sheffield areas was not causing any problems. It is working very well. Sheffield CCG knows what it is doing, feedback from staff has been very positive. It was not unusual to have one Accountable Officer being appointed to more than one area. The Officer was working three days in Sheffield and two days in Barnsley and the arrangements for this were working very well.

- The experiences in Barnsley would not necessarily influence the decisions in Sheffield. The improvement plan was about getting things right for Sheffield. The key was about how everyone involved works together.

6.5 RESOLVED: That the Committee:-

(a) thanks Nicki Doherty, Lucy Ettridge, Dr. Marion Sloan and Mike Potts for their contribution to the meeting;

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

(c) feels assured that the vision, values and objectives of the improvement plan are the right ones, and that the focus on 'place' is the right approach; and

(d) will liaise with the CCG as to the most appropriate time for the Committee to consider further feedback on the implementation of the improvement plan.

7. AGE RELATED TV LICENCE POLICY

7.1 The Committee received a briefing report on the BBC's recent decision to stop funding free TV licences for all over 75s from June, 2020. The report provided information on why the decision was made, the reasons for criticism and how the changes were likely to affect Sheffield.

7.2 Present for this item were Steve Chu (Age UK), Irene Day (Sheffield 50+) and Chris Walker (Citizens Advice Sheffield).

7.3 Steve Chu stated that there was a national campaign asking the Government to take back responsibility for funding the free TV licences to those eligible. It was felt that the BBC had been put in a difficult position by the Government forcing them to take this decision, and at present the petition started by Age UK has 608,000 signatures, and Age UK were hoping to reach a target of 650,000. Mr. Chu said that 49% of those over 65 relied on television for a host of reasons including companionship and keeping in touch with world events. He was urging the City Council to follow the lead taken by Leeds City Council to issue a statement supporting the petition.

7.4 Irene Day referred to two friends of hers, one of whom had recently passed away. She commented that one of her friends she had no family of her own and her television was a lifeline for her. She added that her other friend had worked all her life, paid her taxes and, following illness had become depressed, but relied on

her TV so much. Mrs. Day said that social isolation was a hidden threat to many people and highlighted the risk of vulnerable people being taken to Court for non-payment of a TV licence.

7.5 Chris Walker gave another dimension to the matter. He stated that due to the design of the system, those people over the age of 75 who claim pension credit will continue to get a free licence. However, there are many people who are entitled to claim Pension Credit but don't for one reason or another, and many aren't aware that they are entitled to receive it. Mr. Walker said that if everyone claimed, the Government would potentially spend a lot more than they would save from not funding the TV licences.

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

- Social isolation tends to get worse after the age of 65. Due to modern living, families don't always live in the same city, or even the same country anymore.

- There was a lot of bureaucracy around means testing and making sure that people were aware of what they were entitled to claim for. For some people, they felt there was a stigma around claiming benefits and for others, they simply don't know how to. Following the introduction of Universal Credit, as with all welfare changes, there are always winners and losers.

- Citizens Advice and Age UK highlighted the difficulties involved with promoting benefit uptake. The most vulnerable people sometimes weren't able to open simple letters and read what they say. Also, there was an expectation that people use the internet to access information and complete application forms, but a lot of those who can't afford to buy a licence also don't own a computer or have use of the internet. One to one support and outreach are the most effective ways of helping people to access benefits, however they are resource intensive. Age UK was already operating a waiting list for its support services.

- Members of the Committee felt that it was important to consider how the Council can use its resources to promote Pension Credit uptake, for example through Housing+, strategic housing forum, links with social housing providers and through Ward Councillors working in communities.

- Members of the Committee felt that there was a role for the BBC in promoting Pension Credit as part of the changes to free licence eligibility.

7.7 RESOLVED: That this Committee:-

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

(b) agrees to take up the campaign to raise public awareness regarding this

matter and write to the BBC asking if there are plans, when withdrawing the TV licence, to advise people of the different options available to them;

(c) recommends to Cabinet Members that consideration is given to how the Council can raise awareness of the changes to free TV licence eligibility and promote Pension Credit uptake through using Council staff who work on the front line; working with our partners and other service providers in the City, e.g. social housing providers; encouraging Councillors to work with their contacts in communities, for example Community Groups, TARAs etc.;

(d) asks Age UK and Citizens Advice Sheffield to consider what materials could be used as part of the effort to raise awareness of the changes and promote Pension Credit uptake; and

(e) requests that the Chair of the Committee writes to the BBC urging them to promote Pension Credit uptake as they transition to the new system.

8. WORK PROGRAMME 2019/20

8.1 The Committee received a report of the Policy and Improvement Officer (Emily Standbrook-Shaw), attaching the Committee's draft Work Programme for 2019/20.

8.2 RESOLVED: That the Committee approves the contents of the Draft Work Programme 2019/20, as set out in the report and agrees that a task and finish group be established to look at continence services.

9. COUNCILLOR PAT MIDGLEY

9.1 RESOLVED: That the thanks of the Committee be conveyed to the former Chair, Councillor Pat Midgley, for the work she has undertaken as Chair of this Committee, since May, 2016.

10. DATE OF NEXT MEETING

10.1 It was noted that the next meeting of the Committee would be held on Wednesday, 11th September, 2019, at 4.00 p.m., in the Town Hall.

Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
11th September 2019

Report of: Dawn Walton, Director – Commissioning, Inclusion & Learning, Sheffield City Council
Brian Hughes, Director of Commissioning and Performance, Sheffield Clinical Commissioning Group
Clive Clark, Deputy Chief Executive, Sheffield Health and Social Care NHS Foundation Trust
Dr Steve Thomas, Clinical Director for Mental Health, Learning Disabilities and Dementia, Sheffield Clinical Commissioning Group

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Subject: The Sheffield Mental Health Transformation Programme

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Author of Report: Sam Martin, Head of Commissioning – Vulnerable People (Sheffield City Council)
Jim Millns, Deputy Director of Mental Health Transformation (Sheffield City Council, NHS Sheffield CCG and Sheffield Health and Social Care NHS Foundation Trust)
Melanie Hall, Strategic Commissioner Mental Health (Sheffield City Council)
Heather Burns, Head of Commissioning, Mental Health, Learning Disabilities and Dementia Commissioning Portfolio (NHS Sheffield CCG)
Heidi Taylor, Clinical Effectiveness Pharmacist (NHS Sheffield CCG)
Michelle Fearon, Director of Operations & Transformation (Sheffield Health and Social Care NHS Foundation Trust)
Dr Abhijeeth Shetty, Consultant Pychiatrist (Sheffield Health and Social Care NHS Foundation Trust)

Summary:

The Sheffield Mental Health Transformation Programme is a collaborative programme of work that has been jointly developed and is being jointly delivered by Sheffield City Council (SCC), NHS Sheffield CCG (SCCG) and Sheffield Health and Social Care NHS Foundation Trust (SHSC).

The programme aims are:

- to secure better outcomes for people with mental health problems by working far more collaboratively;
- deliver more effective services through innovation and creativity;
- ensure services are far more localised, individualised and focused on prevention and early intervention; and
- to marshal resources more efficiently across health and social care to focus on shared outcomes and avoid 'cost shunting'.

The Mental Health Transformation Programme currently consists of 26 project areas which includes 4 large scale transformational schemes. These large scale schemes are focused on Promoting Independence, Dementia Care, Primary Care Mental Health and Physical Health.

The Scrutiny Committee received a report in January 2018 which outlined the programme and the individual component projects. This report now focuses in more detail on some of the impacts and outcomes delivered by the programme to date, and considers how the programme might develop further in the future.

Type of item:

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

The Scrutiny Committee is being asked to:

- Consider the impacts of the Sheffield Mental Health Transformation Programme as outlined in this report and
- Provide views, comments and recommendations for future developments.

Background Papers:

1. *The Sheffield Mental Health Transformation Programme* Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee 17th January 2018 (Click Here)

2. *Sheffield Strategy for Mental Health* (Click Here)

3. *The Five Year Forward View for Mental Health* (Click Here)

4. *Implementing the Five Year Forward View for Mental Health* (Click Here)

5. *The NHS Long Term Plan* (Click Here)

6. *NHS Mental Health Implementation Plan 2019/20 – 2023/24* (Click Here)

Category of Report:

OPEN

The Sheffield Mental Health Transformation Programme

1. Introduction

1.1 The Sheffield Mental Health Transformation Programme is an ambitious programme that has been jointly developed and is being jointly delivered by Sheffield City Council (SCC), NHS Sheffield CCG (SCCG) and Sheffield Health and Social Care NHS Foundation Trust (SHSC).

1.2 The overarching aim of the Programme is to address what are predominantly long-standing issues in Sheffield, whilst remaining focused on quality and prevention. Taking a more holistic approach to the delivery of mental health care will improve the lives of people with mental health problems and mean resources are used more effectively. It will also help to focus on the wider determinants of mental ill health and develop more preventative services. This is very much in keeping with national policy and guidance, including the NHS Long Term Plan[1] which aims to promote person centred care underpinned by principles relating to health and social wellbeing, prevention, promotion and early intervention.

1.3 Prevention is an important element of the overall programme. If we get this right, this will not only improve the outcomes for individual service users but will ultimately deliver financial efficiencies as we will rely far less on secondary health care services. This aspiration therefore underpins the entire transformation programme (as well as the city's Public Health and Mental Health strategies).

1.4 The Programme began in 2017 and was originally intended to run for 4 years until 2021. We are therefore just over half way through, which means we have the ideal opportunity to reflect on the impact and success of the programme so far; and importantly decide how we can continue to work together in partnership to make further improvements for the people of Sheffield.

2. Context

2.1 Mental health problems are common; one in four people will experience a mental health problem in their lifetime and around one in one hundred people will suffer from severe mental ill health.

2.2 People with good mental health and wellbeing tend to experience lower rates of physical and mental illness, recover more quickly when they do become ill (and remain healthy for longer) and generally experience better physical and mental health outcomes. Good mental health and

[1] https://www.longtermplan.nhs.uk/

wellbeing also represents a significant asset in terms of underpinning broader outcomes such as educational attainment and employment opportunities.

2.3 Conversely people with a severe mental illness have a threefold increased risk of premature death than those without such an illness and a reduced life expectancy of approximately 16 years for women and 20 years for men. Although suicide accounts for around 25% of these deaths, physical illnesses account for the other 75% with cardiovascular disease being the most common cause of premature death in people with mental ill health and diabetes the most significant cause of increased ill health. In addition smoking rates in people with mental health problems are, on average, twice as high as those in the general population; as a consequence, smoking related illnesses are also much more common.

2.4 It is estimated that in Sheffield around 17.1% of the adult population (over 80,000 people), have either depression or anxiety. In addition around 0.9% of the Sheffield population (over 5,000 people) have a severe mental illness (such as psychosis or severe depression)[2].

2.5 As a city, Sheffield spends around £150 million on mental health services each year, of which around £86 million (57%) is spent on services provided by Sheffield Health and Social Care NHS Foundation Trust. The other 43% is spent on a variety of services provided by other NHS providers, residential and nursing home providers and the Voluntary, Charitable and Faith sector.

2.6 The commissioning of, and in many respects the delivery of mental health services in Sheffield has however had been historically fragmented. Commissioning plans in particular had been largely developed in isolation, meaning opportunities to consider broader clinical and societal benefits, looking at much wider care pathways, were not fully exploited.

2.7 An integrated approach to care and support is therefore the right direction of travel for meeting the changing needs of our population, particularly in the context of increasing numbers of older people and people with long-term and complex conditions. Fragmented and disjointed care can have a negative impact on patient experience, result in missed opportunities to intervene early, and can consequently lead to poorer outcomes. Poor alignment of different types of care also risks duplication and increasing inefficiency within the system (for example referrals between agencies to address different aspects of an individual's needs). People tell us that they want their health and social care more joined up and not see lots of people, they want a more centralised offer of help when they need it.

[2] https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/

2.8 Commissioners and providers have therefore worked hard over the last 4 years to build productive working relationships. In 2017 SCC and SCCG established a pooled budget arrangement as part of the Better Care Fund (predominantly covering working age mental health spend), and have recently created an informal integrated commissioning team. In addition we have also worked hard to build constructive and open relationships with our providers, enabling us to deliver a number of significant achievements which are outlined later in this report.

3. The Programme

3.1 The Mental Health Transformation Programme currently consists of 26 project areas which includes 4 large scale transformational schemes. These large scale schemes are focused on Promoting Independence, Dementia Care, Primary Care Mental Health and Physical Health. A summary of each project is detailed below:

Project Name	**Project Objective**
Section 117 Aftercare (Reviewing Function)	To ensure that all individuals who are in receipt of Section 117 Aftercare Services are receiving clinically appropriate and effective care.
Reducing Anti-Depressant Use	To reduce the amount of antidepressant medication that is prescribed in Sheffield (where it is clinically appropriate to do so).
Section 12 Fees	To reduce the amount spent on section 12 fees and also increase the availability of section 12 approved doctors.
Crisis Care Pathway	To ensure that all aspects of crisis care in Sheffield are operating effectively and are having the optimum impact.
Transforming Care	To reduce the number of hospital beds that are commissioned to provide care for people with learning disability and/or autism. This will be achieved through an improvement in community services including better and more accessible crisis support,
Promoting Independence	To support adults with enduring mental health needs to live more independently in the community.

Dementia Care Pathway	To develop work plans focussing on '*Living Well with Dementia*'; assessment/respite provision and intensive community support; and reviewing high dependency and on-going care services.
Neighbourhood Health and Wellbeing Service	To consider options for how to progress the development of a Primary Care Mental Health Service which will deliver better outcomes for individuals through more personalised holistic care and through earlier intervention.
Developing a Psychiatric Decision Unit (PDU)	To provide an effective alternative to A&E, a place of safety for those needing immediate care (and attention) plus provide an informal facility from which to provide ad-hoc and immediate treatment to avoid crisis situations.
Bespoke Packages of Care (Including CHC and IFR Reviews)	To review those service users who currently have complex care needs and are in receipt of high cost packages of care and varying levels of additional observations; across the CHC, s117 and IFR portfolios.
Mental Health Five Year Forward View	To ensure that all requirements of the MH5YFV are delivered.
Eating Disorders	To redesign our eating disorder services to improve the experience of service users and ensure that people get the 'right help at the right time in the right place'.
SHSC Service Specification Reviews	To undertake a robust review of all current specifications as included in the SHSC Contract. This is to ensure they are evidence based, fit for purpose and strategically aligned.
Legacy CHC Grant Arrangements	To jointly review all (legacy) CHC grant arrangements that are currently in place.
Perinatal Mental Health	To enhance the current Perinatal Mental Health service through national transformation funding.

Better Care (Physical Health)	To ensure that people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and interventions.
Transitions	To improve both the effectiveness and the service user experience relating to the transition pathway from CYP to Adult Mental Health Services.
Autism	To design and develop a solution in terms of addressing the current demand for the SAAND Service. Currently this is far outstripping capacity. The average waiting time is over 52 weeks.
VCF Sector	To identify key pathways where better integration across statutory and voluntary sector services can be explored. This will improve the service user experience and clinical outcomes.
Personality Disorders	Consider options for the development of a community based specialist personality disorder service.
Trauma PTSD	To scope the potential impact of developing an early intervention trauma service.
Prevention and Early Intervention	To address the determinants of mental ill-health, including (but not limited to) housing, debt and physical health. Ensure that sources of help and support are well publicised and are available to everyone at the earliest opportunity.
Access and Waiting Times	Ensure that plans are in place to deliver the waiting time standards, as detailed in the NHS Long Term Plan.
Digital and Data	To develop a strategy for ensuring that we fully utilise data and digital technology to help improve services and the outcomes of those who use them.

Vulnerable Groups	To develop specific plans to address the needs of individuals who could be described as vulnerable. These are groups whose outcomes, generally speaking, tend to be worse than the general population.
Housing, Benefits and Employment	To ensure that the wider transformation programme does not focus entirely on health and social care. Housing, benefits (income) and employment are significant factors that impact on the recovery and wellbeing of all individuals who experience mental ill health.

4. What Has The Programme Achieved?

The following sections of the report set out in more detail the work of a number of key projects which form part of the overall Transformation Programme, and the impact these projects have had.

4.1 Section 117 Aftercare (Reviewing Function) and Promoting Independence Projects

There are two key components to these projects:

- Increased oversight of the high cost funding panel and raising the profile of social care in mental health; and
- Creating a recovery and rehabilitation model in residential care using a social investment bond and life chances fund

4.1.1 What Have The Projects Done?

4.1.2 For many years the city has had a 'high cost funding panel' where health and social care packages costing over £15,000 per year have been agreed. In 2016 a new policy and approach to the panel process was implemented.

4.1.3 Previously the panel was used mainly as a 'gateway' to funding. The panel was not involved in planning but acted mainly as a sign-off after the person had in many cases already started in a placement. Now the panel requires a planned request with agreed conditions if a decision is required urgently. The panel also acts plays an *advisory* role - indicating alternatives to 24 hour care through provisions under the Care Act such as personal assistants, mixed packages and direct payments. Requests to the panel require more consideration by frontline practitioners of what the needs of the person, rather than just availability of a placement. This more considered and person centred process has enabled many people

to move from hospital to their own tenancy (instead of residential care) which gives them a more secure future and a more independent life.

4.1.4 The Transformation Programme has also raised the profile and importance of *social care* as a priority within the overall mental health system. The programme enabled us to recruit a senior social worker to review health and social care packages with the delegated function from both the CCG and SCC. So far over 150 people have now had a comprehensive person centred review of their needs. In some instances no change has been made to the package (or the costs) but more frequently packages *have* been revised and in 18 instances clients have been moved into supported accommodation and other ordinary housing with care support in a planned way. An audit of these 18 clients in February 2019 showed a 96% sustainment rate; in other words those people had maintained their new tenancy/accommodation and had not required readmission to 24 hr care.

4.1.5 All clients within the remit of this project have complex needs, severe and enduring mental health problems and in many cases long histories of hospital and institutional care. The cohort includes clients subject to Home Office restrictions and Community Treatment Orders. Reviewing work requires extensive engagement with clients, their families, advocates, providers, community mental health teams and this can be a slow and delicate process, lasting several months in some circumstances.

4.1.6 In one particular case, the individual had been in residential care for over 6 years; the care was good but did not encourage independent living. For example the staff used to shower him, and read him a book at night. Through the work of the reviewer, this person now lives in his own tenancy with help from his sister. He now showers himself with visual prompts and after having his eyes tested he now reads the book himself, which he much prefers.

4.1.7 Further case studies are detailed in *Appendix A*.

4.1.8 Alongside the clear benefits and impacts this work is having on individual people's lives, it has also led to a reduction in mental health social care costs from a total of £258,000 in 2016-17 to £133,000 being the forecast spend in 2019-20:

4.1.9 This collaborative way of working is now 'business as usual' and has paved the way for the more ambitious project focused on reshaping our approach to residential provision.

4.1.10 The work on the panel and new approach to reviewing people's care has also helped commissioning staff to have a more 'informed conversation' with service providers who deliver health and social care. Providers have seen that increasingly our ambition is to work actively to promote recovery and independence, and reduce the number of people needing

traditional residential care type offer. A number of providers are therefore already responding very positively to this approach and are shaping their offer to be more rehabilitation focused.

4.1.11 The commissioning team has held provider events over the last 3 years with all current and potential providers. The events are an opportunity to listen to the market and speak with them about up and coming trends and planning related issues. Through this market shaping and development we have prepared the residential care market and home 'one to one' support for change. We have secured a social investment bond and consortium of providers willing to change to residential rehabilitation. This was led by the commissioning team with support from the social policy team and commercial services within Sheffield City the Council.

4.1.12 The outcomes of this work have resulted in:

- The integrated commissioning partners (SCC, CCG, SHSC) investing £3 million in to our existing Mental Health residential rehabilitation services;
- Access to £750,000 funding from the Government's Life Chances Fund;
- Sheffield is working with a South Yorkshire Consortium to actively help people to recovery from the effects of serious mental illness though skilling people up to have full and active lives in their own home;
- A social investment organisation - *Big Issue Invest* - is working with us to change the residential care market to focus on rehabilitation so people can live in their own homes successfully;
- The project is starting in August 2019 and will be funded for the next 5 years; and
- The Project will see more people receiving support and will deliver savings of up to £1.4 million over the next 5 years.

4.1.13 <u>What Impact Have The Projects Had?</u>

- Through this work the section 117 reviewing function has become 'business as usual' and a more recovery focused approach to care planning has become more embedded in service culture;
- 51 people are now living in less restrictive settings, making more independent decisions about their day to day lives;
- Costs have been reduced by approximately £2 million across the health and social care system;
- Residential care staff have reported having more job satisfaction;
- Residential homes which have moved to residential rehabilitation, report lower sickness and 'a new energy' in the way people are supported;
- Reduction in the number of residential beds used;

- Shaping the market to offer residential rehabilitation not just a 'safe and secure' offer. Three residential care homes have moved to residential rehabilitation and two others are indicating they will move soon;
- Sheffield has secured additional £750,000 life chances fund to support the delivery of the move from residential to own tenancy; and
- The new processes have 'trail-blazed' the way SCC, CCG and SHSC make commissioning decisions collegiately.

4.2 Mental Health Liaison

4.2.1 What Has The Project Done?

4.2.2 The Sheffield Mental Health Liaison Service provides specialist mental health assessment and care to anyone over the age of 16 who is admitted to Sheffield Teaching Hospitals NHS Foundation Trust or who attend the Emergency Department at Northern General Hospital.

