Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 27 November 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, Lewis Dagnall, Mike Drabble, Jayne Dunn, Adam Hurst, Talib Hussain, 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
27 NOVEMBER 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 - 8)
To approve the minutes of the meeting of the Committee held on 16th October, 2019.

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

7. Sheffield Continuing Healthcare - Collaborative Service Development Update (Pages 9 - 38)
Report of Sara Storey, Interim Director of Adult Social Care, Sheffield City Council

8. Winter Planning (Pages 39 - 92)
Report of Sara Storey, Interim Director of Adult Social Care, Sheffield City Council.

9. CQC Local System Review Action Plan (Pages 93 - 106)

Report of Jane Ginniver, Deputy Director (Development), Accountable Care Partnership.

10. Work Programme (Pages 107 - 114)

Report of the Policy and Improvement Officer.

11. Date of Next Meeting
The next meeting of the Committee will be held on Wednesday, 15th January, 2020 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 16 October 2019

PRESENT: Councillors Cate McDonald (Chair), Steve Ayris (Deputy Chair), Sue Alston, Angela Argenzio, Lewis Dagnall, Mike Drabble, Jayne Dunn, Adam Hurst, Talib Hussain, Martin Phipps and Garry Weatherall

Non-Council Members (Healthwatch Sheffield):-

Lucy Davies

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Vic Bowden, Jackie Satur and Gail Smith.

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 In relation to Agenda Item 6 (Transformation and Integration), the following declarations were made:-

- Councillor Mike Drabble declared a personal interest by virtue of him providing mental health counselling services in non-urgent Primary Care and chose to remain in the meeting during consideration of the item

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

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 11th September, 2019, were approved as a correct record subject to the amendment in paragraph 7.1 (Update on the development of the Joint Dementia Strategy Commitments and the Commissioning Plan for Dementia) to read “The Committee received a report written by” instead of “The Committee received a report from”.

4.2 *Matters Arising*

4.2.1 The Policy and Improvement Officer confirmed that:-

(a) the follow-up documents, requested in paragraph (d) of the resolution in Item 6, has been circulated to Councillors; and

(b) the extra information regarding population figures has been circulated to Members of the Committee, as requested in paragraph (c) of the resolution in Item 7.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 There were no public questions or petitions.

6. TRANSFORMATION AND INTEGRATION

6.1 The Committee received a joint presentation and report of the Sheffield Accountable Care Partnership, Sheffield City Council and NHS Sheffield Clinical Commissioning Group (CCG), setting out the impact the Accountable Care Partnership, the Better Care Fund and the Joint Commissioning Committee was having on the health and social care transformation and integration in the City.

6.2 Present for this item were Anthony Gore, GP (Woodseats Medical Centre and Clinical Director, (Sheffield CCG), Brian Hughes (Director of Commissioning, Sheffield CCG), Sara Storey (Director of Adult Social Care, Sheffield City Council), Mark Tuckett (Director, Sheffield Accountable Care Partnership) and Councillor George Lindars-Hammond (Cabinet Member for Health and Social Care).

6.3 The report was supported by a presentation given by Mark Tuckett and Sara Storey, which put into context the Sheffield system, giving details of the health and social care staff and its partner organisations, service providers, commissioners, the NHS, the local authority and the voluntary sector. Mark Tuckett referred to the annual spend across health and social care and gave the percentages that were spent on treatment and on prevention. He said that integration was important to deliver better care for the people of Sheffield and help make spending go further. Sara Storey referred to the Home First Scheme which was being developed to help people return home from hospital sooner after an inpatient stay and offer continuing support.

6.4 Councillor George Lindars-Hammond, Cabinet Member for Health and Social Care, stated that he would like to see a system in the city that, utilising aids and adaptations, keeps people in their homes rather than being admitted into care or hospital and that there was a need to integrate the way services were commissioned with the focus being on keeping people well.

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

- Feedback from Home First Teams has shown social isolation to be a major

problem. The teams require time to build relationships with those who are isolated and whose needs are minimal as well as complex.

- It has been found that people in poverty tend to have the worst health outcomes and ultimately have shorter lives and there was a need to ensure that everyone has the best start in life to ensure that no-one is isolated.