4.2.3 The new service is available 24 hours a day. It is available to individuals who have been diagnosed or have a suspected mental health problem, people who need additional help during their hospital stay or who have psychological difficulties as a consequence of a physical illness. This includes individuals who have self-harmed or are expressing suicidal ideas or plans.

4.2.4 Since 2018 the liaison mental health offer has also been complemented by the introduction of an integrated IAPT (Improving Access to Psychological Services) service. This development has introduced psychological therapists who work alongside physical healthcare practitioners. This is particularly important because people with physical healthcare needs, including life limiting conditions or disabilities, are also at higher risk of mental health issues including depression or anxiety. It is important that services are able to respond effectively to the needs of these patients.

4.2.5 We are also in the process of extending our perinatal mental health service and have been successful in securing additional funding from NHS England to support this. This will provide a more effective service for mums to be who experience mental health problems, to enable them to have a more positive pregnancy and birth experience and make for a better start in life for their babies.

4.2.6 Liaison mental Health service development is a key component of the new national NHS Long Term Plan. Through the work outlined about Sheffield will *already be fully compliant* with the 'core 24' standards outlined as a future target in the Long Term Plan, having achieved this in 2018.

4.2.7 Our ambition is to ensure that care support and treatment is based on *need not on the availability of services*. A key element of the mental health liaison teams remit therefore is to ensure:

- Awareness training is continually delivered;
- Consultation is always available to all staff in wider health and social care services; and
- That services across the Sheffield Teaching Hospitals sites provide holistic seamless care.

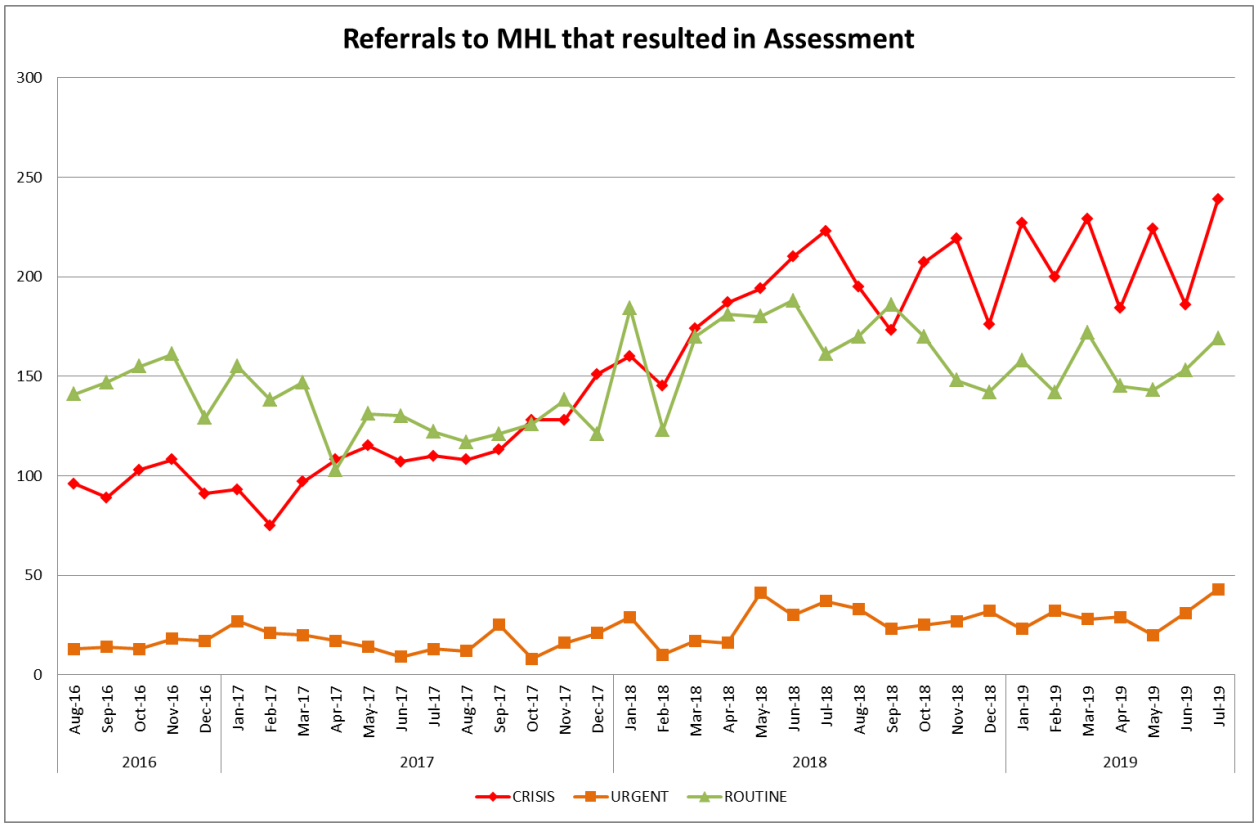
4.2.8 <u>What Impact has the Project Had?</u>

4.2.9 The project has, from November 2017, increased the availability of mental health professionals in inpatient and outpatient settings.

4.2.10 Comparing the 12 month periods August 2016 - July 2017, and August 2018 - July 2019 the Liaison service has seen:

- A 47% increase in the average number of referrals per month, from 354 to 521;
- A decrease in the amount of referrals received that end up being discharged without assessment, from 218% to 25%. This is seen as an indicator that there are fewer *inappropriate referrals* as clinicians get to know the service and what it can offer; and
- A 54% increase in the average number of assessments per month from 354 to 521, split as follows:

	Crisis	**Urgent**	**Routine**
2016-17	99	16	138
2018-19	204	29	158
	106% increase	81% increase	14% increase



4.2.11 In July 2019 the Liaison service was reviewed by the National Psychiatric Liason and Accreditation Network, which is part of the Royal College of Psychiatrists as part of a National accreditation process in line with nationally agreed quality standards. The report from this visit has not yet been published in final form, but the draft report includes a number of points that can be shared with the Scrutiny Committee.

4.2.12 In terms of the working of the Liaison Team, the review highlighted a range of support available to different staff groups. The team reported that they feel supported in their roles with a range of training opportunities available, including monthly CPD activities. Staff also reported there is a thorough and detailed induction into the team, with a 4-day Trust induction and 6-week local induction. The service is proactive, particularly working to overcome challenges and identifying new ways to respond to these. The team have access to the decision unit within the Care Trust, who support them in the role as well as in relation to patient outcomes. Information given to patients about the liaison team is clear and detailed.

4.2.13 A quote from the review: "*The team here is extremely supportive and professional and the leadership is the best I have ever experienced in my 30 years of working. There is constant communication within the team, whether in email form or verbal and I never feel unable to seek advice no matter who is on duty. I have nothing but praise for everyone and feel very privileged to work within the team*"

4.2.14 In terms of the team working with clinicians and colleagues in acute services, colleagues gave very positive feedback on the liaison team moving to being a 24 hour service. The support discharge team were found to be very useful as a resource to enable patients to be fully supported on discharge. Communications worked well with acute services, and the training provided by the team to acute services was well received, as it is delivered in an accessible format (including through, for example, breakfast club type sessions). One of the clinicians surveyed in the review was quoted as saying "*When the liaison team is involved it can change the dynamics of how we manage complex patients. It is a game changer*".

4.2.15 Patient feedback as part of the review was positive, for example:

- "*The nurse who saw me was kind and professional*"
- "*The staff listened to me and give me time to try to explain my problems*"
- "*They treated me well and helped me with my depression and support. They discussed medication and asked my choice*"

4.2.16 <u>Case Studies from the Mental Health Liaison Service</u>

4.2.17 **John** was a 30 year old man with a 10 year history of contact with Mental Health Services in Sheffield. He had a diagnosis of borderline personality disorder and had frequent unscheduled contact with different services. He had been discharged from the Mental Health Recovery Service due to non-engagement with scheduled community care support. Up to this year he had had 17 admissions to the Acute Medical Unit at the Northern General Hospital following self-harm. John was considered to be at high risk of accidental death due to misadventure and a high risk of irreversible harm due to repeated paracetamol overdoses. Acute service staff found it very hard to work with John repeatedly when he presented in crisis.

4.2.18 Under the new arrangements a Senior Practitioner from Liaison Psychiatry took over clinical leadership and organised a Professionals Meeting involving senior practitioners from Decisions Unit, Recovery Service, Intensive Home Treatment Service and Single Point of Access.

4.2.19 It was agreed that an Occupational Therapy assessment would be carried out at John's home to determine his level of functioning and the safety of the home environment. In order to prevent further unplanned care seeking admissions to Emergency Department and Acute Medical Unit, regular *planned* admissions to the Psychiatric Decision Unit at the Northern General was offered for a month. During these admissions, John would be offered crisis and contingency planning and helpful coping strategies and improve his awareness of triggers for self-harm. If this helped then longer term psychosocial interventions would be offered by the Recovery Service.

4.2.20 Since this plan was implemented John has not presented to the Emergency Department or self-harmed. He has had 2 planned admissions to the Decision Unit and has engaged in a crisis and safety plan. The Occupational Therapy assessment found that John's housing is poor and he was being threatened by drug dealers in the area. He has been referred for medical priority for rehousing. Due to consistent engagement will be referred to Recovery service for a social care package including befriending service to improve social activities.

4.2.21 **Yasmin** is a 20 year old woman who sought asylum in the UK and had been living in Sheffield for 18 months. Yasmin had more than 30 attendances at the Emergency Department with chest pains and palpitations. All the usual test results came back normal, and Yasmin was diagnosed with severe anxiety.

4.2.22 Yasmin was seen in the Liaison Psychiatry clinic, and a complex history emerged of post-traumatic stress disorder following being subject to torture in her home country and being socially isolated in the UK. She had anxieties about her health, psychotic depression and heard voices commanding her to die by hanging. Yasmin started a course of antidepressant and antipsychotic medication, and was referred to the Home Treatment team who monitored medication and provided a support worker to improve her social inclusion. Through this she established contact with her local mosque and other community organisations

4.2.23 Yasmin's social network has grown and her low mood, hearing voices and suicidal thoughts have improved. However her post traumatic stress and health anxiety remain, though are less acute. Yasmin has since been discharged from Home Treatment to the Improving Access to Psychological Therapies Service (IAPT) for Cognitive Behavioural Therapy to manage the health anxiety, with a long term plan to then begin to address the post-traumatic stress.

4.3 Reducing Antidepressant Prescribing

4.3.1 What Has The Project Done?

4.3.2 The purpose of this project is to explore potential and possible options for reducing the prescribing of antidepressant medication in Sheffield. This was an area that was highlighted as an opportunity to review as prescribing data shows that Sheffield was higher than the national average in prescribing of antidepressants.

4.3.3 The current National Institute for Clinical Excellence (NICE) guideline for depression in adults (CG90) recommends that:

- For adults with mild to moderate *depression* clinicians should consider offering low-intensity psychosocial interventions (e.g. computer based cognitive behavioural therapy);

- For adults with persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and/or moderate and severe depression in adults clinicians should offer either high intensity psychological therapy or antidepressant medication.

4.3.4 A number of factors should be considered when deciding the treatment most suitable for an individual patient (for example patient preference, how likely the patient is to stick to a treatment plan, and previous response to other treatment options). If a response is seen to an antidepressant, this usually happens with 2-4 weeks after commencing treatment. The current national measure for accessing IAPT (Improving Access to Psychological Therapies) for high intensity psychological therapy is 6 weeks, although low intensity inventions can be offered straight away. These factors are taken into consideration when discussing options with patients.

4.3.5 There are other conditions and NICE guidelines that recommend antidepressants, the main alternative condition being *anxiety disorders*, e.g generalised anxiety disorder (GAD), post-traumatic stress disorder (PTSD) and obsessive compulsive disorder (OCD). The use of antidepressants for GAD is part of a stepped care pathway, generally *after* psychological support has been offered.

4.3.6 The duration of time that a person should be on an antidepressant is always patient and condition specific based on clinical assessment and judgement. However, NICE guidelines recommend:

- Patients with depression should remain on treatment for *at least 6 months after remission*. People with recurrent or severe depression or at high risk of relapse should consider staying on treatment for *at least 2 years*; and
- Patients with GAD should remain on treatment for at *least 12 months* after remission as the likelihood of relapse is high.

4.3.7 NICE is currently updating its guideline for depression in adults (CG90), this was due to be published in September 2018, however has been delayed until December 2019 to allow more time to assess evidence and effectiveness of treatments available.

4.3.8 <u>Initial Sope of the Project</u>

4.3.9 The following were suggested actions in the original scope of the project:

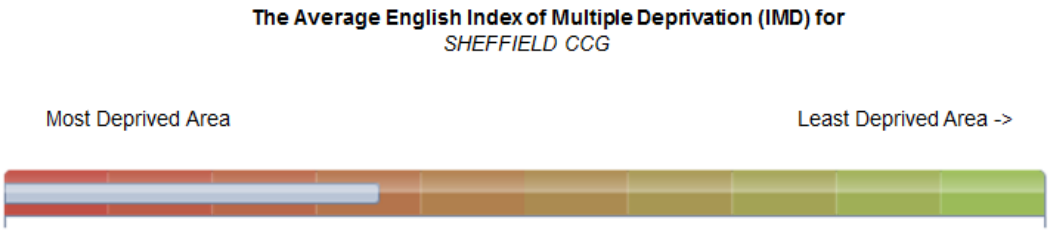
- Conduct and audit current use of antidepressant against NICE guidance
- Consider the pros and cons of establishing a neighbourhood special interest Mental Health GP or Health Care Practice to whom patients could be referred to assess appropriate pathway and ongoing review of patients with depression;

- Review the formulary recommendations which are used locally; and
- Undertake education and training of GPs regarding NICE pathways / IAPT and carry out targeted medication reviews, for some patients including those with increased anticholinergic burden score (increases risks of side effects), those who have been on treatment for longer than 2 years; or on the medications which are more expensive or which have higher risk of side effects, where a more cost effective or option with a better safety profile may be a suitable alternative.

4.3.10 Ongoing and additional investment in IAPT provision was also anticipated to have an impact on prescribing patterns, with greater access and reduced waiting times to psychological therapy it was anticipated that the use of antidepressants may reduce.

4.3.11 In 2016-2017 clinicians in Sheffield issued 643,854 prescription items for antidepressant medication (excluding amitriptyline that is mainly used for other indications). This cost £2,590,748. To help put this into perspective this accounted for 5% of the total prescribing budget for the city and 3% of all items dispensed.

4.3.12 Sheffield is more deprived than the England average and NHS Right Care data (2017) stated Sheffield has a higher prevalence of depression when comparing against similar 10 CCGs. The graphic below is from ePACT2:



4.3.13 Multi-morbidity is more common among more deprived populations – especially those that include a mental health problem. There is research evidence that the *number of conditions* a patient has can be a greater determinant of a patient's use of health service resources than the specific diseases or conditions.

4.3.14 People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds (economic, social etc). The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities. There is evidence that the relationship between having multiple long-term conditions and experiencing psychological distress is exacerbated by socio-economic deprivation in two ways. Firstly, a greater proportion of people in poorer areas have multiple long-term conditions. Secondly, the effect of this

multi-morbidity on mental health is *stronger* when deprivation is also present.

4.3.15 Although addressing the mental health needs with medication and psychological therapies can help individual patients when the condition arises, this alone is not enough. A wider approach is needed to address deprivation as well as providing tools and resources to promote healthy lifestyles to reduce multimorbidity and mental health conditions (e.g. physical exercise, healthy diet, smoking cessation).

4.3.16 Additional investment in IAPT has directly been used to develop the Sheffield Health and Wellbeing service. This service is aimed to support people with long term physical health conditions with their mental health, or to offer early interventions and support to prevent mental illness in groups that are more likely to becoming mentally ill due to their long term conditions.

4.3.17 The increased prevalence in Sheffield, increasing public awareness and growing lack of stigma associated around mental illness is likely to result in an increase in patients presenting to their health care professional seeking advice at times when they are not feeling mentally well.

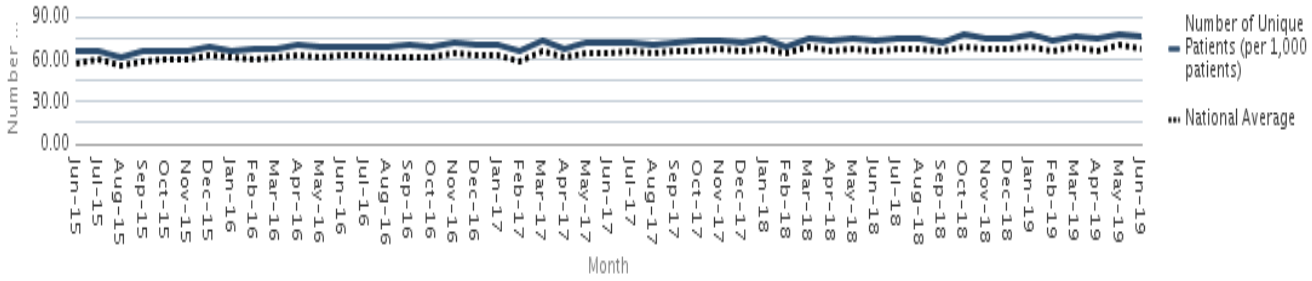
4.3.18 <u>Actions Taken to Date</u>

- Due to the delay in the update of the NICE guideline for depression (CG90) a local audit of antidepressants has not yet happened.
- After exploring a number of routes, NHS Sheffield has now been successful in securing funding to *increase Mental Health expertise in primary care setting and* across the interface with the adult and children mental health specialist teams. A recruitment process for a pharmacist to carry out targeted work in this area is underway.
- The *Sheffield Formulary* offers guidance and advice to primary care clinicians around the most clinically effective and cost efficient choices. The chapter relating to mental health was updated in April 2018. This was then shared via a number of routes; utilising the GP clinical practice systems; GP practice bulletin; GP attached pharmacists, locality and practice meetings.
- Local protocols to support the care and management of patients that present with depression and generalised anxiety disorder (GAD) have been produced, shared and promoted using various methods, including an education session at a primary care Protective Learning Initiative (PLI).
- The addition of dosulepine and trimipramine to the Sheffield STOP list. These were added to the guidance because compared to alternative antidepressants they increased risks (dosulepine has an increased side effect profile) and costs respectively. Medicines included in the Sheffield STOP list should not be initiated in new patients and existing prescribing should be reviewed at the next routine review.

- Investment in core IAPT has continued to increase year on year as part of a separate strand of the Transformation Programme. On top of this growth, additional investment into the IAPT service over the last three years has been made to directly fund the integrated IAPT work (the Sheffield Health and Wellbeing service).

4.3.19 What Impact has the Project Had?

The proportion of unique patients prescribed antidepressants in Sheffield over the last 3 years (per 1,000 patients):



4.3.20 The graph above, taken from the ePACT2 mental health dashboard, is showing the number of unique patients being prescribed an antidepressant over time. From this it can be seen that Sheffield continues to track slightly above the national average, apart from a couple of months where levels seem to dip.

- From local prescribing data the number of prescription items for antidepressant medication has increased from 643,854 in 2016/7 to 717,009 in 2018/19.
- Adding dosulepin and trimipramine to the STOP list has seen a reduction in the number of items and spend on these two medicines. This reduction has resulted in improved patient safety and a reduction in costs of £31K (annualised).
- IAPT activity continues to grow year on year. The number of people within Sheffield CCG (i.e. registered with a Sheffield GP) accessing IAPT has increased from 12,960 (in 16/17) to 13,335 (in 18/19), an increase of 5.21%. The national 6 and 18 week waiting time targets, set at 75% and 95% respectively, continue to be achieved. The proportion of people being seen within 6 weeks has improved from 84.52% in 16/17 to 89.67% in 18/19. The proportion seen within 18 weeks has improved from 98.17% to 99.03%.

4.3.21 The increasing rate of diagnosing depression / GAD is seemingly greater than the rate of people in remission and thus stopping antidepressant medication. This can be seen from the increasing volume of prescriptions being dispensed and investment and use of IAPT services.

4.3.22 Feedback from Clinicians

4.3.23 In writing this report feedback was sought from a small number of GPs, responses are below:

- '*My guess is that the numbers of new starters may have slowed but there is a growing group who value their antidepressant and are hard to get off. The meds themselves are physically difficult to wean off and often the original problems don't go away either*.'

- *'Whilst the increase in IAPT services is very welcome it may not be adequate or sufficient to fully meet the ever changing demand. Although the therapy offer at hand to the clinician has changed in this time, it doesn't mean that patient expectation will have changed to match this over the same time.'*

- *'GP colleagues may not follow guidelines particularly about watchful waiting and we are not so good at discontinuing antidepressants after successful treatment. Just like colleagues have previously stated that there are (in their perception/experience) huge wait times for Memory Clinic when in fact the whole diagnostic pathway is currently 6 weeks from referral to diagnosis, we still think similarly for Core IAPT services, when the data/evidence says that nearly 90% of people are seen within a 6 week pathway and 100% (well, 99.6%!) in an 18 week pathway. Of course many of those people will also be using antidepressants as well as psychological interventions.'*

- *'We should invest in more psychological support and treatments, but we should also be directing resources to prevention of illness and promotion of wellness which goes well and way beyond the remit of the NHS.'*

4.3.24 Conclusion

4.3.25 The high use of antidepressants is a complex and challenging issue, and not completely unique to Sheffield. It is difficult to conclude whether the actions taken by the project so far, which have undoubtedly led to some changes in prescribing practice, have been offset by an increased number of new patients presenting with depression or anxiety.

4.3.26 There is increasing acuity of mental illness presentations across the system, and unmet need is being revealed. GPs and other professionals sometimes don't recognise that there are psychological interventions available in a timely manner before prescribing becomes necessary. In such a complex system as the NHS it often takes time for information about changes to services to become well known across the system. GPs sometimes therefore feel that prescribing is the only option open to them, when often it isn't.