- There is no simple answer and the Accountable Care Partnership was looking to invest more in the voluntary, community and faith sector, already investing £50,000 in this area. With a 97% spend on treatment and 3% on prevention, there was a need to encourage staff to focus on prevention.

- There is to be a Community Hub in each neighbourhood with a trial in the south-east of the city just getting off the ground and it was hoped that a lot could be learned from this. There is a trial "drop-in point" with social care staff taking place as it had been found that people preferred this rather than everything done formally and it was intended to roll out this across the city.

- Re-organisation has always been done at a national level, and the proposed structure of changing how things work locally, by linking services together in the future, will be better for the city. There was a need for flexibility in deciding what to change locally, with a strong commitment to place-based commissioning.

- Each organisation within the structure has its own governance arrangements and policies but the emphasis has to be on how the different teams understand each other and work together to identify and seek solutions to problems that arise. Sometimes cases are worked through several times before a solution is found. Although there are a large number of staff involved, as long as there was a single point of access, it doesn't matter who does what.

- The delivery of mental health transformation service has not been without challenge but by removing some of the bureaucracy, collaborative working can deliver benefits that working in isolation alone cannot.

- When facing frontline staff and key professionals, people were not interested in who works for who, so long as the care they required was available at a single point of access.

- Home First is a new service and was continuing to gather information, especially working alongside the Ambulance Service. When someone requests an ambulance, they don't always need one and Home First can pick up on these cases to free-up ambulances for more urgent needs.

- More work needs to be done on the accountability and transparency of some parts of the system. Differences in how the Council and NHS make decisions pose challenges for joint commissioning but progress has been made in terms of making decisions in public.

- The development of the Integrated Care System at South Yorkshire and Bassetlaw is not hindering local-place based ambitions. Activity happens at South Yorkshire and Bassetlaw level where appropriate, but underneath that there is freedom and flexibility to do what is right for Sheffield.

6.6 RESOLVED: That the Committee:-

(a) thanks Anthony Gore, Brian Hughes, Sara Storey, Mark Tuckett and Councillor George Lindars-Hammond for their contribution to the meeting;

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

(c) places on record that:-

- Progress was being made, and the Committee is keen to see this progress accelerated.

- The importance of transparency and accountability was a key theme.

- The Committee is in favour of a focus on prevention, but believes there needs to be more transparency around how a preventive approach is funded.

- The Committee recognises the importance of a place-based, bottom up approach to transformation and integration in localities, and has concerns about 'top down' approaches.

- The Committee likes the provision of qualitative information in reports, but quantitative indicators are needed as well – what does 'good' look like, and how are different groups across the city affected. Tackling health inequalities needs to be at the heart of this work.

7. WORK PROGRAMME

7.1 The Committee received a report of the Policy and Improvement Officer, attaching the Committee's draft Work Programme for 2019/20.

7.2 RESOLVED: That the Committee approves the contents of the draft Work Programme 2019/20.

8. DATE OF NEXT MEETING

8.1 It was noted that the next meeting of the Committee will be held on Wednesday, 27th November, 2019, at 4.00 p.m., in the Town Hall.

APPENDIX 1

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

Report of:

Sara Storey
(Interim Director of Adult Social Care, Sheffield CC)

Alun Windle
(Deputy Chief Nurse, NHS Sheffield CCG)

Subject:

Sheffield Continuing Healthcare - Collaborative Service Development Update

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Author of Report: Paul Higginbottom,
Senior Programme Manager Ongoing Care
Paul.higginbottom@nhs.net

Summary:
The Ongoing Care Programme is delivering collaborative change informed by people in receipt of care, their representatives and our workforces. The aim is to improve the service experience and outcomes across a range of services relating to continuing healthcare.

Having presented the service developments to the committee on the 20th March 2019, we have been asked to provide a further update on how the changes implemented are impacting on the service experience for people in receipt of care and their representatives.

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

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

The Scrutiny Committee is being asked to:
Review the developments and provide their views, comments, and recommendations.

_____

Papers submitted:

The below documents have been submitted to the Committee.