4.3.27 It is important to note that sometimes it is absolutely necessary to both prescribe medication AND have psychological interventions for a patient. Additionally, sometimes 'antidepressants' are used for other purposes e.g. treating anxiety or migraine or premenstrual syndrome

4.3.28 This highlights the importance of the Transformation Programme as an interrelated set of strategic activities, not just a group of 'standalone' projects. It strengthens the case for a more comprehensive approach to mental health wellbeing and prevention

4.3.29 Next steps

- Once the updated NICE guidelines for depression have been published we will review our local guidelines, formulary and protocols and cascade any advised changes in practice accordingly.
- We will work with the newly recruited pharmacist to promote MH pathways and guidelines and audit / review patients on long term antidepressants and assess if IAPT is being offered in line with national / local guidelines.
- Public Health England are currently undertaking a review looking at prescribed drugs that may cause dependence, this is due to be published in September 2019. Antidepressants have been part of this review [3]. Once this report is published we will review it to see if there are any suggested actions that need to be taken locally.

4.4 Transforming Care

4.4.1 What Has The Project Done?

4.4.2 Transforming Care was a national three year transformation programme, originally due to finish at the end of March 2019. The programme aimed to reduce over reliance on admitting people into specialist hospitals who have learning disability and/or severe autism but who also who have additional highly complex behaviours that are challenging to support within community settings, by developing alternative community service models to provide care in less restrictive environments.

4.4.3 Many people nationally had previously "lived" inappropriately for several years in hospital, as alternative skilled community provision was not available for people with additional very complex needs. These may include behaviours that are challenging to support such as self-injurious behaviours, or those that present a risk of harm to others, through for example serious aggression and offending behaviours.

4.4.4 However, a series of undercover exposures and national scandals around poor care and criminal abuse in some, mainly private, hospital settings across the country drove the government to develop the Transforming Care Programme to commit to transformational change.[4]

[3] https://www.gov.uk/government/collections/prescribed-medicines-an-evidence-review

[4] https://www.england.nhs.uk/learning-disabilities/care

4.4.5 The programme is therefore built on the fundamental principle that '*Hospitals are not homes'.* Admission to hospital should therefore take place for the least possible length of time, and only if other less restrictive alternatives are not possible to address the presenting complex mental and behavioural needs of the individual. Whilst initially aimed at adults, the programme was extended to include children and young people. NHS England commission inpatient hospital treatment for this age range, but we work in partnership with them to reduce admissions where possible, and to discharge children into appropriate community settings.

4.4.6 The programme therefore set a national target of a minimum reduction of 45-65% of CCG commissioned specialist hospital inpatient capacity and 25-40% of NHS England commissioned capacity over the 3-year period, to drive a reduction in over-reliance and inappropriate usage of hospital admissions for this specific group of people with learning disability and complex behavioural needs.

4.4.7 To respond to this programme, Local Authorities, Clinical Commissioning Groups and NHS England Specialised Commissioners were asked to form a Transforming Care Partnership (TCP) in each region, to work together on implementation. The TCP for this area is South Yorkshire and North Lincolnshire (SY&NL TCP) comprising Doncaster, Rotherham, North Lincolnshire and Sheffield CCGs and the corresponding Local Authorities.

4.4.8 The SY&NL TCP had 45 adult CCG inpatients at the start of the programme, and NHS England set an end target reduction of no more than 10-15 inpatient beds commissioned by CCGs for our TCP area by the end of March 2019.

4.4.9 This emphasis on '*Hospitals are not Homes*' also included a new national model of enhanced community based support, "Building the Right Support"[5] which NHS England and ADASS both committed to. The model states that each area is expected to reinvest savings from hospital bed closures into enhancing community services to provide alternative care in less restrictive environments, and to develop local provision to meet needs, so that people could be cared for closer to home.

4.4.10 Due to a national failure to deliver on this Transforming Care agenda, the programme has now been extended to run until April 2021. However it should be noted that our South Yorkshire Transforming Care Partnership has been nationally highlighted for the progress made on moving people out of hospital and into less restrictive environments, and has been identified as having been one of the most successful areas in the delivery of this programme in the country, with Sheffield itself highlighted for its performance.

[5] https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

4.4.11 What Has The Project Done?

4.4.12 Sheffield CCG and Local Authority started this programme with 25 people in adult inpatient beds, seven of whom were in a local Assessment and Treatment Unit, Firshill Rise, run by Sheffield Health and Social Care NHS Foundation Trust (SHSC). The rest of the placements were purchased in out of city locked rehabilitation placements by SHSC in a devolved commissioning arrangement for detained patient care. This represented an opportunity to improve the lives of this cohort of people by identifying less restrictive environments in which to provide their care.

4.4.13 All 25 of the original cohort of 25 people have now been discharged into less restrictive environments, such as residential care and supported living settings, and are now living more independent lives.

4.4.14 Many of these individuals were previously under Ministry of Justice restrictions, so this represents significant transformation in the lives of the individuals concerned. This change has been achieved through coordinated, determined and sustained effort by Social Workers, Clinicians, and leaders within the Local Authority, Sheffield CCG and SHSC to achieve this major improvement in the lives of these individuals, and greater personal freedom, from living in less restrictive settings than a hospital affords.

4.4.15 Overall, over the 3 year programme duration, 54 people have been discharged into community placements, as 12 additional patients were stepped down by NHS England from secure hospitals to care commissioned by Sheffield, and additional new people were admitted appropriately, treated and discharged through the Assessment and Treatment Unit in Sheffield, for varying lengths of stay during this period The average length of stay has significantly reduced over the three year period fromover 180 days to 90-180 days average.

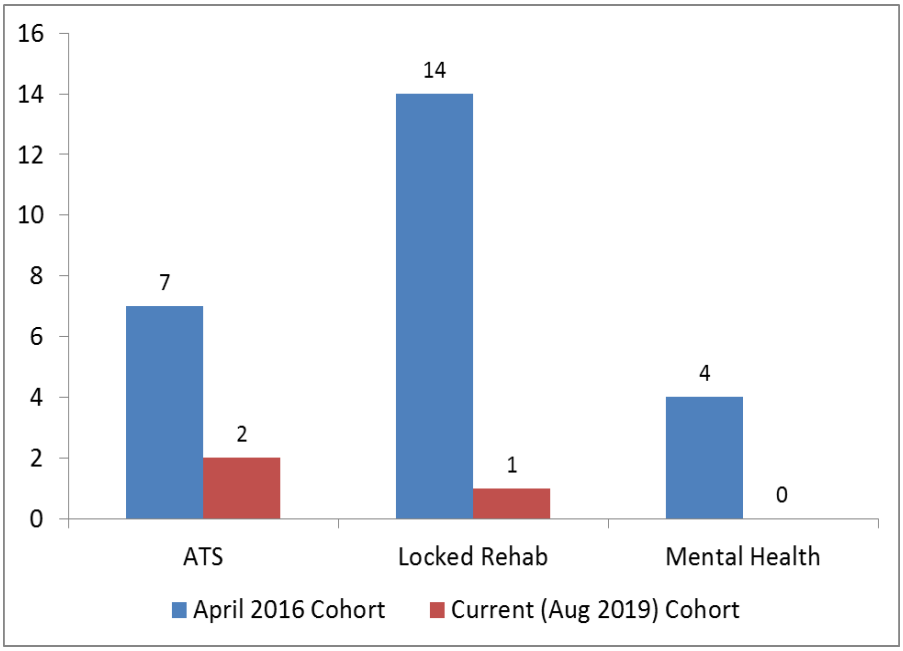
4.4.16 In line with the national aims of the programme Sheffield has successfully discharged 23 people with a length of stay in hospital of over 5 years, including 3 patients who had had been in hospital settings for over 30 years.

4.4.17 Sheffield has successfully *avoided* over 50 people being admitted to hospital as part of the programme, through timely multiagency Care and Treatment Reviews, and preventative interventions. There are currently now only 3 Sheffield adults receiving treatment in hospital beds, commissioned by Sheffield CCG. Sheffield has therefore surpassed its target of seven hospital beds for adults in use by the end of the original programme in March 2019, as people are receiving better care closer to home to avoid unnecessary admissions.

4.4.18 Additionally Sheffield has significantly reduced the usage of out of city locked rehabilitation beds and acute mental health wards for inpatient admissions for people with Learning Disabilities, so that the majority of admissions are now to the specialist Assessment and Treatment Unit in Sheffield.

4.4.19 We have also seen successful discharges and avoided admissions for children and young people, (CYP) but will be focussing more resource on admissions avoidance for this group, through the provision of a specialist CYP Care and Treatment Review Coordinator, and through the recently commissioned Home Treatment Team for young people. We are also reviewing the provision of services to young people with autism, as this is an area of prevalence growth.

4.4.20 Transforming Care Cohorts 2016-2019: CCG Inpatient Locations



4.4.21 What Impact Has The Project Had

As described previously, people who had delayed and often blocked discharge pathways out of hospital settings, are now rigorously tracked at admission, and agencies work more effectively together to plan robust discharges. This means that individuals are able to move to less restrictive environments more quickly and sustainably, once their episode of care has successfully stabilised their original presenting conditions. Individuals experience a return to a more “ordinary life” living within community settings, rather than segregated in hospitals. For the original cohort of people, particularly those individuals who had “lived” in hospitals for many years, the transformation has been enormous, as they now have more choice and control, and live more integrated lives within communities, in less restrictive settings.

4.4.22 **Case Study 1**: One man in his forties, spent many years in restrictive hospital care out of city, under restrictions imposed by the Ministry of Justice, and is now living in specialist supported living in his own tenancy with support, doing paid work as an Expert by Experience

4.4.23 **Case Study 2**: One woman in her fifties who was detained under the Mental Health Act in hospital for several years is now living in a specialist new build residential unit and has stated that she is happy that she is "not a patient anymore" and is participating in more community based activities.

4.4.24 **Case study 3**: One man who was considered to be one of the most complex people to support due to a long history of aggression, has moved into a specialist residential setting, after careful discharge planning. This took many months to achieve due to the destabilising effect that change had previously had on him, and included a very lengthy introduction to his new staff team. He has settled into his new home better than had been anticipated and participated in a five mile walk within the first week of moving in.

4.4.25 In addition to the impact on individuals as illustrated above, Sheffield has implemented the nationally recommended model of Positive Behaviour Support, and over 500 staff and family members in the city have been trained in this approach to better support people with the additional complex needs described earlier. This has been identified as an area of good practice in our region.

4.4.26 Market stimulation has taken place with commissioners across the region to attract community care providers to the area and to the city who have more highly specialist skills to successfully support this cohort of people with complex needs. There was previously a limited market, due to the highly specialist nature of the skills required to support people well, and due to the difficulty of attracting providers to work with small numbers of people who present with this high level of complexity. This lack of appropriate provision previously led to hospital admissions as care packages with less skilled providers broke down.

4.4.27 Work has started on 2 new build sites of self-contained apartments built to a high specification, designed to better support people with additional complex needs, partially funded by a recent successful capital bid of £674k from NHS England, to add to a previous bid of circa £500k, which contributed to the Local Authority accommodation strategy for this cohort of individuals, to reduce reliance on out of city residential placements in the future.

4.4.28 Greater collaboration and consistency of approaches are now embedded into the management and coordination of support for the adult Transforming Care cohort between social workers in the Future Options Team and SHSC clinicians, working closely with Sheffield CCG, based on the best practice approaches that were evidenced in the Named

Social Work pilot. This has been highlighted as positive practice regionally, and has led to smoother discharges, as the Future Options team have the necessary skill, experience and can give greater continuity to this complex cohort of individuals than social workers with more generic skills.

4.4.29 As stated above, the national service model, "Building the Right Support" required local areas to move towards a community-based approach and to reduce the reliance on inpatient hospital facilities such as Sheffield's Firshill Rise, by enhancing specialist community services. Some additional capacity has therefore already gone into the community clinical teams aimed at providing better support to individuals with complex needs. However, we have further ambitions to enhance this service offer to individuals and their family and paid carers, to meet the requirements of "Building the Right Support."

4.4.30 We have therefore been engaging with people with learning disability, their family carers and paid staff, clinicians and other stakeholders around what would sustain people to live within their own communities, as an alternative to hospital care, working with *Speak Up Rotherham*, an organisation of self-advocates with lived experience of learning disability. It is therefore intended to extend access to specialist clinical support into the evenings and weekends, when currently no specialist clinical support is available. This will be funded, as nationally mandated, by releasing the costs associated with the reduction in the use of inappropriate hospital care.

4.4.31 There is an acceptance of the benefit of working together to co-commission the region's remaining Assessment and Treatment Unit at Firshill Rise, run by SHSC, with commissioning colleagues across Rotherham and Doncaster, as Sheffield had been successful in reducing its reliance on inpatient beds and no longer needs all of the beds that we previously commissioned. This collaborative commissioning approach will enable Sheffield CCG to invest more into the above community services, in order to deliver the national model of evidenced based practice, as outlined in "Building the Right Support", whilst retaining some local hospital provision.

4.4.32 This will improve the lives of more people with learning disability, complex needs and their families in Sheffield, and enable us to implement what they have identified as the best ways to sustain people within their own homes and communities.

5. Wider System Impacts

5.1 Financial Benefits

5.1.1 The Transformation Programme is underpinned by a Memorandum of Agreement (MOA), which provides a framework for how the Clinical Commissioning Group (CCG) , the Council (SCC) and the Sheffield

Health and Social Care Trust (SHSC)e to work together, ensuring that we remain focused on quality and outcomes not on organisational priorities. It also details how the programme will be refreshed and expanded, so as to meet system wide efficiency requirements, including workforce development, capacity management and also financial efficiencies. Whilst the MOA has not been the only reason why partner organisations work differently, it has certainly provided an important and clear point of reference and framework.

5.1.2 The MOA also articulates how the 3 partners will share both the benefits and the potential risks of working together. Whilst improving quality does of course remain the primary focus, the financial sustainability of each constituent partner is equally important (if one fails, we all fail). This has ensured that we have systematically approached financial efficiency in a way that mutually benefits each organisation, and avoids 'cost shunting', even when this occurs inadvertently. The programme has therefore positively changed inter-organisational behaviour.

5.1.3 In year one of the programme we delivered £2.6m efficiency and in year two a further £3.9m (which included SHSCs contribution). In year three we are currently forecasting £2.2m in financial efficiencies. This has been delivered largely by addressing inefficient practice, for example by ensuring individuals have the opportunity to live fulfilling and rewarding lives outside of institutional care, that people in crisis can receive appropriate support and treatment in the right environment and that we provide holistic care based on needs not based on artificial access criteria.

5.1.4 We remain committed to delivering the programme based on the principles of improving quality, improving experience and improving outcomes; and therefore everything we do is subject to clinical and professional scrutiny.

5.2 Service Reconfiguration

5.2.1 As well as the examples highlighted in section 4 of this report; the scope of the programme effectively extends to every aspect of mental health, learning disability, autismand dementia care in Sheffield. In particular we are consistently looking for opportunities to improve and enhance clinical quality and outcomes through collaboration, creativity and innovation.

5.2.2 In addition to the 5 examples given therefore, the programme has also delivered the following key improvements:

- We have developed, for the very first time, a genuine system wide Dementia Strategy for Sheffield;
- We have developed a new (proposed) eating disorders pathway, which has been undertaken with service users, carers, experts by experience and other interested parties;

- We now have psychological therapists working alongside physical healthcare clinicians in 10 clinical pathways at STH;
- We are just about to launch a system wide physical health strategy/programme;
- We have streamlined the relationship and sexual health service; and
- We have recurrently secured all investments into the Children's and Young Peoples Local Transformation Plan (as part of our lifespan mental health aspirations – see section 6.1).

5.3 Societal Benefits

5.3.1 This Transformation Programme aims to collectively change how we approach mental health commissioning to improve the lives of people with mental health problems, through our joint focus on addressing the wider determinants of mental ill health, as part of the city's Public Health and Mental Health strategies.

5.3.2 Positive mental health and wellbeing underpins a range of wider societal benefits, such as happier and healthier individuals, stable and secure families, increased educational attainment and increased levels of employment. These benefits help build and maintain thriving families andcommunities in our city, and a healthier local economy.

5.3.3 In Sheffield for the 80,000 citizens who have either depression or anxiety and over 5,000 people who experience severe mental illness, they have a poorer quality of life and poorer health than other citizens, which can impact on their families, friends, neighbours and employers. Given this prevalence and the impact on physical health, by working in an integrated way to transform care across health and social care we aim to improve these life experiences and outcomes for individual service users and their family and friends, which will also create a wider benefit to society, through our focus on mental health promotion, prevention and on early intervention.

5.3.4 Additionally, theTransformation Plan will also achieve financial efficiencies in the reduction in our use of the most expensive parts of the secondary health and social care services through an improved community offer through our focus on mental health promotion, prevention and on early intervention.

6 Challenges and Next Steps for the Programme

6.1 Lifespan Mental Health

6.1.1 Levels of Acuity and Demand are rising in both children's and young peoples and adult mental health services. In other words more people are coming forward for help, with more serious and complex problems. We are therefore keen to enact a commissioning approach that will have a long-term sustainable impact on the wider system not just on specific parts of the traditional 'care' pathway. For us this means taking a *lifespan*

approach to the commissioning and provision of care. This means creating a system where:

- The focus is on early intervention and prevention;
- Where we see a reduction in the number of individuals who develop severe and enduring mental ill health;
- We genuinely adopt person centred care principles, where services are provided based on need. Age, for example, would no longer be used as criteria for determining access;
- 'Non-health' issues are taken into account when determining packages of care and support; such as housing, debt and employment etc.
- We focus on the whole, rather than individual component elements of our families. As we now know the family dynamic during pregnancy, infancy and childhood has a direct impact on a child's mental health and wellbeing; and
- Where improved Infant mental health is measured by school readiness and Improved School Mental Health is measured by reduced school exclusions in primary and secondary school.

6.1.2 Our overarching ambition is to create a 'one stop shop' approach for mental health; where parents and their children are treated by a single team of professionals, thus presenting us with an opportunity to proactively address intergenerational problems.

6.2 Health Inequalities

6.2.1 In widely publicised national evidence, it is acknowledged that there is up to a 30 year mortality gap between people with severe mental ill health and the rest of the population. People with mental health conditions are therefore dying earlier from preventable and treatable health conditions.

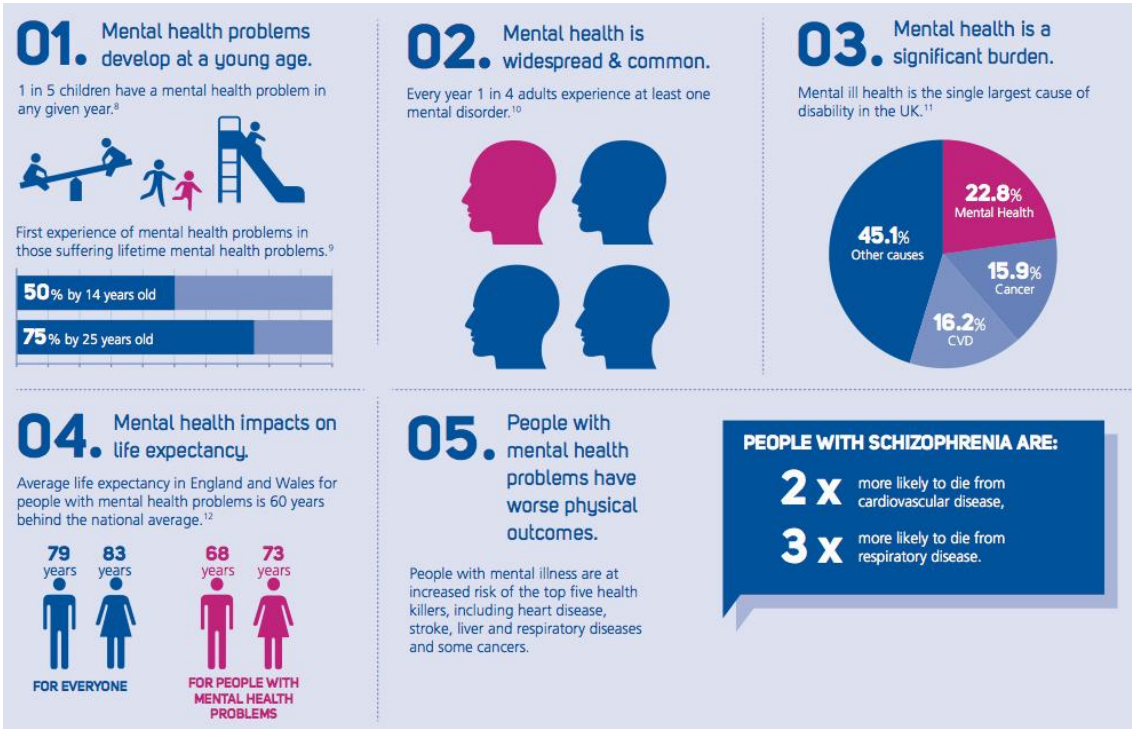
6.2.2 Mental illness has a similar effect on life-expectancy to smoking, and a greater effect than obesity, and is also associated with increased chances of physical illness, such as coronary heart disease, Type 2 diabetes, or respiratory disease.

6.2.3 In addition, poor physical health increases the risk of mental illness. The risk of depression is doubled for people with diabetes, hypertension, coronary artery disease and heart failure, and tripled in those with stroke, end-stage renal failure and chronic obstructive pulmonary disease. Children experiencing a serious or chronic illness are also twice as likely to develop emotional disorders.[6] [7] [8]

[6] https://www.centreformentalhealth.org.uk/publications/long-term-conditions-and-mental-health-cost-co-morbidities

[7] http://www.bris.ac.uk/cipold/

6.2.4 The infographics below illustrate the health inequalities faced by people who experience mental ill health.

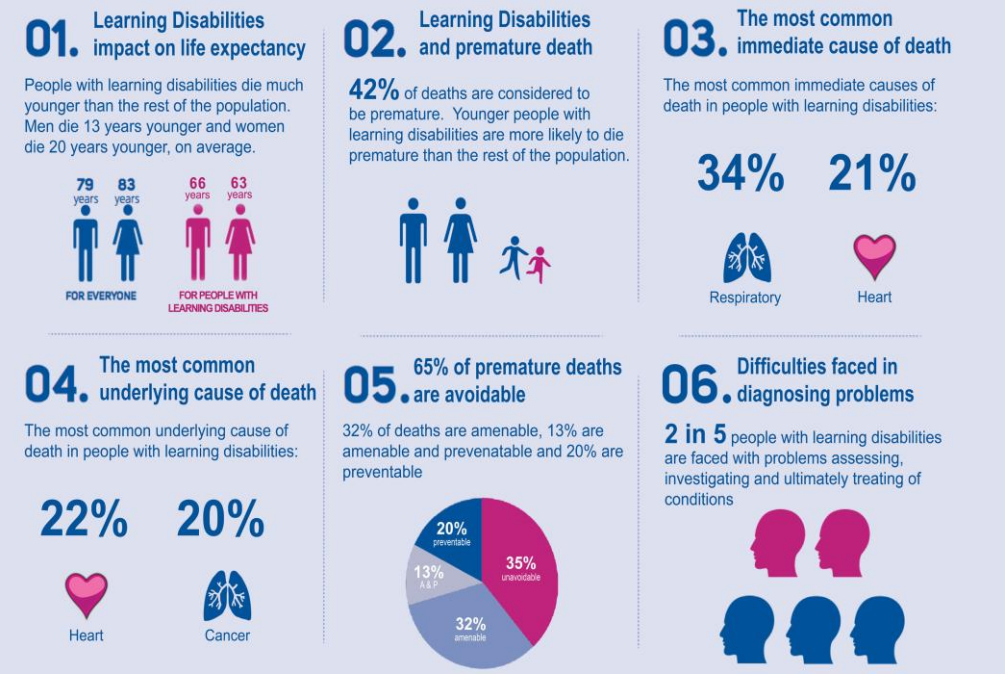


6.2.5 There are similar patterns for people with learning disability, who face the additional health inequalities associated with communication and physical impairments and who may have less opportunity to express their needs, or to seek access to health services themselves See infographics overleaf

6.2.6 The Learning Disabilities Mortality Review (LeDeR) programme is a national review of the underlying causes of the premature deaths of people with learning disability, in which Sheffield is an active participant.[9] It is the first national programme of its kind aimed at making improvements to the lives of people with learning disabilities by understanding the inequalities in health and social care that may have contributed to their premature deaths. Reviews are being carried out with a view to improve the standard and quality of care for people with learning disabilities to reduce their health inequality, and reduce preventable deaths. People with learning disabilities, their families and carers have been central to developing and delivering the programme nationally and locally.

[8] http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf

[9] http://www.bristol.ac.uk/sps/leder/



6.3 Parity of Esteem

6.3.1 Society has traditionally not seen health conditions in a holistic and integrated way, and there is a national disparity between the way that we value and invest in the physical health of our population compared to their mental health. There is therefore an impact of this *social inequality* on *health inequality*.

6.3.2 *Parity of Esteem* is the principle through which mental health should be given *equal priority* to physical health when planning and delivering services. Although currently, nationally, mental health problems account for 23% of the burden of disease, mental health services account for only 13% of NHS spending. In order therefore to reduce the burden of physical and mental ill health we need to take a more integrated approach to collaboratively addressing the underlying social determinants of ill health, such as poverty, unemployment, poor housing, to address the social and health inequalities that disparity of esteem leads to.

6.3.3 The Integrated Transformation Programme of work enables us to better understand the societal factors at play which lead to health inequality, and to collaborate in a more coordinated way when we design and commission services to address these factors.

6.3.4 Many of our Transformation Projects as described above contribute to this approach. Others include joint work with partners around improving access to specialist employment support, improving access to GP delivered physical health checks for people with learning disability and for people with severe mental illness, developing the dementia strategy in the city, improving access to diagnosis and support for autism.

6.3.5 We have initiated the multiagency Physical Health Implementation Group, which has a series of workstreams aimed at identfying and addressing health inequalities faced by this group, led by Dr Steve Thomas, Clinical Director and GP, with support from Liz Tooke, from Sheffield City Council.

6.4 Developing an Improved Offer

6.4.1 For the Integrated Transformation Programme to be judged as effective, it has to be tangible to local people as users of local services and their families and friends. We want to improve the way that we engage with people to seek their views, preferences and experiences of mental health services, and the services offered to people with learning disability, autism and dementia.

6.4.2 We have therefore externally commissioned a piece of work to help us to improve the way that we both engage with and co-produce local services so that we are able to understand from a user's perspective what an improved offer would look like.

6.4.3 An improved offer from the perspective of us as partners across health and social care also means improving our joint understanding of our priorities and objectives, so that we can work more effectively together to develop plans that really do lead to improved commissioning outcomes.

6.4.4 Previously, as separate organisations, we would develop and implement plans in isolation, which would often lead to inefficiency, duplication or gaps in services. Now, by working collaboratively, we are able to see where decisions previously taken in isolation can be improved by having a full perspective on impact and outcomes

7. Recommendations

a. The Healthier Communities and Adult Social Care Scrutiny and Policy Committee is recommended to:

- Consider the development and impacts of the Sheffield Mental Health Transformation Programme as outlined in this report and provide views; and
- Provde comments and recommendations for future developments.

Appendix A
Case Studies

CASE STUDY 1 – 'Lucy'
Lucy is diagnosed with schizophrenia and a learning disability. She has been unwell for many years and was admitted to hospital every year until 2009. She has a significant risk history, involving being sexually inappropriate, setting fires, being threatening towards family members and assaulting other patients and staff.

From 2009 to 2015 Lucy was treated in hospital and spent a number of years in a nursing home outside of Sheffield. Following discussions with Lucy and her mother, it was agreed that she would be better placed living in Sheffield where her support team and mother would be able to visit more easily and regularly, and Lucy wanted to return to Sheffield. There was concern that Lucy was being "over cared for" at the nursing home during the day, and that they were not enabling her to be as independent as she was capable of being.
Various residential places were considered in Sheffield and it was hoped that the placement would continue Lucy's journey towards independence.
Lucy moved to specialist residential accommodation in Sheffield in April 2016. She re-settled in Sheffield, and continued her recovery from mental ill health. A re-assessment in January 2018 gathered evidence that she did not require this level of care anymore, and indicated that she was ready to move on to greater independence, in accordance with her own wishes.

Assessment of Lucy's mental health needs led to the conclusion that his needs could be met outside of registered care home provision. Lucy was shown various supported accommodation options. There was a measure of resistance from both the residential home who had formed an attachment to Lucy in her time there, as well as concern from his mother, who was worried that Lucy's mental health might deteriorate if she moved. In accordance with the 2014 Care Act, an advocate was employed to assist the process.

Suitable independent supported accommodation in an area that Lucy wanted was found. The care hours were tailored to the needs that Lucy has, notably giving assistance around meals, medication and feeling supported in the community. Lucy moved to her new independent accommodation with visiting support in June 2019. This move had the support and backing of both the commissioners for Health and Social Care in Sheffield.

Since moving Lucy has settled well. Enough support hours were commissioned to ensure that the move out of residential care was both safe and helped Lucy to adjust to the change in environment. This was reviewed again in August

2019, and the hours were reduced by 11 hours a week in line with Lucy's continued recovery. It is envisaged that Lucy will continue to progress in her mental health recovery, and that her reliance on support organised by statutory services will reduce further in the future.

CASE STUDY 2 – 'Sean'

Sean has a diagnosis of Paranoid Schizophrenia and has been involved with mental health services since 1993. He also has a number of physical health problems.

Sean was admitted to hospital in August 2008 after living independently in his own flat. He had become quite ill, not taking medication, seriously neglecting himself and his flat and falling into debt, as well as exhibiting worrying behaviour that could be a serious risk to himself or others. Whilst in hospital on a number of occasions he assaulted staff and other patients.
Sean was discharged to an out of city nursing home in August 2009, as it was felt too unsafe for him to continue living independently in the community and Sean lived there until 2018.

In 2016 a comprehensive review of Sean's needs and wishes was undertaken, which indicated that 24 hour residential accommodation, rather than nursing care, would be more suitable for him. Incidents of challenging behaviour had not been evident for several years.

However, Sean did continue to have on, was that he had needs relating to his physical health. These physical needs were initially cited by the nursing home, his advocate and community mental health team as reasons why he should not move on. Work was done with all concerned regarding drugs and medication for these conditions. It was planned that the physical health needs for S could all be met in a residential setting, by staff who had the relevant training, and through the relevant local community health services.

Sean made it known directly and with the aid of an advocate that he did not want to move out of his current accommodation, which he had come to view as his home. Indeed, thinking and talking about moving, seemed to increase his anxiety, and cause a periodic worsening in his voices, becoming more de-motivated and becoming less physically well. Work was undertaken at a pace which allowed Sean to make the necessary adjustments and consider the more positive aspects of moving. In turn Sean recovered from these anxieties and the effects they had.

Sean went to see a number of residential homes, who all said that they could accommodate him and manage his mental health aftercare needs, as well as

his physical health difficulties. Due to unpleasant memories, Sean stated that he wanted to stay out of Sheffield. In accordance with his wishes, a residential home was found, geographically close to where he had been living for a number of years. In addition to this, a residence was found that would allow him to have a larger bed, have somewhere to exercise outside, and have satellite television, which were three specific preferences he had for move on accommodation. Sean moved to the new residential home in June 2018 and has lived there successfully and positively since.

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

Report of: Dawn Walton, Director: Commissioning, Inclusion and Learning
Brian Hughes, Director of Commissioning and Performance, Deputy Accountable Officer

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Subject: **Update on the development of the joint dementia strategy commitments and the commissioning plan for dementia**

Author of Report: Joanne Knight, Strategic Commissioning Manager – Older adults and dementia

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Summary:
This report summarises:-

- The progress so far in developing a joint city strategy for dementia,
- The next steps for the strategy and implementation – making it a reality
- The current commissioning plan achievements
- Some specific detail about the dementia friendly communities work

This report has been requested by the Scrutiny Committee to enable it to consider and comment on the plans and progress so far

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

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

The Scrutiny Committee is being asked to:
The Committee is asked to consider the proposals and provide views and comments

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Background Papers:
Sheffield Dementia Strategy Commitments

The Dementia Strategy Consultation report
The Prime Minsters Challenge on Dementia 2020

Category of Report: OPEN
Most reports to Scrutiny Committees should be openly available to the public. If a report is deemed to be 'closed', please add: **'Not for publication because it contains exempt information under Paragraph xx of Schedule 12A of the Local Government Act 1972 (as amended).'**

Report of the Director of Commissioning Inclusion and Learning

Title of report Update on the development of the joint dementia strategy commitments and the commissioning plan for dementia

1. Introduction/Context

1.1 Dementia is a broad term used to describe a range of progressive neurological disorders. These disorders are characterised by a range of symptoms including memory loss, mood changes, and problems with communication and reasoning.

1.2 The total number of people estimated to be living with dementia in the City in excess of seven thousand. This equates to 1.21% of the population which is slightly lower than the national average of 1.3%.[1]

1.3 In Sheffield, the recorded dementia prevalence was 0.86% for the period 2015-16 compared to 0.76% nationally. This means that identification and diagnosis of people with dementia is better than average in Sheffield but still falls short of the likely "true" number of people with the condition

1.4 The number of patients admitted to hospital who are living with dementia is increasing both locally and nationally. If prevalence of dementia continues to increase as predicted, this will pose a significant challenge for health and social care services. The following indicators suggest this is probably an area of concern for Sheffield

- Sheffield had a significantly higher rate of emergency dementia admissions (aged 65+) compared to nationally during 2015/16
- Sheffield had a significantly higher rate of inpatient admissions (aged 65+) for Alzheimer's disease during 2015/16
- Sheffield had a significantly higher rate of inpatient admissions (aged 65+) for unspecified dementia during 2015/16[2]

1.5 There is currently no certain way to prevent all types of dementia. Vascular disease however can be prevented. Consequently,

[1] Sheffield JSNA

[2] Sheffield JSNA

reductions in the incidence of vascular and mixed dementias may be expected to follow. There is, for example, evidence to suggest that the incidence of vascular dementia may be reducing in the UK, by as much as 2.7% per year.

1.6 In 2015 the Department of Health launched the 'Prime Minister's 2020 Challenge on Dementia', building on work from the previous strategy launched in 2012. The document called for local action to agree and work together on local plans and approaches to help transform dementia care.

1.7 Public, voluntary, community and private sector organisations across Sheffield committed to work together to improve the care and support for people of all ages living with or caring for those living with dementia to enable them to live life to their full potential. The development of the Sheffield Dementia Strategy Commitments forms our response to the Prime Minister's Challenge document

1.8 The strategy developed over a 12 month period with robust co-production, discussion, debate and consultation with a significant number of stakeholders across the city with particular emphasis on inclusion of people with dementia and their families at every stage.

1.9 The consultation took place during December 2018 and January 2019 and the outcome was very encouraging and positive especially about the joint working and desire to develop the offer to people with dementia and their families. Although there were a number of questions and ideas raised these were more relevant to the next stage of the strategy which is action planning rather than requiring alterations to the strategy commitments.

1.10 During the strategy development stage it was agreed that the commissioning of support for people with dementia should continue to progress providing it was broadly in line with the emerging themes

1.11 This report therefore summarises:-

- The progress so far in developing a joint city strategy for dementia,
- The next steps for the strategy and implementation – making it a reality
- The current commissioning plan achievements
- Some specific detail about the dementia friendly communities work

1.12 This report has been requested by the Scrutiny Committee to enable it to consider and comment on the plans and progress so far

2. Update

The strategy

2.1 The strategy and its 13 commitments are in the process of being formatted into a final edition for publication (A list of these is attached at Appendix A)

2.2 It is part of the Mental Health Transformation Programme and a multi-agency group, the dementia strategy implementation group (DSIG) continues to oversee the strategy development and is driving it forward. The DSIG has commitment from SCC in the form of a lead Head of Service, a programme officer from the CCG and many representatives from the public, private and voluntary sector

2.3 This group reports directly into the Mental Health, Learning Disability and Dementia Delivery Board which has members from the CCG, the Council and Sheffield Health and Social Care NHS Foundation Trust (SHSC).

2.4 The next stage is to map current activity against each of the commitments and identify the priorities. This will not only give a greater understanding of the scale of the ongoing work but also identify any gaps or initiatives which could have the most significant and positive impacts for people living with dementia and their families. A significant part of this process will be (as per commitment 13) to identify key measureable targets and baseline data so it is possible to measure success. We know that one of the measures needs to be a wellbeing one but that this needs to be a consistent measure across the city, work is already taking place within public health to identify this and a tool to measure it.

2.5 Work has already started on this process, a workshop (including people with dementia and professionals) held in May 2019 was set up to identify the priority commitments for action. Although there was no consensus about which commitment to prioritise the following were areas of significant interest:-

- Information and advice post diagnosis
- Reducing stigma and making Sheffield more dementia friendly
- Improving the quality of care for people admitted to A&E and Sheffield Teaching Hospitals
- A more co-ordinated approach to care and support
- Support for families

2.6 To support this development and drive priorities forward the CCG, SHSC and SCC have funded a part time project officer who will be in post from September 2019 and will begin to work on ways to identify and take forward the priorities. This will replace a gap left by the previous post holder who left in early 2019.

2.7 Pending this appointment, work has already commenced to form a governance structure of working groups that will report to the DSIG and will develop the detailed action plans

2.8 As part of this governance we will be establish a support and challenge group which will ensure there is sufficient challenge on the strategy implemented, this group will have people with dementia and their carers' as an integral part.

Commissioning Plan

2.9 An SCC commissioning plan to develop dementia support has been in place since Nov 2018 (see below table 1) and was agreed by the then Individual Cabinet Member. The CCG are cited on this and some of the work is being undertaken jointly

2.10 There is also other work being taken forward linked to the strategy, the table below (table 2) describes some of this work and the potential impacts

2.11 More recently the CCG have agreed to developing a joint commissioning plan which SCC will lead on behalf of the CCG

Activity	How	Expected Impact(s)	Linked to
Capacity building for dementia friendly communities	Grant awarded to Sheffield Dementia Action Alliance (SDAA) for 3 years 2018-21	Increase in the numbers of people aware of dementia and it impact which in turn will • Reduce the stigma associated with dementia • Begin to re- educate the general population • Create more dementia friends who will support others More efficient and effective working joining up the friendly cities work by establishing common themes across Age Friendly City, Autism Friendly City and Dementia Friendly City	**Commitment 1** **Sheffield will become a dementia friendly city.**
Developing user voice	Grant to Sheffield Dementia Involvement Group (SHINDIG) for 3 years 2018-2021	The voice of people with dementia and their families is increased There is a safe space for people to express their views Increased number of planning events inclusive to people with dementia and their families/carers as well as involving staff from different services across the city	**Commitment 4** **For people with dementia support in Sheffield will be more personalised, local and accessible to help people to remain independent for as long as possible.**

Activity	How	Expected Impact(s)	Linked to
Community Activities	One-off Innovation Fund to encourage local organisations to do inter-generational activities around dementia Re-procure four Dementia Cafés	Increased number of schools and care homes linked into local communities Younger people have a greater understanding of dementia Increased inclusion in the community for residents of care homes Cafes now established in 5 areas of the city offering • Advice and information • A social meeting place in communities • Peer group support, working through problems together	**Commitment 4** **As above** **Commitment 5** **We will provide high quality support to families and carers of people with dementia in Sheffield to help people with dementia maintain their independence for as long as possible**
Community support developments in local neighbourhoods	16 PKW partnerships supported with funding to arrange a range of support activities for people with dementia and proactively contact people recently diagnosed	Local support and activities for people with dementia and their families Support tailored to the local community Every person diagnosed by the memory service and neurology have a contact in their local community Every person diagnosed is proactively contacted within 6 months of diagnosis	**Commitment 4** **As above** **Commitment 5** **As above**

Activity	How	Expected Impact(s)	Linked to
Dementia Specialist Advice ***In conjunction with CCG***	Commission a specialist advice service for other professionals to ensure care is co-ordinated and people can live well at home. They will also be early identifiers of crisis situations and help co-ordinate a multi-agency action plan **From October 2019**	Staff working with people with dementia are up-skilled to continue working with people with dementia and this leads to is less change in the person's life More people with dementia and their families stay supported by people they are familiar with More people in the city supported to continue working with people with dementia Fewer handoffs between services More people are dementia aware building the dementia friendly city Fewer crisis situations by recognising individuals symptoms and assisting staff to manage this via multi -disciplinary working, where necessary setting up crisis meetings Less reliance on social care and fewer people admitted to hospital as a result of crisis	**Commitment 4** **As above** **Commitment 5** **As above**
Day Opportunities (care and community based models) ***Joint with CCG***	Re design and re model day activities for older adults both community and care based **To commence 1.7.20**	Increased number of carers can take a break People with dementia are supported in stimulating and good quality environments Improved holistic approach to day opportunities so support is adaptable to cope with changing needs	**Commitment 4** **As above** **Commitment 5** **As above** **Commitment 10**

	Redesign and remodel day support for younger adults with dementia **To commence 1.4.20**	Increased number of opportunities for younger people with dementia to connect Improved advice and information offer to younger people which reflects their situation e.g. work, family	**Care and support services will take account of the needs of people with dementia**

Table 1

Activity	How and when	Impact	Link to Strategy Commitment
Dementia diagnosis pathway across primary and secondary care	Regular meetings across SCC, Primary Care, Neurology (SiTRAN) and SHSCT to establish and agree the pathway for diagnosis **Ongoing complete by March 2020**	Diagnosis pathway established agreed and recorded and treatment options agreed and shared People are clearer about the diagnosis route Reduction in diagnosis time	**Commitment 12** **We will provide guidance to clinicians in relation to the best medicines for dementia, including when to initiate and review medication**
Engage in research activity	SiTRAN leading and contributing to regional and national research projects **Ongoing**	Sheffield links in to recent research and able to find better treatment options Sheffield is established as a lead partner in research and this ultimately benefits the citizens of Sheffield	**Commitment 2** **Commitment 11** **We will support the clinical and non-clinical research community in Sheffield.**
QEIA (Quality Impact Assessment for dementia strategy) ***SCC lead on behalf of CCG***	SCC completing quality impact assessment to understand the major impacts **Ongoing**	Greater understanding of the adverse impacts of the strategy More awareness of the diversity and gaps as a result	**Commitment 13** **We will monitor the strategy and the implementation plan supporting it**

Activity	How and when	Impact	Link to Strategy Commitment
STH dementia plan of action	A range of dementia related activities and developments including, dementia friendly environments, staff training and awareness, good practice engagement sessions etc.	Improved staff awareness, Quality of environment improved Improved quality in hospital settings Reduce isolation in secondary care	**Commitment 9** **We will improve care for people with dementia attending A&E and those admitted to Sheffield Teaching Hospitals**
Understand the current purpose and future model (mapped to the strategy) of CCG commissioned services **Joint with CCG**	Through mapping and specifying services e.g. memory service, CDSS, CMHT, Woodland View, Birch Avenue, DRRT etc. By 31/3/20	Understand detail behind the services including numbers, cost etc. Map of current activity and purpose through specifications Align services to the strategy and identify gaps in provision Improved working across the system leading to better co-ordinated and more efficient services A whole system pathway is established	**Commitment 2 - We will ensure preventative health become an integral part of the dementia work** **Commitment 3 - We will improve access to the diagnosis of the diseases that cause dementia at the earliest possible stage for the people of Sheffield.** **Commitment 10**

Activity	How and when	Impact	Link to Strategy Commitment
Scope the requirements for enhanced care for people with dementia	SCC to work on behalf of the CCG to look at a model of support for people with enhanced needs	Improved model of support for people with enhanced needs Support tailored to the individuals needs and circumstances	**Commitment 4** **Commitment 5** **Commitment 10**

Table 2

Dementia Friendly Communities

2.8 Dementia friendly communities encourage everyone to share responsibility for ensuring that people with dementia feel understood, valued and able to contribute to their community. It is a place or culture in which people with dementia and their carers' are empowered, supported and included in society, understand their rights and recognise their full potential.