1. Front Cover Sheet
2. The 'slide deck' Continuing Healthcare Service Developments
3. Story of Difference – Embracing the practice principles of: Involvement, empowerment and collaboration.
4. Feedback on the service experience from the single contracted 'Care at Night' service which was launched on the 6th May 2019.

Category of Report: OPEN

Report of the Interim Director of Adult Social Care and the Deputy Chief Nurse of NHS Sheffield Clinical Commissioning Group

Sheffield Continuing Healthcare - Collaborative Service Development Update

1. Introduction/Context

1.1 The Ongoing Care Programme is delivering collaborative change to services, informed by people in receipt of care and their representatives, aimed at improving the service experience and outcomes across a range of services relating to continuing healthcare.

Having presented the service developments to the committee on the 20th March 2019, we have been asked to provide a further update on how the changes implemented are impacting on the service experience.

The information provided gives a summary of the developments completed in relation to Continuing Healthcare, complemented by the introduction of the joint commissioning of services, and communicates how the developments are having a positive impact on the service experience for people in receipt of care and their representatives.

2. Main body of report, matters for consideration, etc

2.1 The slides provide information on the actions we have taken and how this is benefitting people in receipt of services.

Some of the developments are in their infancy such as the 'How did we do Questionnaire?', which is subject to a controlled implementation to allow for close review and revision, with the aim of continuing to work closely with people in receipt of care and their representatives to help evidence the outcomes.

The Ongoing Care Programme is developing jointly commissioned services which are benefitting people in receipt of a range of services, some of which are related to Continuing Healthcare, including fully funded services and joint packages of care.

A key aim of the programme is to support the delivery of Continuing Healthcare assessment and care management services which are consistent, compliant with the national framework, and deliver a high quality and safe service experience.

2.2 Jointly commissioned services are delivering value for money.

3 What does this mean for the people of Sheffield?

3.1 Continuing Healthcare assessment and care management services are equitable in that they identify the presence of a 'primary health need' in a consistent manner, with processes developed collaboratively across health and social care.

3.2 The values and behaviours which were co-produced with people in receipt of care and their representatives set the standard for our workforces in the manner in which services are delivered.

3.2 Jointly commissioned services such as the Care at Night offer continuity of care, enabling people who experience a change to their eligibility to continue to receive services from the same care provider.

3.3 People in Sheffield have a 'strong voice' with the 'How did we do Questionnaires' capturing the service experience, encouraging people in receipt of care and their representatives to contribute to helping to inform future service development aimed at continual service improvement.

4. Recommendation

4.1 The Committee is asked to review the developments and provide their views, comments, and recommendations.

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Sheffield Continuing Healthcare
Collaborative service development update

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Dani Hydes: Head of Continuing Healthcare, Sheffield CCG
Sara Storey: Interim Director of Adult Social Care, Sheffield CC

27th November 2019

The actions we have taken	How this is benefitting people in receipt of services
Values and Behaviours Values and Behaviours for Ongoing Care Services Co-produced for the delivery of ongoing care services. We are in the process of incorporating the values and behaviours into a set of integrated 'Practice Principles' currently being launched across Adult Social Care.	A consistent approach to the way in which we work with people in receipt of care and their families; We always involve the person. We empower and support people to live the life they choose. We collaborate working as one team to deliver helpful, responsive and timely support.