2.9 Most authorities chose to work with a dementia alliance who acts as a unique platform that aims to bring about a society-wide response to dementia. Members make individual commitments to action within their organisations, setting out what they hope to achieve to support people affected by dementia.

2.10 Most dementia action alliances work on the cornerstones of dementia friendly communities which are awareness, social and cultural engagement, human rights, capability building, and access to dementia friendly services and physical environments

2.11 The dementia action alliance was given a grant in 2018 for 3 years to drive dementia friendly communities work. Some of their achievements include:-

- 21 businesses who are member organisations, these include small voluntary organisation and multi nationals such as Nat West bank
- Supported the development and awareness of a further 81 dementia friends including staff from First contact at Howden House and from locality teams in social care
- Worked with care homes on establishing dementia friendly environments
- Delivered Pastoral support to providers including attending their partnership meeting and planning for their event.
- Delivered Bronze Enrichment for the Elderly Dementia stars for a number of community partnerships
- Liaising with all 16 PKW partnerships about dates for delivering training and pastoral support.
- 85 people have attended Enrichment for the Elderly Dementia stars training session feedback has been incredible with participants saying 'really thought provoking' 'The delivery is excellent' 'the best dementia training I have been to- I can't wait for the next one".

2.12 Much more work is planned in this area including work with city centre shops and organisations, the development of a toolkit which will help organisations see what they need to do to become dementia aware and a more co-ordinated approach to creating friendly environments so working more closely with people looking at autism friendly and age friendly cities.

2.13 It is anticipated that this work will impact by reducing the stigma associated with dementia, make environments more conducive and accommodating and ensure people understand and use approaches which make people with dementia feel accepted and safe

3 What does this mean for the people of Sheffield?

3.1 The development of the joint dementia strategy, subsequent action and commissioning plan should afford the people of Sheffield:-

- A more inclusive city environment where people with dementia are accepted understood and their potential as ordinary citizens is recognised
- A city where statutory agencies work together in partnership recognising that the outcomes for people with dementia and their families will be improved by doing so
- Improved co-ordination and quality of support
- A shared vision across the city designed with and for people with dementia and their families
- A reduced number of crisis situations leading to either admission to longer term care or hospital
- Preventing or delaying the onset of dementia by modifying lifestyle and behaviours in mid-life
- For all people living with dementia and their families/carers to feel empowered and know where to go to seek information, advice and help.
- To be able to access timely care and support that enables them to live well at home for as long as possible and to die with dignity.
- To live in dementia friendly communities. A dementia friendly community is a place where people with dementia are understood, respected and supported.

4. Recommendation

4.1 The Committee is asked to consider the information in this report and provide views and comments

Appendix A

A List of the Strategy Commitments

1	**Sheffield will become a dementia friendly city.**
2	**We will ensure preventative health become an integral part of the dementia work**
3	**We will improve access to the diagnosis of the diseases that cause dementia at the earliest possible stage for the people of Sheffield.**
4	**For people with dementia support in Sheffield will be more personalised, local and accessible to help people to remain independent for as long as possible.**
5	**We will provide high quality support to families and carers of people with dementia in Sheffield to help people with dementia maintain their independence for as long as possible**
6	**Sheffield will continue to provide out of hospital emergency assessments and short term care when people need it and in the most appropriate setting**
7	**Sheffield will continue to provide specialist inpatient assessment and treatment for people who are unable to receive care in their own homes.**
8	**We will make sure that people get access to personalised, good quality palliative and end of life care when they need it**
9	**We will improve care for people with dementia attending A&E and those admitted to Sheffield Teaching Hospitals**
10	**Care and support services will take account of the needs of people with dementia**
11	**We will support the clinical and non-clinical research community in Sheffield.**
12	**We will provide guidance to clinicians in relation to the best medicines for dementia, including when to initiate and review medication.**
13	**We will monitor the strategy and the implementation plan supporting it.**

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

Report of: Brian Hughes (Director of Commissioning, NHS Sheffield Clinical Commissioning Group (CCG)

Subject: Urgent Care Review – Update

Author of Report: Rachel Dillon, Strategic Programme Manager NHS Sheffield Clinical Commissioning Group

Summary:
The purpose of this report is to update the Committee of the findings from the most recent review of urgent care since NHS Sheffield Clinical Commissioning Group (SCCG) took the decision in September 2018 to agree that the approach and proposals to change urgent care services would be reconsidered.

The report describes the key findings of the review and the proposals to address the root causes of the problems identified in the engagement.

As a result of the review, we will be addressing the problems in urgent care by improving current services (evolution) rather than radically procuring/reconfiguring services (revolution).

This update is being provided as agreed at the Committee meeting in February 2019.

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

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

The Scrutiny Committee is being asked to:
The Committee is asked to note the findings and approach and offer advice on how best to engage with communities to ensure that information about urgent care services is clear and accessible.

Background Papers:
Papers from OSC meeting of the 27th February 2019 and 10th October 2018

Category of Report: OPEN

Report of the Director of Commissioning, NHS Sheffield Clinical Commissioning Group
Update on the Urgent Care Review

1. Introduction/Background

1.1 Sheffield Clinical Commissioning Group (CCG) undertook a consultation between September 2017 and January 2018, seeking public input into proposals to reducing duplication and simplifying access to urgent care services; improving access to urgent care in GP practices and reducing pressure on A&E. A final report and recommendations were brought to the Primary Care Commissioning Committee in September 2018. It was agreed that the approach and proposals would be reconsidered and new proposals would be developed.

1.2 The Urgent Care Team evaluated the approach to identify lessons learnt and on reflection, highlighted a number of areas which could have been better. These included the need to gain partner buy in and understanding of the problems within urgent care, stakeholder engagement at all levels and the need to be transparent, both in process and outcomes. The lessons learnt and new approach were shared with the CCG Governing Body and presented to the Accountable Care Partnership (ACP) Board, securing agreement to provide strategic oversight through the most relevant ACP work streams.

1.3 Following, agreement, in order to develop new proposals, the Urgent Care Team invited partners and public representatives to be part of a refresh of reviewing urgent care services in the city. The objectives were to:

1.3.1 To understand why people use services, their experiences and what is important to them and what needs improvement.
1.3.2 Work in partnership with public and stakeholders to identify the key problems and issues and their root causes.
1.3.3 Be open and transparent with the public.
1.3.4 Meet our legal duties to involve including the Gunning principles.

2. Engagement – Approach and Findings

Approach

2.1 The full engagement report is at Appendix 1. Below are the highlights from the report. Learning from feedback during the urgent care consultation, it was important we were transparent, open and that stakeholders and public helped us design and lead the process. Therefore we had oversight from three key groups:

2.1.1 **Design Group –** Co-designed the approach, analysed information gathered and tested and challenged the products and processes developed by the CCG's Urgent Care Programme Team.

2.1.2 **Partner and Public Reference Group –** Members of the public and representatives from partner organisations locally and regionally offered experiences of urgent care services, offered oversight of the process and analysed themes and trends as they emerged from the outreach engagement with communities. It coproduced the definition of urgent care, the final list of problems and tested the approach, described later in this paper.

2.1.3 **Strategic Public Engagement, Equalities and Experience Committee (SPEEEC) –** A subcommittee of the CCG Governing Body which recently on behalf of the Governing Body, assured the process that had been undertaken and were assured that appropriate and proportionate engagement activity had been undertaken and the Gunning Principles had been adhered.

2.2 The engagement used a mixed approach as set out below and overall, 2,587 people contributed to this stage of the urgent care review. This is in addition to the 14,000+ contacts in 2015, 234 surveys in 2016 in waiting rooms, 289 community members from homeless, greatest deprivation, substance misuse, students, asylum and temporary living in 2017, students, 3,000 responses to the 2017-18 formal consultation and 2,106 telephone surveys in 2018.

Method in most recent engagement.	Number of respondents
Online surveys (public) @50 e-contacts to partners, councillors, community groups, practice patients groups, for dissemination to their contact groups.	1,783
Online survey (frontline staff) e-contacts to all GP practices, Pharmacies, Care Homes, all partners and @25 community organisations.	317
Outreach engagement work in communities	309
Discussions with patients in A&E, Minor Injuries Unit and the Walk-in Centre	20
Reference Group (public and staff in partner organisations)	63
Patient journeys (including targeted general practices) such as Pitsmoor, Page Hall and Porterbrook and the Healthcare Surgery.	95
Total	**2,587**

2.3 In this review, we specifically engaged with and heard from communities in Lowedges, Batemoor and Jordanthorpe, Stocksbridge and Oughtibridge, Darnall, Roma and Slovak communities, Pakistani communities, people with respiratory conditions, with physical impairments and mobility challenges, people with learning disabilities, with Autism, Mental health conditions, the Homeless community and Students. Contrary to the previous engagement

work, this phase focused on why people use services, their experiences and what is important and/or needs most improvement within urgent care.

Findings

2.4 The full engagement report is included at Appendix 1 but for ease the main points are summarised below. The key themes are:

2.4.1 There was praise for the quality of care in ALL services but
2.4.2 the vast majority of staff (69%) and patients (72%) agreed that urgent care services in Sheffield needed to IMPROVE.
2.4.3 It's a fragmented urgent care system.
2.4.4 The main problems can be themed into four areas: pathways, knowledge, culture and resources.

2.5 **Definition of Urgent Care.** A key lesson learnt from the previous consultation was to use clear and easy to understand language. The workshop attendees developed and agreed a definition of urgent care below which the majority of survey respondents agreed was a good definition.

> Urgent care means advice and treatment for illness* and injuries for all ages thought to be urgent (care needed within 24 hours) - but not life threatening.
>
> *"Illness includes mental and physical health."

2.6 **Patient Behaviour.** We wanted to gain insights into why and how patients access urgent care services. The most pertinent themes from both the survey and broader engagement was that:

2.6.1 The top reasons why people contacted the service they chose were:

- due to a previous experience;
- that they knew they would be seen there; and
- they knew it would be open.

2.6.2 Previous experience could be driven by either a positive or negative experience, but does show that patient behaviours really influence how urgent care services are used.

2.6.3 For some communities, 999 or GP was the automatic response, and some communities were unaware of the Minor Injuries Unit (MIU). This differed to the public survey as MIU was the 3rd choice of service to go to first.

2.6.4 Most people completing the survey got to the services by car, however outreach feedback told us that lack of own transport and cost of transport were barriers to using services further afield.

2.7 **People's thoughts about urgent care. What is important and what needs improvement.** In the staff and public questionnaires, we asked what was most important about urgent care services and what needed most improvement.

2.7.1 For the public, the following were both the most important and needed improving:

- being seen at my own GP practice;
- being seen on the same day;
- being seen by a healthcare professional best able to treat me.

2.7.2 For staff, it was:

- being able to provide enough same day appointments;
- having an up to date list of all services I can signpost to;
- access to services which can deal with urgent non health problems.

2.8 Same day access was the common theme for both. Respondents to both questionnaires were also asked what they would do if they were the boss of the NHS in Sheffield. Both staff and the public agreed that improving access was the top improvement they would make.

The Root Causes

2.9 All of the problems identified throughout the engagement have been themed into four root cause areas. These root causes were developed by workshop attendees and checked and revised at points when new information from the engagement was received. All of the below are related to access in some way, either entering into the service, the experience within the service, and then completion of the journey.

2.10 Overall, both staff and public have said the quality of the services is good, but that the interface between different services causes disjointed pathways and fragmentation. Each service or organisation has historically addressed these challenges in isolation, which may provide a temporary fix but these are not always sustainable. In order to make long term sustainable improvements to address these problems the system needs to work collaboratively. No single organisation can fix these.

2.11 All the symptoms/problems identified throughout all the engagement since 2015 and the most recent review have been grouped into four main root causes which have informed our current thinking.

I. **Confusing and inconsistent pathways**. Services are not integrated; there is a lack of consistent triage and signposting; patients felt they were passed from pillar to post, repeating their story; staff felt less confident in referring to mental health services and services for 16-18 year olds.

II. **Inconsistent knowledge and lack of knowledge** Staff and public highlighted not knowing what urgent care services offer and the services to refer on to. A common theme for improvement was communication and support for people with disabilities and impairments. There were diverse communities (geographical, health need, cultural) who were not aware of all the urgent care services they could access including MIU and 111.

III. **Differences with culture, behaviour, environment/health inequalities**. Tension between demand and need was raised by both public and staff. Inconsistent management of risk across services. Behaviours driven by experience rather than the right place to go to. Cultures have different expectations and people's circumstances (access to transport and communication) hinder access to the right services.

IV. **Ineffective use of resources and lack of resources**. If a service can't manage demand, it bounces into another part of a stretched system. Patients have difficulties accessing both physical and mental health services and there's a shortage of time to care. All services rely and compete for the same pool of GPs and urgent care staff.

3. The Agreed Approach to address the problems

3.1 The agreed approach was tested at the last of the Public and Partner Reference Group workshops. There are a number of factors which have had to be taken into account in developing the best approach.

3.1.1 The quality of urgent care is good in Sheffield and the approach has needed to build on this.

3.1.2 The approach has to be right for Sheffield and one which can be delivered in a changing NHS architecture in a time of uncertainty.

3.1.3 The approach has needed to take into consideration and align with the national and local developments already taking place, such as the national funding as part of the NHS England Long Term Plan to develop Primary Care Networks; part fund additional multi-skilled staff in primary care networks, more funding into community services and mental health; and other national funding Sheffield has received, e.g. to develop community mental health services. This is because these changes could potentially increase staffing and impact on patient flow.

3.1.4 The approach has needed to build on and complement the work already in place. Pathways across the system are being developed by the system partnership in urgent care, primary care, Children's urgent care and mental health services. A potential risk is that the areas are developed in isolation and exacerbate the fragmented system and won't address the root causes identified. So the approach has had to provide a real opportunity for a joined up collaborate approach across all the pathway work.

3.1.5 The approach has had to reflect that most of the NHS and care system provides some type of urgent care in Sheffield. By its nature, it includes mental health and physical health, children and adults, health and care and is sought by the public across Sheffield, day and night, in various settings, including but not limited to: GP practices, pharmacies, a range of helplines, A&Es, Minor Injuries Unit and Walk-in Centre. The root causes identified

must be addressed using a collaborative approach across the system in order to ensure sustainable long term improvements.

3.2 As a consequence, the approach agreed for how to address the root causes above is to **improve current services (evolution)** and not radically procure/reconfigure services (revolution).

3.3 No one single organisation can do this in isolation. The Accountable Care Partnership (ACP) recognises this and has agreed to lead the work going forward. It has agreed to focus on **Pathways** and **Knowledge** first.

Improve pathways because:

I. It will improve patient experience.
II. The process of development of pathways will improve system behaviours and improve knowledge.
III. It will make better use of resources.
IV. There are a number of work streams already in place.

and **Improve knowledge** because:

I. Improving accessibility to information and what is available will introduce some quick wins, improve behaviours and make better use of resources.
II. Targeted work in communities will improve access and contribute to addressing health inequalities.

4. Outcomes

4.1 In addressing the root causes, the aim is that the following outcomes will be achieved. They have been developed by the Public and Partner Reference group and will need finalising by a new Task and Finish Group (described later in the paper) with specific measures where possible. The below has to be underpinned with a focus on maintaining and if possible improve clinical outcomes.

I. Clear and consistent pathways.
II. Improved patient experience in urgent care pathways with improved knowledge and understanding of services and capacity.
III. Holistic and person centred approach every time.
IV. Contribute to addressing health inequalities by improving access to services.
V. Staff feel more confident in awareness of and capacity of services.

4.2 Primary care is a key asset of the urgent care system. This proposal aligns with the transformation happening in primary care regarding the planned GP contract investment and network developments over the next three years. There are key interdependencies and common objectives which are key to the success of both urgent care and primary care.

4.3 It should also be noted that the primary care changes could lead to significantly different patient flows. At that point it may be necessary to review the urgent care problems again and re-consider whether any major service changes are required.

5 Next Steps and Governance

5.1 The engagement report and new approach was presented to the (Accountable Care Partnership) Executive Delivery Group in August. They recognised and agreed that to make sustainable long term improvements to urgent care requires all partners to lead the work together and will take ownership of the programme going forward. There are key responsibilities for both the 'system' and the public of Sheffield to take on board if we are to genuinely improve urgent care in Sheffield. Together we need to co-design outcomes and co-produce the solutions. This is a partner and public co-produced programme and will continue to be so in the next phase.

5.2 The aims of the two work streams will be::

5.2.1 **Improve Knowledge and Information –** A task and finish group will be set up with representatives from Primary Care, hospitals, mental health and Pharmacy work streams as well as Communications and Engagement and Public Reference Group representatives. The group will focus on improving information about urgent care services and the access to the information for the public of Sheffield. This will start quickly to ensure any new social marketing aligns to the winter communications plan for urgent and emergency care. It will include targeted work in communities where we found particular gaps in knowledge through the engagement. This will also include work to support staff to signpost patients confidently to the right services.

5.2.2 **Improve Patient Pathways –** This will build on the current work already in place to improve how patients access services urgently.

6 Timeline

6.1 The timeline will start in September 2019. To achieve the outcomes consistently and sustainably, a six month check will be put in place in April 2020 to ensure that work is progressing against the outcomes with another stock check put in place in two years to test the success of the new interventions/outcomes and whether the urgent care root causes have been addressed or have changed. In detail:

September 2019 – September 2020

- Primary Care Commissioning Committee (CCG board) in September for final endorsement of the next steps and change in governance.
- ACP Task and Finish Group set up to deliver knowledge and education work streams (with public co-production).
- Develop set of outcomes and metrics which can be measured.
- Deliver set of tangible and sustainable solutions to develop knowledge and education interventions, introducing quick wins before winter.

- Identify clear easy mechanism for reporting on the inter-dependent pathways work streams related to urgent care through ACP.
- Six month review to ensure work is progressing against the outcomes. Review key pathways.

March 2021 to September 2021

- Review to test the success of the new interventions/outcomes and whether the urgent care root causes have been addressed or have changed.

7 Recommendations

7.1 The Committee is asked to note:

7.1.1 The Engagement Report and the key problems highlighted in the Engagement Report.

7.1.2 The approach to address the root causes.

7.1.3 Consider how the committee can contribute to the new Information and Knowledge work stream.

NHS Sheffield Clinical Commissioning Group

Urgent Care Engagement

Key Findings Report

August 2019

Contents

Appendices

NHS Sheffield Clinical Commissioning Group would like to thank everyone who contributed to this report particularly members of the public, staff and those working in voluntary and community organisations such as Darnall Wellbeing, The Terminus Initiative and Mencap.

1. Executive Summary

Between December 2018 and May 2019, NHS Sheffield CCG engaged the public, partners and staff on urgent care services in the city. The engagement included an online questionnaire to gain views from the local population of Sheffield and staff in front line services, interviews and group discussions involving targeted groups (including harder to reach communities) and patients at the Walk-in Centre, A&E and in GP surgeries.

The themes in this report were developed with input from public and partner representatives via a Public and Partner Reference Group and a Design Group.

Key themes from the information gathered during this phase of the engagement

Overall

- There was praise for the quality of services, especially the quality of care in local GP practices in all the engagement methods we used.
- Transport remains an issue for communities in the areas of highest deprivation, particularly the cost of travel. Other broader transport concerns included the cost of parking, travelling whilst ill and travelling with sick children.
- When asked if respondents agreed or disagreed that urgent care services in Sheffield needed to improve, the majority of staff and patients stated they strongly or slightly agreed.

Confusing and inconsistent pathways

- People who live with mental health conditions and learning disabilities rely on services that they know and trust – their local GP or 999. There was very limited awareness of 111, the walk in centre or minor injuries unit. Staff who support people living with mental health conditions and learning disabilities are cautious when making decisions in relation to care navigation.
- Themes from staff in providers related to better pathways between services and access to diagnostics, alongside staff and patient education to raise awareness of services. Improving mental health services was also a big theme.
- Staff were significantly less confident that they knew the right service to refer onto when a patient had a mental health rather than physical health need.
- Access to GP or practice nurse appointments remains an issue, which was highlighted in the previous engagement. During the outreach engagement, the Walk-in Centre provides a highly valued alternative for people requiring quick access, out of hours or at a weekend.
- Other access issues such as waiting times and availability were also raised. When asked about one thing respondents would do, if they were the boss of the NHS in Sheffield, the most common theme from the public and staff was to improve access, including increased appointments and availability at GP practices and reduce waiting times. Staff also responded with increasing staff and workforce numbers, improving patient education and improving communications and engagement.

Inconsistent knowledge and lack of knowledge

- There is limited awareness about the availability of urgent care services and other supporting services which staff can refer too.

- There was a general lack of awareness of the Minor Injuries Unit and what could be treated there amongst all communities interviewed during the outreach work. In the patient journeys work, no one's first point of contact was the Minor Injuries Unit. However, in the survey, minor injuries unit was the third service which patients went to first. The majority of respondents to the survey were from the lesser deprived areas.
- There was a lack of knowledge by staff of appropriate places to refer onto for people living with mental health urgent care needs.

Culture and behaviour differences

- The biggest driver of people's behaviour for why they chose the urgent care services they did, was previous experience of using the service, they knew they'd be seen and knew the service would be open. This could be either a positive or negative experience which could impact on how they accessed services.
- Circumstances such as transport and cost of parking remained an issue in the more deprived communities.

Lack of and inefficient use of resource

- There is a shortage of time to care. If one service is unable to manage the demand, it bounces into another part of the system – day or night or between primary, community and secondary care.
- It means patients have difficulty accessing the right services for physical and mental health or care at the right time and staff don't get the time they want to care for their patients appropriately.
- Staff responded in the survey that increasing staff and workforce numbers would help improve urgent care services.

Definition of Urgent Care

- The vast majority of respondents agreed with the following definition of urgent care:

"Urgent care means advice and treatment for illness* and injuries for all ages thought to be urgent (care needed within 24 hours) - but not life threatening.

*Illness includes mental and physical health."

An infographic (see Appendix A) has been developed to illustrate the key findings of the Urgent Care Review 2019.

2. Background

Between 2015 and 2018, the CCG undertook engagement with the public of Sheffield about urgent care. The engagement identified a number of problems and issues with urgent care services. This included access to GP appointments, confusion about what services to use, the system not working cohesively, and barriers for some people that influenced the services they chose to use.

The engagement helped inform an urgent care strategy and a public consultation, which took place between September 2017 and January 2018. At the time, the Government introduced Urgent Treatment Centres as a policy to nationally address the same problems.

The aims of the proposals made in the public consultation were to improve urgent care services in Sheffield, by:

- Simplifying services, reducing duplication and confusion,
- Improving access to GP appointments to guarantee that everyone who needs an urgent appointment can get one within 24 hours, and mostly on the same day.

During and after the formal public consultation, concerns were raised about the proposals contained in the consultation as well as how the consultation had been undertaken. As a result, in September 2018, the CCG took the decision to explore further and refresh what the problems and issues are with urgent care with stakeholders and the public of Sheffield.

Consequently, between December 2018 and May 2019, Sheffield CCG engaged with the public and staff on urgent care services in the city.

The objectives were:

- To understand why people use services, their experiences and what is important to them and what needs most improvement
- Work in partnership with the public and stakeholders to identify the key problems and issues
- Be open and transparent with the public
- Meet our legal duties to involve including the Gunning principles.

3. Oversight

Learning from feedback during the urgent care consultation, it was important during this engagement that we were transparent, open and that wider stakeholder involvement helped us design the process. We therefore had oversight from three key groups:

1. Design Group – Co-designed the proposals and reference group workshops, analysed outputs and highlighted areas for further consideration, tested and challenged the products and processes developed by the Programme Team.

2. Reference Group – Members of the public and representatives from partner organisations locally and regionally offered their experiences of the urgent care system, offered oversight of the process, and analysed themes and trends as they emerged from the outreach engagement with communities.

3. Strategic Patient Engagement, Equalities and Experience Committee (SPEEEC) - A subcommittee of the CCG governing body who offered strategic oversight of the engagement process on behalf of governing body, ensuring that our statutory duties and moral obligations to the people of Sheffield were being met.

4. Report Structure

Included in the report are all the findings from the quantitative and qualitative engagement. The main thread of the report is a set of top line findings from the online survey which provides quick reference to all the questions asked. Any significant differences in opinion across the demographic groups are also illustrated and commented on throughout the report.

The views of people from community outreach (qualitative work) are after the survey question analysis, to complement, compare, contrast and enhance the analysis.

It should be noted that when the survey results are discussed within the report, often percentages will be rounded up or down to the nearest one per cent. Therefore occasionally figures may add up to 101% or 99%.

When considering how people have answered the questions, it is clear that words have different meanings for different individuals and communities, and therefore perception of terms will influence the answers given. This has been highlighted in the free text where appropriate.

5. Methodology

This engagement used a mixed method approach with an online questionnaire to gain views from the local population of Sheffield, interviews and group discussions involving targeted groups (including harder to reach communities and patients at the Walk-in Centre, A&E and in GP surgeries), and an online survey for staff.

6. Responses

Overall, 2,587 people have contributed to this stage of the urgent care review (including 317 staff from provider organisations.

Method	Month/Year	Number of respondents
Online surveys (public)	Feb – Mar 2019	1,783
Online survey (staff)	Mar 2019	317
Outreach engagement work in communities	Feb – Mar 2019	309
Discussions with patients in A&E and the Walk-in Centre	Mar 2019	20
Public and Partner Reference Group	Dec 2018 – Jun 2019	63
Patient journeys (including targeted general practices)	Jan – Mar 2019	95
Total		**2,587**

In terms of how reliable the results are, the quantitative data is accurate to +/-2.32% margin of error at a 95% confidence level. This means that, for example, if 70% of respondents agreed with the statement that urgent care needs to change, we could be 95% confident that if all the public in Sheffield had answered the question then between 67.68% and 72.23% would have agreed.

7. Overview Of The Engagement

7.1 Qualitative community outreach engagement

Feedback from these communities builds on previous engagement and consultation[1] from 2015 onwards.

Time-intensive qualitative research techniques were used, including in-depth semi-structured interviews, individual discussions and group interactions, to gain a richness of data to inform this review. This involved people sharing deeply personal stories and experiences as well as the impact the urgent care system had had on them. Where appropriate, examples have been matched to feedback from the online survey and additional information is highlighted in appendices.

Overall, 309 people were engaged in the outreach engagement (see Appendices B-D). 273 people lived in the Lowedges and Darnall areas of the city as these were under-represented in the previous engagement activity and are specific areas of high deprivation. Individuals with specific protected characteristics or life experience were encouraged to be involved:

- 8 people living with learning disabilities / difficulties
- 25 people living with mental health conditions
- 8 people with experience of substance misuse
- 100 people from the Pakistani community
- 20 members of the Roma Slovak community
- 8 people living with respiratory conditions

The activities included conversations with people from 12 different countries (UK, Iraq, Ireland, Hungary, Senegal, Nigeria, Bulgaria, Romania, China, Pakistan, India and Yemen).

In addition, 9 people who live with a learning disability or difficulty who access services at Mencap contributed as did 19 students at the University of Sheffield who were playing sports and therefore at risk of injury.

Qualitative feedback from these communities is included throughout the analysis alongside demographic data to illustrate how different geographical communities and those with protected characteristics are experiencing urgent care services.

In addition, 20 users of services at the Walk-in centre and adult A&E were interviewed (see Appendix E – F). This builds on previous engagement at children's A&E and in the Minor Injuries Unit in 2016.

[1] https://www.sheffieldccg.nhs.uk/get-involved/the-201718-consultation.htm

7.2 Patient Journeys

In addition to the outreach work and in order to understand what the patient journey looks like from patient perspectives, a journey map was developed for people to complete that provided information on the journey through the urgent care services in Sheffield, not about the problems and issues faced (see appendix G). The maps were tested and completed by participants at the workshop held on the 17 January 2019, and amended before being used to collect information from the places listed below. 95 journey maps were completed in total from:

- Participants at 3 x targeted engagement sessions at The Terminus Initiative
- Patients at Manor Clinic and Firth Park Clinic (community nursing services)
- Patients at The Healthcare Surgery (waiting room)
- Patients at Page Hall Medical Centre (waiting room)
- Patients at Porter Brook Medical Centre (waiting room)
- Patients at Pitsmoor Surgery (waiting room)
- Patients at University Health Service (waiting room)
- Participants at Chilypep.

7.3 Public online survey

The public online survey ran from 8 February 2019 to 29 March 2019. The following numbers of the public completed the online survey and shared demographic information in comparison to the Sheffield population. A summary table of the responses to all questions can be found in Appendix H.

To help promote the survey, over 50 emails were sent to various organisations for wider dissemination to partners, councillors, community groups, voluntary, charity and faith organisations, and the media. In addition, the CCG shared and posted various posts on Facebook and Twitter with groups identified as seldom heard in the previous engagement.

Demographic	Online survey feedback	Sheffield population
Sex	949 (72%) were female and 360 (28%) were male	This compares to 50/50 for the Sheffield population
Carers	334 (26%) were carers	10% are unpaid carers
Disability	196 (15%) lived with a disability. Asked subsequently about the type of disability: 116 (50%) live with a long-standing illness or health condition, 84 (36%) live with a physical or mobility disability, 58 (25%) live with a mental health condition and 10 (5%) live with a learning disability or difficulty	19% of the population lives with a disability or long-term condition
Race	1,201 (94%) were white British and 67 (6%) were Black, Asian, Minority Ethnic and Refugee (BAMER)	White British people 84% BAMER 16% of Sheffield's population.
Age	218 (18%) under 40 years old, 216 (18%) were between 40-50, 235 (19%) were between 50-60, 277 (23%) were between 60-70, 219 (18%) were between 70-80, 53 (4%) were 80+.	55% under 40, 13% 40-50, 12% 50-60, 9% 60-70, 6% 70 – 80 and 5% 80+

Religion or belief	36 (49%) said they were Christian, 40% had no religion, nearly 1% were Muslim and 0.5% Buddhist	53% of are Christian, 39.7% No religion 6% Muslim, 0.6% Hindu 0.4% Buddhist, 0.2% Sikh and 0.1%.Jewish
Parents	328 (25%) were parents of a child under 16	36% of households include children.
Access to technology	148 (11%) did not have access to a smart phone, 1,285 (99%) have access to the internet at home and 17(1%) do not	

7.4 Staff Survey

The staff survey was launched on the 1 March and closed on the 29 March 2019. We promoted the survey via GP practices, care homes, partners and around 25 community organisations. It was completed by the following staff:

Provider	Responses
GP practices	130
Sheffield Teaching Hospitals (inc GP Out of Hours)	67
Other	55
Sheffield Children's Hospital	24
Primary Care Sheffield	19
Walk-in Centre	13
Sheffield Health and Care Trust	6
Pharmacy	3

'Other' consisted of respondents from Sheffield City Council, Care Homes and Voluntary, Community and Faith organisations. Please refer to Appendix I for further detail about the responses.

7.5 Design Group

The Design Group was established with the following aims:

- To design the proposals
- To design workshops
- Test and challenge products developed by Programme Team.
- Review outputs from the workshops and highlight any areas for further consideration
- To review the feedback of the engagement

Membership of the Design Group was by invitation for stakeholders identified including the following:

- Patients (volunteers from the public reference group)
- Sheffield CCG
- Sheffield Teaching Hospitals NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust

- Sheffield Health & Social Care NHS Foundation Trust
- Primary Care Sheffield
- One Medicare
- Sheffield City Council
- Yorkshire Ambulance Service
- Healthwatch
- GP Practices
- ScHARR (School of Health and Related Research)
- Public Health
- Local Pharmaceutical Committee
- Local Medical Committee

The group has met monthly from December 2018 to June 2019 and will continue to meet to have oversight of the process.

7.6 Public and Partner Reference Group

The Public Reference Group was established with the following aims:

- To share members' experiences of the urgent care system
- To oversee the process followed
- To analyse the outputs from public engagement and consider themes and trends

Membership of the Public Reference Group was by invitation for:

- Organisations from the Voluntary, Community and Faith sector
- Members of Patient Participation Groups representing GP surgeries across the City
- The University of Sheffield and Sheffield Hallam University
- Healthwatch Sheffield
- Save our NHS

In December 2018 we held an initial workshop with representatives from the Public Reference Group and a separate workshop with representatives from our Partner Organisations across the system, including:

- Sheffield Teaching Hospitals NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Yorkshire Ambulance Service
- Sheffield City Council
- NHS111
- Primary Care Sheffield

In January 2019 we held a joint workshop with members from the Public Reference Group and our Partner Organisations. Feedback from attendees led us to combine the groups to form a Public and Partner Reference Group.

This group met a further four times between February 2019 and June 2019, including a specific workshop to consider children's urgent care services. Please refer to Appendix J for a summary of the Public and Partner Reference Group Workshops.

8 Key findings

The public survey consisted of 22 questions – closed and free text. The results are summarised in the following sections alongside additional insight from the outreach engagement work, where appropriate. A summary table for each response can be found in Appendix H.

The staff survey consisted of 16 questions.

8.1 Definition of urgent care

As part of reference groups and stakeholder engagement, a draft definition of urgent care. was developed:

"Urgent care means advice and treatment for illness* and injuries for all ages thought to be urgent (care needed within 24 hours) - but not life threatening.
*Illness includes mental and physical health."

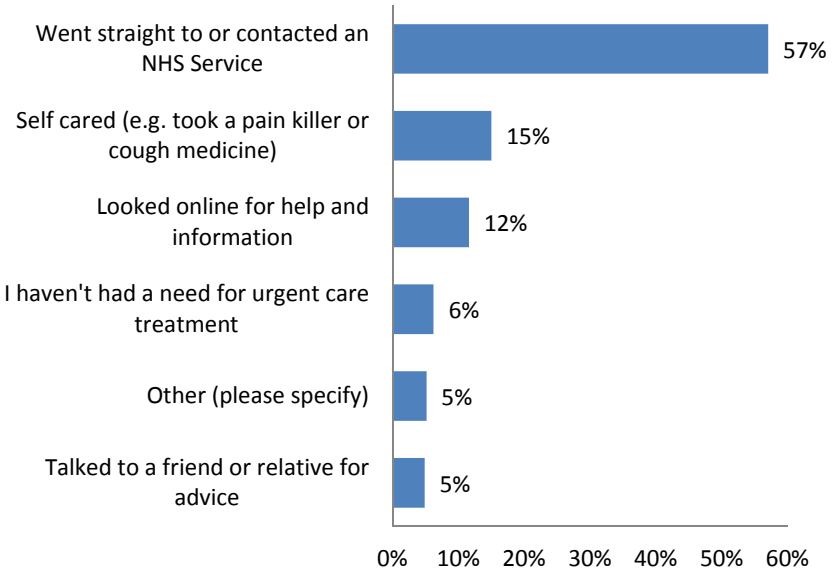
In the survey, we asked people if they agreed with the definition. The vast majority (94%) of people agreed. Of the 6% who did not agree, respondents offered alternative suggestions summarised in the quotes below:

> *"Urgent may not be doctors definition but patient may feel it is"*
>
> *"I think urgent could be interpreted or understood by some as emergency."*
>
> *"Urgent care = life threatening."*
>
> *"I would change this to "urgent care means advice and treatment for illness* and injuries for all ages thought to be urgent (care needed within 24 hours) - including illnesses that need to be treated within 24h so they don't become life threatening"*
>
> *"If it is urgent surely 24 hours is too long."*
>
> *"Within a few hours - up to 6."*
>
> *"Instead of urgent care it should be renamed urgent treatment. Care is confusing for a lot of people due to care is used in care homes, care which is used for personal care and finances."*
>
> *"If it were called "non-emergency urgent care" I think people would understand the distinction better. Most members of the lay public will not naturally draw a distinction between "urgent" and "emergency."*

8.2 Services people accessed and why

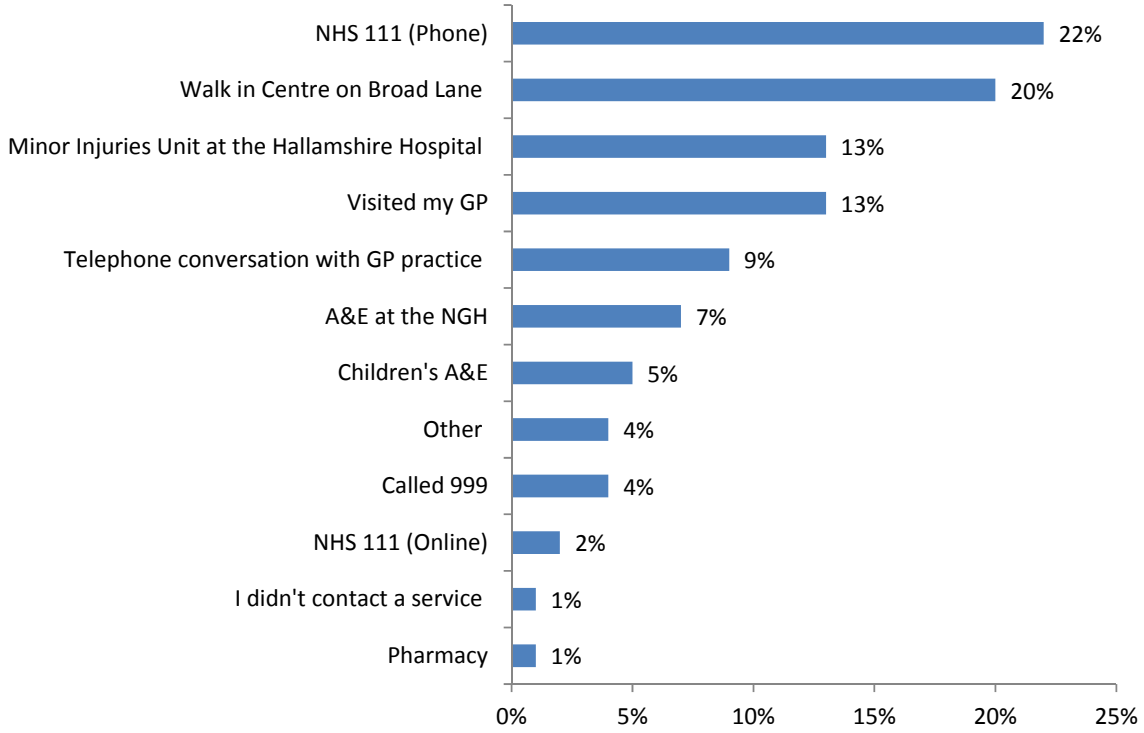
94% of respondents to the public survey had used urgent care services. Thinking about the last time, 54% used the service for themselves, 16% for a child, 9% for an adult they cared for, and 21% for an adult.

Thinking about the last time you had an urgent healthcare need for you or someone you care for, what did you do first?



- Overall, the majority of people (57%) contacted or went straight to an NHS service initially for their urgent care need.
- Males were proportionately more likely to go straight to an NHS service rather than look online or self-care in comparison to females.
- It would appear that people in the most affluent areas of the city are more likely to go to NHS services initially than those in the most deprived areas.
- Parents of children under 16 are more likely than average to look online than go straight to an NHS service.
- People from Black, Asian, Minority Ethnic and Refugee groups are no more or less likely than average to go straight to an NHS service.
- People who live with a disability are more likely to go straight to an NHS service.

Which NHS service did you contact first for advice?



- The biggest proportion of respondents' first contact with an NHS service was NHS 111 (23%), with 22% phoning and a further 2% going online. This is followed by 22% of people who visited or phoned their GP practice. 2 in 5 people went to the Walk-in Centre (20%) and 13% of people visited the Minor Injuries Unit (MIU) and 13% A&E – 7% Adults and 5% Children's.
- Carers are more likely than average to contact the GP or Walk-in Centre first
- Parents of a child under 16 were more likely to contact Children's A&E first, followed by NHS 111.
- When seeking advice for themselves, females are more likely to contact their GP first and males are more likely visit the Walk-in Centre initially.
- People living in the most deprived areas of the city are least likely to visit the Minor Injuries Unit.

Community engagement findings (see Appendices D-G)

Based on the outreach engagement with the learning disabilities community at Mencap, it emerged that 999 was the automatic response to minor injury and non-emergency conditions or for carers who often have intellectual disabilities themselves – a direct quote was:

"I need help. I'm not well. I need an ambulance."

Based on the outreach work in Darnall, young Pakistani males (under 40) who identified themselves as suffering from anxiety and depression spoke about ongoing difficulties obtaining appointments and this has resulted in frequent use of the Walk-in Centre.

"I was told that I had to wait a week and I knew that I would get worse if I waited that long"

In both the Lowedges and Darnall communities, the majority of feedback indicated that most people are unaware of the existence of the Minor Injuries Unit and there were suggestions that publicising this service could be helpful. When asked if they would consider using the Minor Injuries Unit in future, for example sprains or burns, there was confusion about which service to use

"How do I know where to go – Walk-in Centre or Minor Injuries Unit?"

This is in contrast to the survey findings, most people said their driver for choosing a service was whichever service was nearer to where they lived.

The majority of people in the Lowedges community who live with learning disabilities and enduring mental health needs either did not know about 111, the Walk-in Centre or Minor Injuries Unit for out-of-hours non-urgent care, or knew and did not wish to use the services, preferring to see their GP at the next available opportunity or use the emergency 999 service.

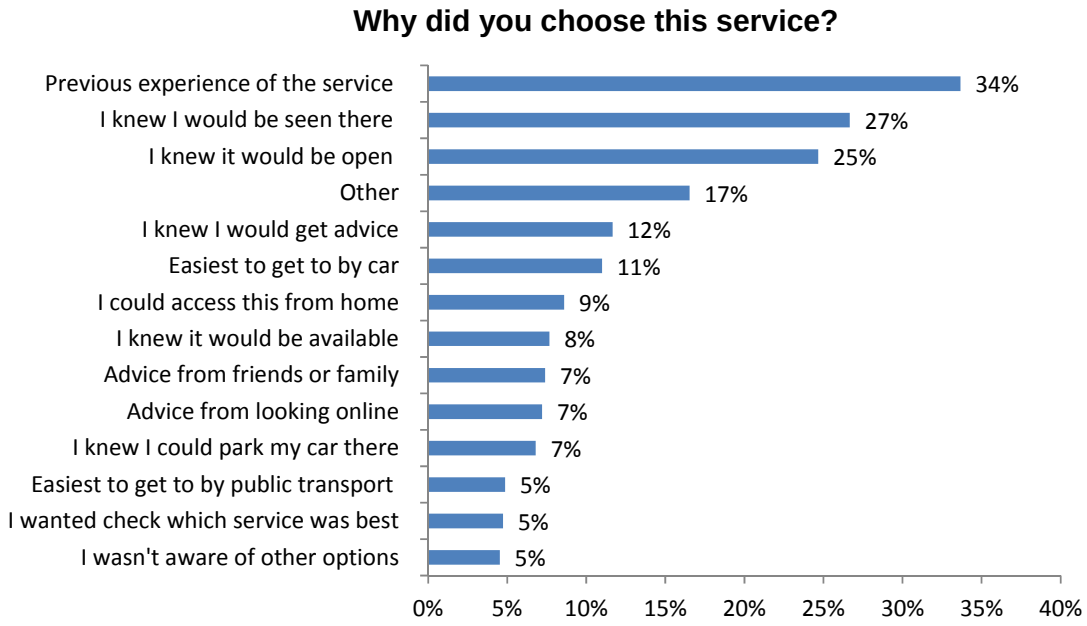
A common theme from the Roma Slovak families was the common clinical practice in their home countries to prescribe antibiotics much more frequently than would be considered appropriate in the UK. This seems to result in patients choosing to attend A&E where there is the expectation of seeing a doctor on the same day as the presenting need, and an expectation that certain medications are more likely to be prescribed.

"UK doctors are not as good as they are (back home), they don't care, and they don't give me and my son the medicines we know we need."

There was confusion regarding where patients should be signposted for urgent dental care, with several patients being told by staff at Walk-in Centre that Charles Clifford does not carry out urgent dental care and being referred back to their GP.

In the engagement carried out in 2015, a key theme was that people said they would go to a pharmacy first, particularly those from the Traveller community. In the most recent engagement activity, only a few people mentioned using their pharmacy.

Based on the information from the patient journey maps, no-one mentioned using the Minor Injuries Unit as the first point of access. A few patients mentioned using the GP hubs. Similarly to the survey, few people mentioned self-care and only one person mentioned using their pharmacy.



- Asked why they chose that service, the biggest driver of people's behaviour was due to a previous experience (34%), followed by they knew they'd be seen there (27%) and said they knew it would be open (25%).
- The fourth most popular answer was "other". Here people said that they had been referred by another professional, it was the easiest service to get too or it was at the weekend.
- In the qualitative responses within the online survey from people who had used A&E, key themes from respondents were that they felt it was the most appropriate service for their need or that they were told to attend by another professional.
- The themes relating to why 999 were called included being encouraged to do so by another professional and feeling that the situation was serious enough to warrant an ambulance.
- In relation to Children's A&E, parents chose that service because they trusted the competence, skill and service available at that site.
- Reasons given for utilising the Minor Injuries Unit included ease of access on foot, that it is the nearest service and that it was the most appropriate service based on the urgent care need. People stated they knew they would get the advice they needed as the primary reason for contacting their GP or NHS111. Other reasons given for contacting NHS111 included previous personal experience of the service, they knew it would be available or they could access it from home.

Community engagement findings

The majority of people in the Lowedges community were concerned about transport costs to the Walk-in Centre and this concern had stopped patients attending. Other comments included concerns regarding the difficulties of travelling whilst ill, travelling with sick children, and the cost of nearby parking.

Students who were aware of the Minor Injuries Unit preferred to attend this service rather than the walk in centre due to its geographical location and the experience of shorter wait

times. Students said that at freshers' induction sessions the Minor Injuries Unit is not referenced and this seems to be reflected in the low levels of awareness of this service.

As mentioned previously, the Roma Slovak population shared that they were more likely to attend A&E rather than their GP due to the expectations of the service they would receive.

Feedback from the focus group at Mencap of people with learning disabilities and their carers was that none of the members had heard of NHS111 but all members present had heard of the walk in centre and 8 members had heard of Minor Injuries Unit.

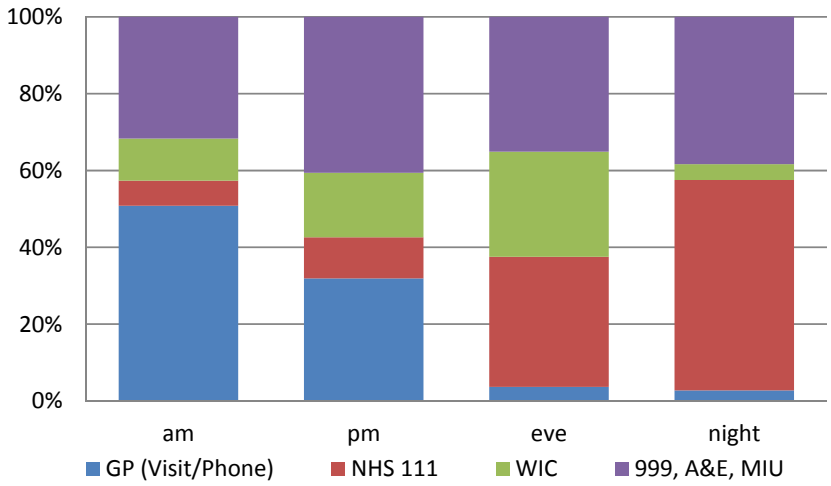
Based on the outreach work in Lowedges, the majority of usage of Walk-in Centre was prompted by local surgeries being closed at weekends and bank holidays. In the Pakistani community, most of the visits to the Walk-in Centre and A&E were prompted because the patient could not obtain an appointment with a GP during opening hours.

Although the sample size from the waiting room at the walk in centre was small, everyone shared that they weren't able to get an appointment with their GP.

8.3 Timings of people accessing services

- Nearly two-thirds of people (64%) used the services on a weekday: 26% in the morning, 21% afternoon and 17% in the evening.
- 32% of people used services at the weekend or bank holiday, with the biggest proportion of this group having used a service between 8am and 12pm (12%).
- People using their GP first is highest in the morning, declining sharply over the day
- Use of NHS111 and the walk in centre increases in the afternoon and evening
- Minor Injuries Unit use declines in the evening as it closes at 8pm.

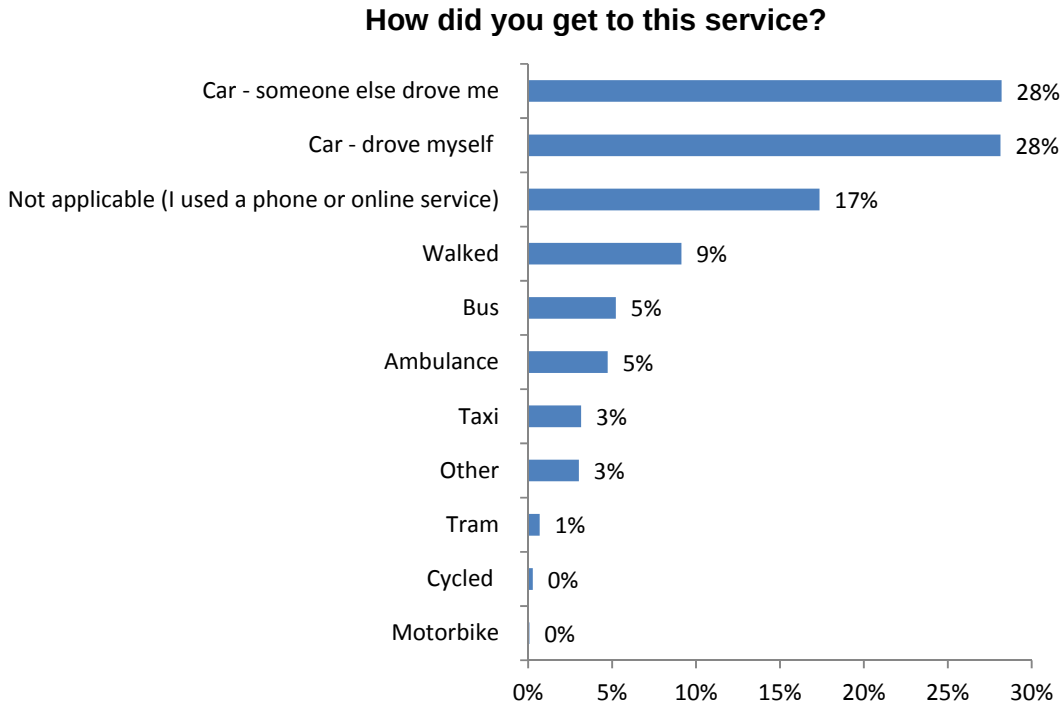
Proportion of people using services by time of day



- The proportion of people responding that they first used 999, A&E and Minor Injuries Unit is consistent at around 35-40% throughout the day.
- The focus of activity mainly switches between GP, NHS111 and the Walk-in Centre

- 50% of respondents using a service in the morning used their GP first. This drops to 32% in the afternoon and 4% in the evening.
- Only 7% of those using a service in the morning used NHS111 first, rising to 34% in the evening and 55% at night.
- 11% reported using the Walk-in Centre first on a weekday morning

8.4 How people travelled to services



- The majority of people (56%) travelled to the service by car. 17% of people didn't travel as it was a telephone or online service. Just 1 in 10 people (9%) walked and 6% got public transport.
- People living in the more affluent areas were most likely to travel by car (55%). Those people living in areas of high deprivation were more likely than average to travel by bus (7%) and least commonly by ambulance (4%).
- When asked if respondents experienced any difficulties getting to services, 87% of respondents answered no. Respondents comments included:

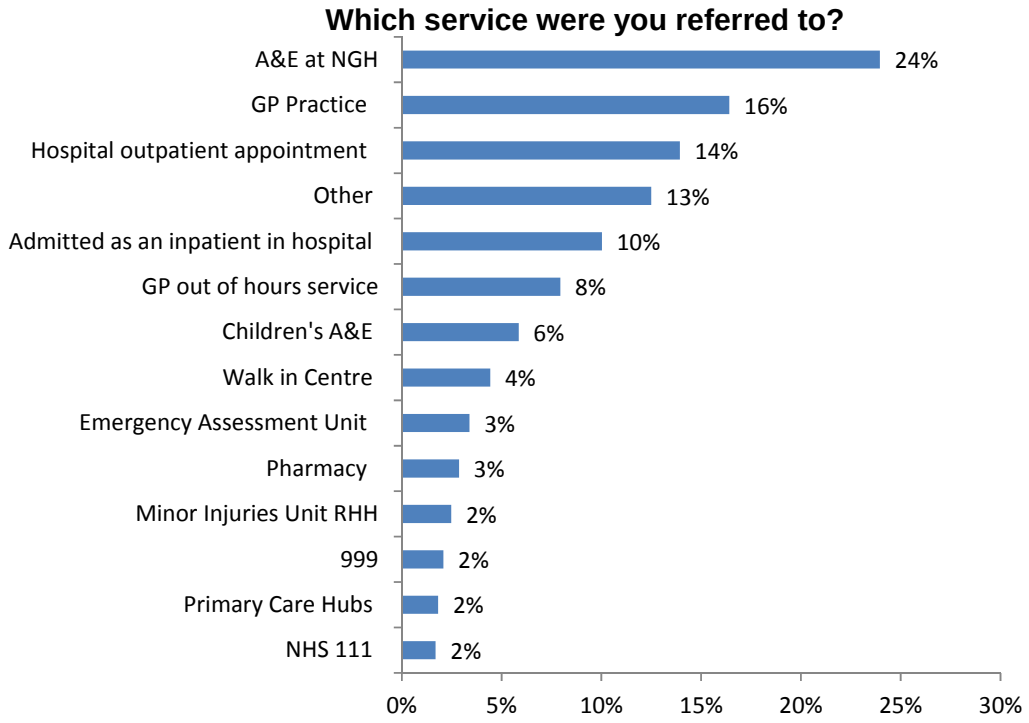
"Had to get a taxi to other side of Sheffield NGH and then a taxi back to children's hospital"

"Car parking at NGH horrendous. Unable to catch bus due to long walk up path to get to hospital"

Actually as no problem with parking given a Sunday morning. However, any other time the car parking would be a nightmare. A multi-storey car park is badly needed at NGH. Also a better bus service, or better still a tram out to NGH!

"Chose Chesterfield hospital as much quicker and easier to access from where I live in the south west of Sheffield"

8.5 Referrals to other services



- Of those who were referred elsewhere, 30% were referred to A&E - 24% A&E at NGH and 6% to children's A&E. 29% were referred to primary care - 16% to their GP practice, 8% GP out of hours, 3% pharmacy, and 2% primary care hubs.
- A small number were referred to Walk-in Centre (4%) and Minor Injuries Unit (2%).
- Of the 13% who said 'other', they were referred for further diagnostics tests, or for specialist treatments.
- After using or contacting their first service the majority of people who filled in the survey (55%) were referred to another service by a healthcare professional or service.
- 31% of those referred had initially made contact with NHS111. This would be expected, however it is interesting to note that a high proportion 53% of those referred to a second service were from services such as Minor Injuries, Walk-in Centre, both A&Es, 999 and GP practices. The reasons behind this need exploring further but could be indicative of problems in pathways and signposting and behaviours which have been highlighted in the patient journeys, workshops and survey results.
- Over a quarter were referred to hospital, 14% as an outpatient, 10% as an inpatient, and 3% to emergency assessment unit.
- The vast majority (96%) went to the service they were referred to.
- Of the patients who were referred to A&E (children and adult) said they were referred by NHS111 (41%), GP (22%) and the Walk-in Centre (16%). GP surgery referrals were via the Walk-in centre (30%) and NHS111 (29%).

8.6 Patient experiences of using services

Thinking about the last time you needed an urgent care appointment with your GP or another healthcare professional in your practice, were you able to get one within 24 hours?

- More than 50% of respondents were able to access an urgent appointment (within 24 hours) at their GP surgery, or with another healthcare professional, last time they requested one. 11% of people couldn't remember or it wasn't applicable in their situation and 33% of respondents were not able to access an appointment when they perceived they needed one.

Based on the respondents' experience of using the services, and referral from one service to another, comments included:

"It was helpful to get advice and signposted to see medical attention."

"The ambulance people were ok but I didn't see them again. And the information I communicated to them was not read up by subsequent doctors and nurses whom I came into contact with so I had to go through the story several times. This was frustrating, confusing and tiresome because I am autistic therefore communication is very difficult for me."

"They were very good but working through the required script ended up saying I needed an ambulance. I refused as I was able to get there myself and was quite local. I was trying to save the NHS money. Now I know what I know I should have accepted as I then needed further NHS "drains" by me utilising 4 GPs, 1 radiographer, 3 hospital visits, a nurse, 2 pharmacists, 2 GP collaborative visits etc. I feel had I have started in the "system" I would have been far less time, trouble and cost to the NHS."

"Absolutely wonderful as always, NHS at its best."

"They were unable to help me - agreed with my diagnosis but could not provide the cream my daughter needed without a GP confirming it so I called the GP and couldn't get an appointment so I then call 111 who then told me to go to the walk

in centre who confirmed the diagnosis which myself and the pharmacist had agreed 3 hours previously and prescribed the cream that the pharmacist had recommended and I went back the pharmacy to collect it. All of this for a 4 year old with impetigo!"

8.7 Public and staff urgent care priorities

Public's urgent care priorities

We asked the public to pick up to five areas of urgent care (from a list of 20) that were most important and up to five that were most in need of improvement.

The most important were:

1. Being seen by a healthcare professional best able to treat them (53%).
2. Being seen on the same day (51%)
3. Being seen at my own GP practice (44%)
4. Being able to walk in for an appointment (31%)
5. Being able to book in for an appointment (30%).

The most need of improvement included a slightly different list to those most important:

1. Being seen at my own GP practice (40%)
2. Being seen on the same day (37%)
3. Being able to book in for an appointment (30%)
4. Being able to see my own GP on the same day (30%)
5. Being seen by a healthcare professional best able to treat me (27%)

The graph overleaf shows the correlation between most important against most in need of improvement.

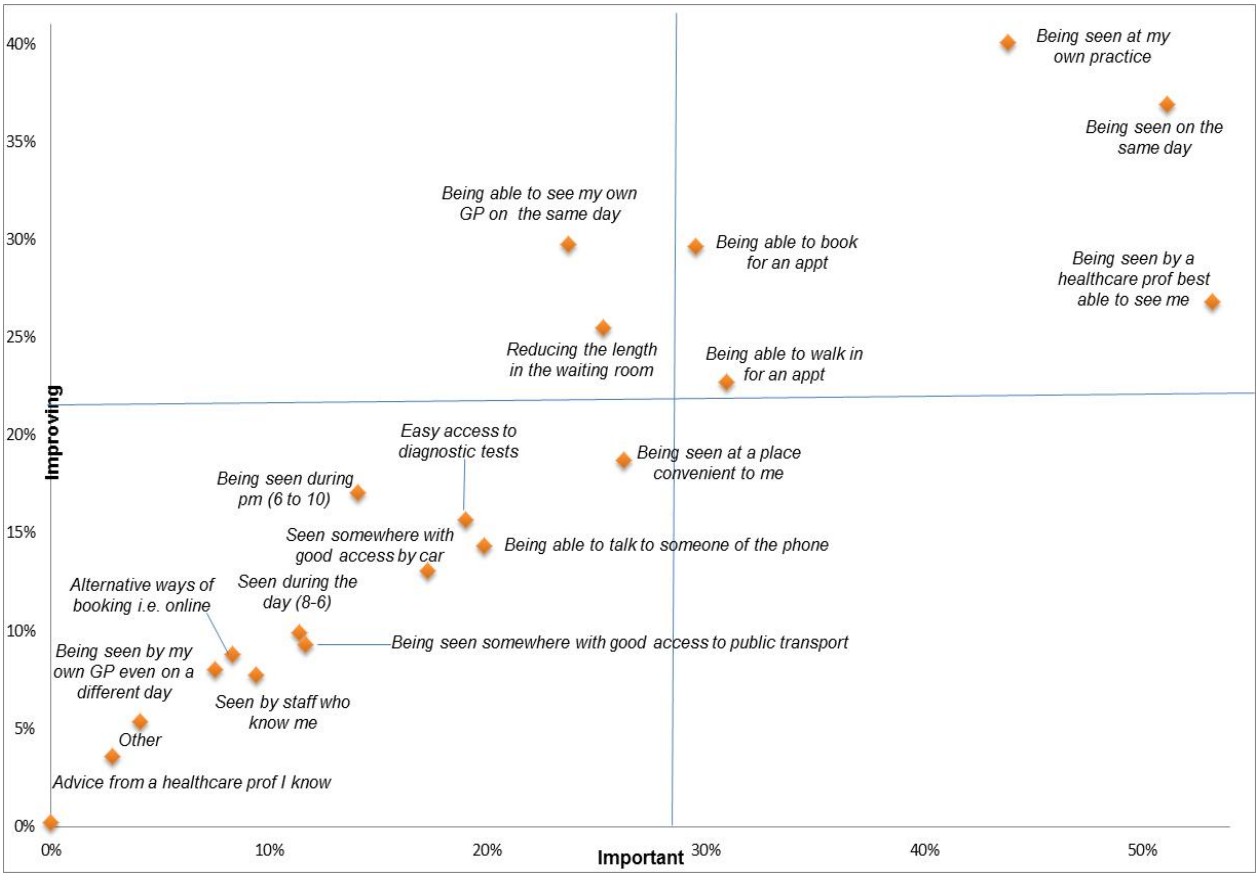
Those in the top right-hand box are those that are classified as the most important and most need improving. These are:

1. Being seen at my own GP practice
2. Being seen on the same day
3. Being seen by a healthcare professional best able to treat me
4. Being able to walk in for an appointment
5. Being able to book in for an appointment

Public's urgent care priorities

Less important but needs improvement

Important and needs improving



Less important and less in need of improvement

Important and less in need of improvement

Although numbers were small and not statistically significant, responses from different demographic groups were as follows:

- Disabled respondents selected 'seeing own GP/someone who knows me' slightly more frequently than the average (20% compared to average of 19%)
- People from Black, Asian, Minority Ethnic and Refugee groups are more likely than average to select 'seeing own GP/someone who knows me' (24% compared to average of 22%) and less likely to select 'being seen on the same day' (19% compared to 21%)
- Respondents from postcodes S10/S11 were more likely than average to select convenience to get to (16% of responses compared to average of 14%) and slightly less likely to select 'seeing own GP/someone who knows me' (18% compared to 19%)

Staff's urgent care priorities

We asked staff to pick up to five areas of urgent care (from a list of 20 that were slightly different to the public list) that were most important and up to five that were most in need of improvement:

The most important were:

1. Being able to provide enough same day appointments (50%).
2. Having an up to date list of all the services I can signpost/refer to (47%)
3. Gaining the trust of the patient, I am providing advice or treatment to (41%)
4. Putting clinical triage in place (41%)
5. Being able to electronically talk to other computer systems across services and organisations (37%).

The most need of improvement was a slightly different list to those most important:

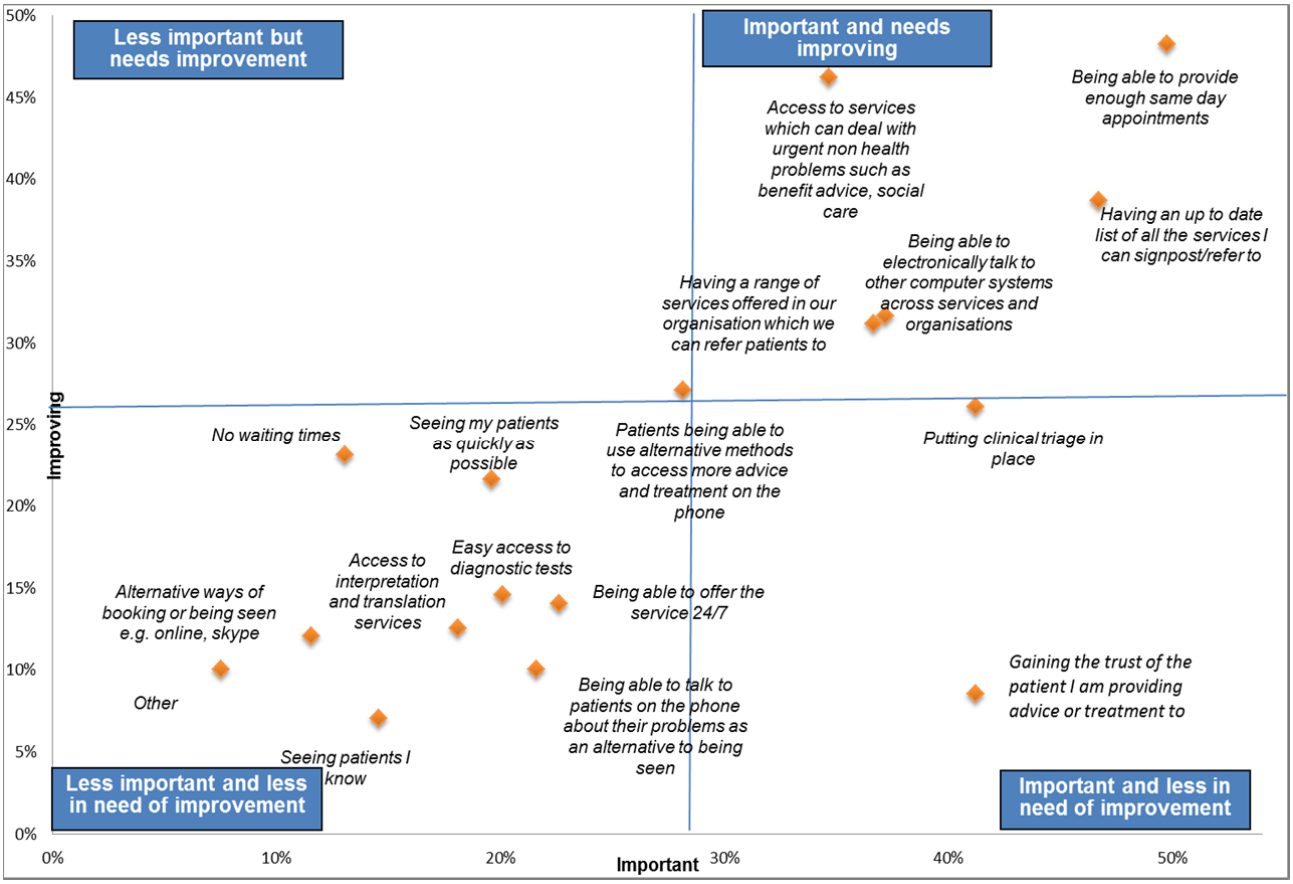
1. Being able to provide enough same day appointments (48%)
2. Access to services that can deal with urgent non-health problems such as benefit advice, social care (46%)
3. Having an up to date list of all services I can signpost/refer to (39%)
4. Being able to electronically talk to other computer systems across services and organisations (32%)
5. Having a range of services offered in our organisation which we can refer patients to (31%)

The graph overleaf shows the correlation between most important against most in need of improvement.

Those in the top right-hand box are those that are classified as most important and need most improving. These are:

1. Being able to provide enough same day appointments
2. Having an up to date list of all services I can signpost/refer to
3. Access to services which can deal with urgent non health problems such as benefit advice, social care
4. Being able to electronically talk to other computer systems across services and organisations.

Staff's urgent care priorities.



One thing people would improve

We asked people if they were the boss of the NHS in Sheffield, what one thing they would do to improve their experience of urgent care services in the city

There was a diverse range of responses from patients to this question, but the top six themes were:

1. Improve access (18%);
2. Don't close services / retain services (13%);
3. Increase number of locations / services (13%);
4. More staff / workforce (11%);
5. Improve patient education (6%);
6. Better triage (5%).

The public shared the following comments:

> *"Make it less confusing to access, and easier to navigate (or be navigated) round the system to get seen by the right person quickly. I drove past the children's hospital to get to GP Collab at NGH (as told by NHS 111), only to be told by the GP to go back to SCH."*

> *"Employ more staff. Do not shut down Walk-in Centres. Make access easy for all."*

"Increase awareness that you can get an out of hours GP appointment from 111. Maybe increase the number of locations that run it."

"Easier access to urgent healthcare in the outskirts of Sheffield, especially where public transport is lacking."

Based on all the feedback received in response to this question, the following words were used (the more prominent the word, the greater the frequency of use):

Public

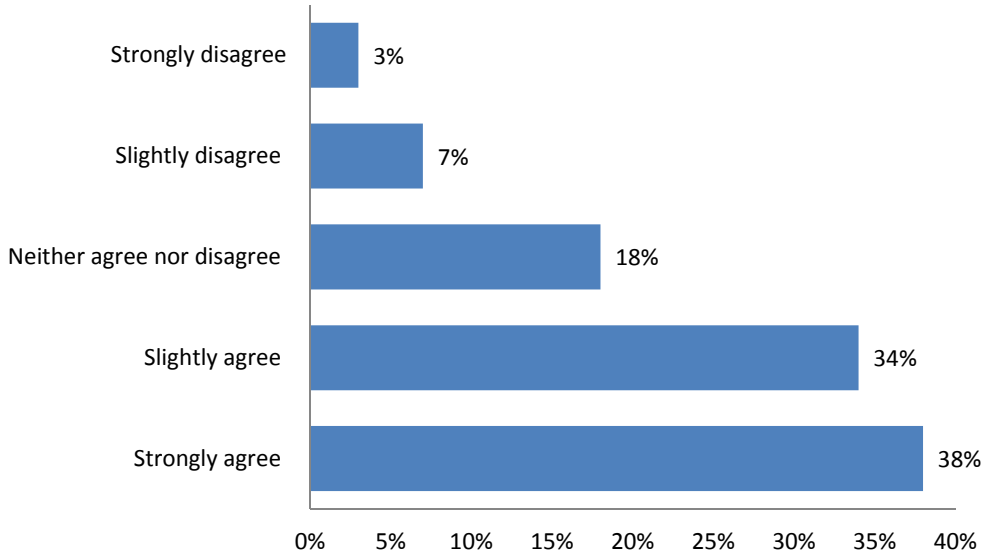
Staff

The top four themes from a staff perspective were:

Theme	Instances
Better pathways between services/ access to diagnostics	77
Improve Patient Education	69
Improve Staff Education	69
Improve Mental Health Services	68

8.8 Need for change

How much do you agree or disagree that urgent care services in Sheffield need to improve?



- Overall, 72% of people who completed the question, strongly (38%) or slightly (34%) agreed that urgent care services in Sheffield needed to improve, 1 in 10 (10%) of people disagreed. This is a net agreement of +62%.
- Older people are more likely than younger people to perceive that urgent care services require improvement
- People who live with a disability are more likely to think that services need to change - 49% strongly agreed that urgent care services need to be improved and 27% slightly agreed.
- From carers who contributed to the survey, 77% strongly or slightly agreed that urgent care services need to be improved and 67% for parents of a child.
- Of those working in urgent care services, 69% of respondents strongly or slightly agreed that services need to change.

9. Overview of similarities and differences from views gained previously in relation to urgent care

Engagement on urgent care started in 2015. A table showing the key themes from all the engagement and consultation undertaken is below.

From May to August 2015[1], the CCG talked to patients and the public using a variety of methods, estimating over 14,000 contacts with individuals and groups specifically relating to the urgent care services review.

Healthwatch Sheffield then carried out surveys in late 2015 and early 2016 at A&E, Children's A&E, Minor Injuries Unit and the Walk-in Centre. The information gathered provided a snapshot of the behaviours of people using these services at a particular date and time.

Pre-consultation engagement activity was undertaken in March 2017[2], with 289 community members from the following six groups, some of whom were considered 'seldom heard':

- Homeless people
- Substance misuse community
- Communities with greatest deprivation
- City workers
- Students
- Vulnerable people

Sheffield CCG then ran a formal public consultation between 26 September 2017 and 31 January 2018 on proposals to redesign urgent primary care within Sheffield. The consultation was then extended by a further 6 weeks. This engagement was in relation to the specific proposals in the consultation document. Then in September 2018, the CCG took the decision to explore further and refresh what the problems and issues are with urgent care with stakeholders and the public of Sheffield. This resulted in the urgent care review from December 2018 to May 2019.

In summary, over the last 4 years, NHS Sheffield CCG has used a variety of methodologies and a range of questions and has approached diverse range of communities. The analyses in the table below shows that themes that have emerged from all the engagement work conducted over this time have been very similar, which allows us to be assured that the views we have collected are a representative sample of the views of the people of Sheffield. There have been consistent themes across all engagement reports, particularly around access to the right service, first time, concerns about public transport and the cost and patients passed from pillar to post.

1 Urgent Care Survey, Healthwatch Sheffield, NHS Sheffield CCG, March 2016

2 Public Engagement with Specific Groups, Summary Report, NHS Sheffield CCG, March 2017

Themes identified from all the engagement activity mentioned above can be seen in the table below:

Summer 2015	Surveys 2015/16	Pre-consultation March 17	Consultation Activity 2017/18	Urgent Care Review 2019
• Access to GP appointments • Confusion about what services to use • System not working cohesively • Mixed view of staff attitude and communication • Differing experiences and knowledge of services – electronic access • Alternative services available closer to home • Discharge failures • Lacking a holistic approach for physical and mental health needs • People use the services they are familiar with and close to home	• Most people had chosen to access the Walk-in Centre because they were unable to make an appointment with the GP • Shorter waiting times and more information about how long they will have to wait • Most people had chosen to access A&E and Children's A&E because they felt that was the service that they needed. • People were mostly looking for medical advice • Most people who had tried to access another service before A&E had called NHS111 and been told to go there • If the service people were accessing wasn't there: - A&E said they would go to WIC - Children's A&E said they would go to the WIC - MIU said they would wait to see own GP - WIC said they would go to A&E • Only 4.6% of respondents stated they were not	• Recognising that phones give lots of people access but the cost and access to phones can be a barrier • Issues around support and after care for vulnerable patients • For homeless, substance misuse and communities of greatest deprivation, visits are higher in A&E than the Walk-in Centre, with some very high frequent attenders • 9 people = 164 attendances at A&E • Lack of specialist support to people with experience of substance misuse and revolving door • Temporary registration creates barriers and impacts on health inequalities • People with low literacy or English as second language find it difficult navigating the system • Service they had used most was pharmacy	CONSULTATION REPORT • Current access to GP appointments meant that urgent care access was not seen as a viable alternative. • Concerns about the proposals around achievability of neighbourhoods/primary care • Local care in the community close to home • Concerns around widening health inequalities and accessibility of NGH site, including transport, and after care for vulnerable patients.(contrary to high use of A&E) • Need for services to remain in the city centre • Lack of knowledge about where and when to access urgent primary care. TELEPHONE SURVEY Feb 2018 • Care in local community • Speed of being seen important – particularly for younger people • Convenient appointments important – but different for times of day depending on age • NGH site a concern as less accessible (e.g. distance, poor transport links, parking) • Public transport a concern	The findings of this review have been described in detail throughout this report. The overall themes that have been identified are: • Confusing and Inconsistent Pathways - Parity between referral and services available for people with mental health rather than physical health conditions - Speed of access important for some communities • Inconsistent knowledge and lack of knowledge - Confidence level of staff in support roles to refer - Staff – training, numbers, signposting etc • Culture and Behaviour Issues, including: - Travel using public transport – particularly cost and travelling whilst poorly - Reliance on services

Summer 2015	Surveys 2015/16	Pre-consultation March 17	Consultation Activity 2017/18	Urgent Care Review 2019
	registered with a GP	• People use services that they know and trust rather than unfamiliar environments • Choice of using a service is based on previous experience and trust	• Loss of city centre services and concern (both MIU & WIC • Need more awareness of what services to use – improve working conditions and capacity of the NHS TELEPHONE SURVEY – Selected Postcodes • Care local to home preferred • Speed of getting an appointment important, particularly to males and younger people • Older people and those living with a disability are more likely to want appointments closer to home in the daytime • Accessibility of NGH site, (distance, poor transport links, parking) • Concern about closure of WIC and MIU • Need more awareness of what services to use	people know and trust • Lack of and inefficient use of resource - Access to GPs including waiting times and availability There was a strong sense that “something needs to change”

Common themes across all engagement

- Confusion about what services to use, the recent review suggested this included patients and staff not knowing where to refer to
- Public transport a concern
- Care local to home preferred
- Access and speed of getting an appointment important
- People who are older and those who live with a disability are more likely to want appointments closer to home in the daytime
- Accessibility of NGH site, with concerns about distance, poor transport links and issues with parking. There was also feedback about lack of accessibility around the site, particularly for vulnerable, infirm and older people.
- Concern about closure of WIC and MIU (consultation onwards)

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Report to Healthier Communities and Adult Social Care Scrutiny Committee
11th September 2019

Report of: Policy and Improvement Officer

Subject: Written responses to public questions

Author of Report: Emily Standbrook-Shaw
emily.standbrook-shaw@sheffield.gov.uk
0114 273 5065

Summary:

This report provides the Committee with copies of written responses to public questions asked at the Committee's meeting on 24th July 2019.

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

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

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

The Scrutiny Committee is being asked to:

Note the report

Background Papers: None

Category of Report: OPEN

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Response to Andy Shallice, Darnall Dementia Trust

Thanks for attending the Healthier Communities and Adult Social Care Scrutiny Committee meeting on the 24th July. As agreed, I'm writing to provide you with an answer to the question you asked:

"*Now the dementia commissioning strategy for day support services has been abandoned, after already running late, can we assume that the significant flaw of separate strands for supporting people with intial/mild dementia, and those with more advanced dementia – so emphasising continuity of care, will be addressed?"*

As explained at the meeting, the Committee will be considering the Dementia Strategy at its next meeting on the 11th September, and will pick up these issues there, however we have followed up your question with the relevant officers and can provide the following information:

"*It is difficult at this stage to say what the model of support will look like however we decided to review the commissioning of day activities/day care because of feedback received during the procurement process. Since that time we have extended all of the current contracts to give us an opportunity to explore the possibilities for day activities/care and seek the views of individuals and organisations'. We will work with partners such as Healthwatch and the CCG to help facilitate this. Once we have this information we will design a model of support based on people's views, research and good practice and value for money amongst other things . A market brief with questions will be going out to providers shortly, this will ask opinions on various approaches to providing day care/activities and all providers are urged to complete this"*

This information will be circulated to all members of the Scrutiny Committee, and will be published with the papers for the next meeting

Response to Sheila Manclark, Darnall Dementia Trust

Thanks for attending the Healthier Communities and Adult Social Care Scrutiny Committee on the 24th July. As agreed, I am writing to provide you with an answer to the question you asked:

"*Following the CCG's 13 Commitments for dementia in Sheffield, how will the revised SCC dementia strategy support the element of these proposing personalised, local support for people with dementia, and support for families and carers?"*

As explained at the meeting, the Committee will be considering the Dementia Strategy at its next meeting on the 11th September, and will pick up these issues there, however we have followed up your question with the relevant officers, and they have provided the following information:

"*The dementia strategy and its 13 commitments were developed by a multi-agency group of people including people with dementia, their families and practitioners from a number of organisations in the city (e.g. GPs, the teaching hospitals, the Council, CCG and voluntary sector). The group who will drive the strategy forward and oversee its implementation is also a multi-agency group to ensure there is accountability for its progress in achieving the aims.*

The next stage for the strategy is to develop action plans which will meet each of the priority commitments. We have already started this process, mapping what is already happening in the city, and how we will ensure the commitments are met. We know there is already a lot of good practice around the city providing tailored and local support to individuals and their families and we would like to capture this good practice but also identify where there are gaps. To do this we will need further conversations with individuals, their families and local organisations. This should happen over the next 12 months.

There is also a commissioning plan for dementia which has been running alongside the strategy development. It is due to be refreshed in 2020 and we are working on a Joint Commissioning Plan with the CCG, who have agreed our approach. In the meantime we have made significant investment into local community based partnership organisations throughout the city who are now starting to develop dementia cafes, information and advice sessions, community group activities amongst many other things. These have all been tailored to the people living in those communities and will be monitored to ensure their success."

This information will be circulated to all members of the Scrutiny Committee, and will be published with the papers for the next meeting.

Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Wednesday 11 September 2019

Report of: **Policy and Improvement Officer**

Subject: **Work Programme 2019/20**

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

The report sets out the Committee's work programme for consideration and discussion.

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

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

The Scrutiny Committee is being asked to:

- Consider and comment on the work programme for 2019/20

Category of Report: OPEN

1 What is the role of Scrutiny?

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

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

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

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

2 The Scrutiny Work Programme 2019/20

2.1 Attached is the work programme for 2019/20. The work programme remains a live document, and there is an opportunity for the Committee to discuss it at every meeting, this might include:

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

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

3 Recommendations

The Committee is asked to:

- Consider and comment on the work programme for 2019/20

HC&ASC Draft Work Programme		
Topic	**Reasons for selecting topic**	**Lead Officer/s**
Wed 11th September 2019 4pm **Mental Health**		
Mental Health Transformation Programme	To understand the impact that the mental health transformation programme is having on people in Sheffield, and to understand the commissioning and finance arrangements behind the programme.	Jim Millns, Deputy Director of Mental Health Transformation and Integration, NHS Sheffield CCG, Sam Martin, SCC
Dementia Update	To consider the City's dementia strategy and the impact it is having on people living with dementia and their families and progress in implementing Dementia Friendly Communities in Sheffield.	Nicola Shearstone, SCC NHS Sheffield CCG
Urgent Care	To consider the CCG's proposals for changing Urgent Care Services in the City.	Kate Gleave and Brian Hughes, NHS Sheffield CCG
Wed 16th October 2019 4pm **Transformation and Integration**		
Joint Commissioning Update	To consider progress in developing Joint Commissioning arrangements and the impact of Joint Commissioning	Greg Fell, John Macilwraith SCC, Brian Hughes, CCG

Accountable Care Partnership	To consider the impact of the Accountable Care Partnership - what it has done, the difference it has made to people and services in Sheffield, and future plans, including the implementation of 'Shaping Sheffield'.	Kathryn Robertshaw, Interim ACP Director
Better Care Fund	To consider how well the Better Care Fund is driving integrated services in Sheffield, what impact is it having, and future plans	John Doyle, SCC/ Nicki Doherty, CCG
Wed 27th November 2019 4pm Improving people's experience of care		
CQC Local System Review Action Plan – focus on Delayed Transfers of Care and Winter Readiness	Delayed Transfers of Care have been a persistent performance issue in Sheffield, and was a key focus of the CQC Local System Review. To understand how the system is preparing for winter 2019/20, and progress on the Local System Review Action Plan – including case studies to demonstrate how people's experience of the system has improved since the review took place.	STH/SCC/CCG/ACP
Continuing HealthCare	To consider whether developments to the CHC process are having the right impact and improving performance and patient experience.	Mandy Philbin, NHS Sheffield CCG Sara Storey, SCC
Wed 15th January 2020 4pm Locality Working		

Working together in Localities	To consider how well services are coming together in areas, including the development of Primary Care Networks, Adult Social Care Locality Teams, People Keeping Well Programme, Social Prescribing and relationship with the voluntary sector.	
Wed 18th March 2020 4pm Performance		
Quality in Adult Social Care	To scrutinise performance against national adult social care indicators, and impact of actions taken to improve quality in social care. To include the draft Local Account.	Sara Storey, SCC
Task and Finish Group		
Continence Services	To consider how well current services help people to maintain their independence and dignity, and the impact of purchasing exclusions on continence pads.	
'Watching Brief' items		
Social Care Green Paper	*To consider the implications of the Social Care Green Paper for Sheffield.*	*Sara Storey, SCC*
Impact of Brexit on the Health and Care Sector	*To consider implications of Brexit on the Health and Care Sector in Sheffield – particularly relating to workforce*	*Director of Public Health, SCC*

Quality Accounts	*To consider NHS provider Trusts Quality Accounts in line with Statutory Guidance – approach to be determined.*	*Various*
Adult Short Breaks	*To consider whether proposals to change Adult Short Breaks require public consultation and scrutiny.*	*NHS Sheffield CCG*
Implementation of the national GP contract	*To consider the local commissioning response to the national changes to GP contracts.*	*NHS Sheffield CCG*
Primary Care Hubs	*To consider proposals around changing locations of Primary Care Hubs in the City.*	*NHS Sheffield CCG*
Bereavement post suicide	*To consider proposals to strengthen bereavement services following suicide*	*Director of Public Health, SCC*
Suicide Strategy	*The City's Suicide Strategy is due to be reviewed in 2020.*	*Director of Public Health, SCC*
Sheffield Health and Wellbeing Strategy	*To consider implementation and impact of the Sheffield Health and Wellbeing Strategy*	*Sheffield Health and Wellbeing Board*
ME	*To consider what is going on in Sheffield to support people with ME.*	*SCC/CCG*

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