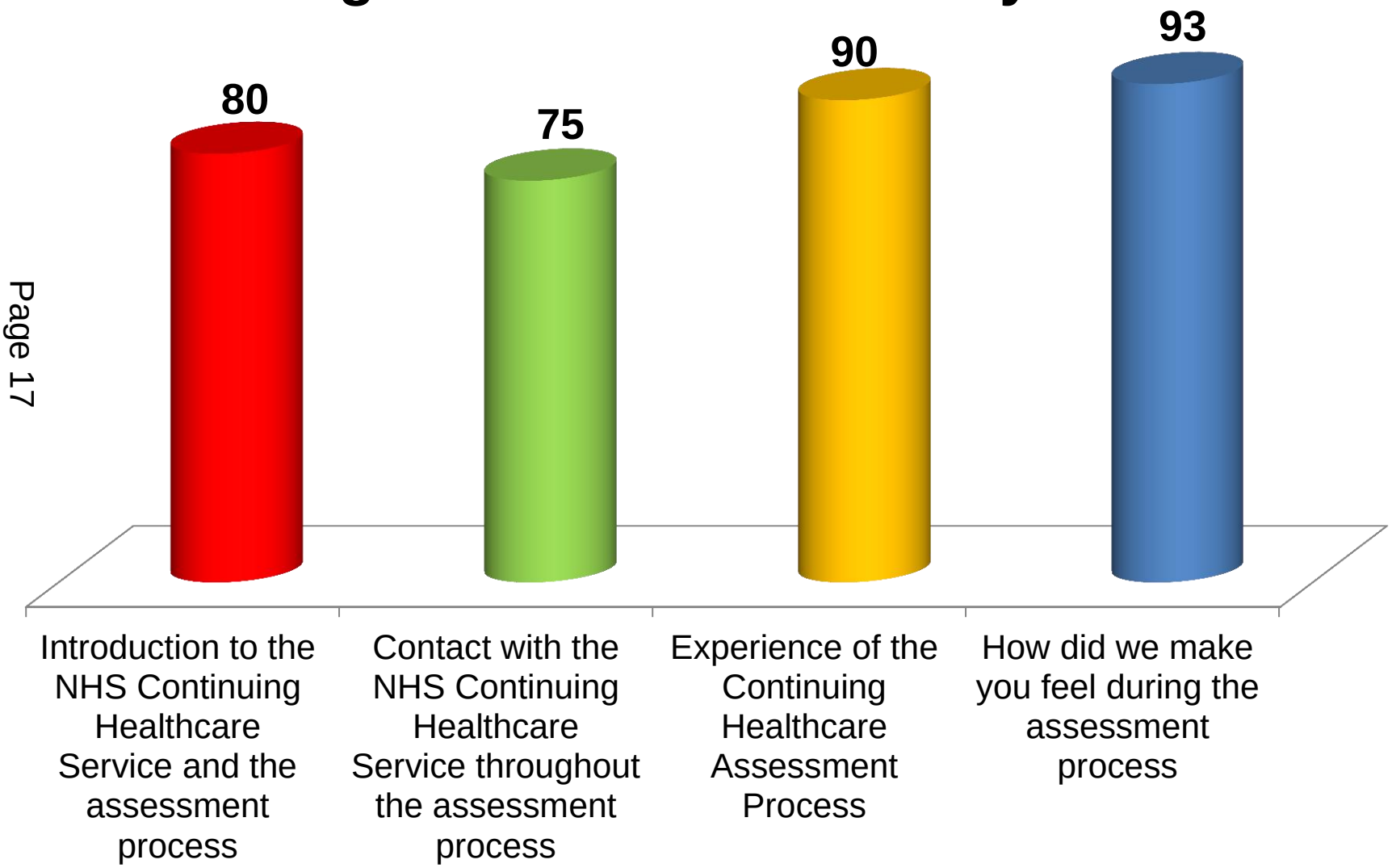
Sheffield City Council

NHS Sheffield Clinical Commissioning Group

The actions we have taken	How this is benefitting people in receipt of services
Continuing Healthcare Newsletter We have launched a Newsletter which is posted on our Continuing Healthcare Website with hard copies circulated to partners such as Healthwatch, Disability Sheffield and Citizens Advice Bureau.	CHC Newsletter April Edition The Newsletter is improving the way in which we communicate with people ensuring that we are more open and transparent.

The actions we have taken	How this is benefitting people in receipt of services
How did we do Questionnaire? We have launched the questionnaire supported by a controlled implementation initially to capture peoples experiences of how we introduce the service and complete the 'Decision Support Tool' assessment process.	 Microsoft Word Document People in receipt of services have the opportunity to share their service experiences with a 'strong voice,' which helps to inform continual service improvement at the same time as providing quality assurance. We will share a summary of the feedback received in our Newsletters to further improve communication.

How did we do Questionnaire?
Percentage satisfaction levels by Theme



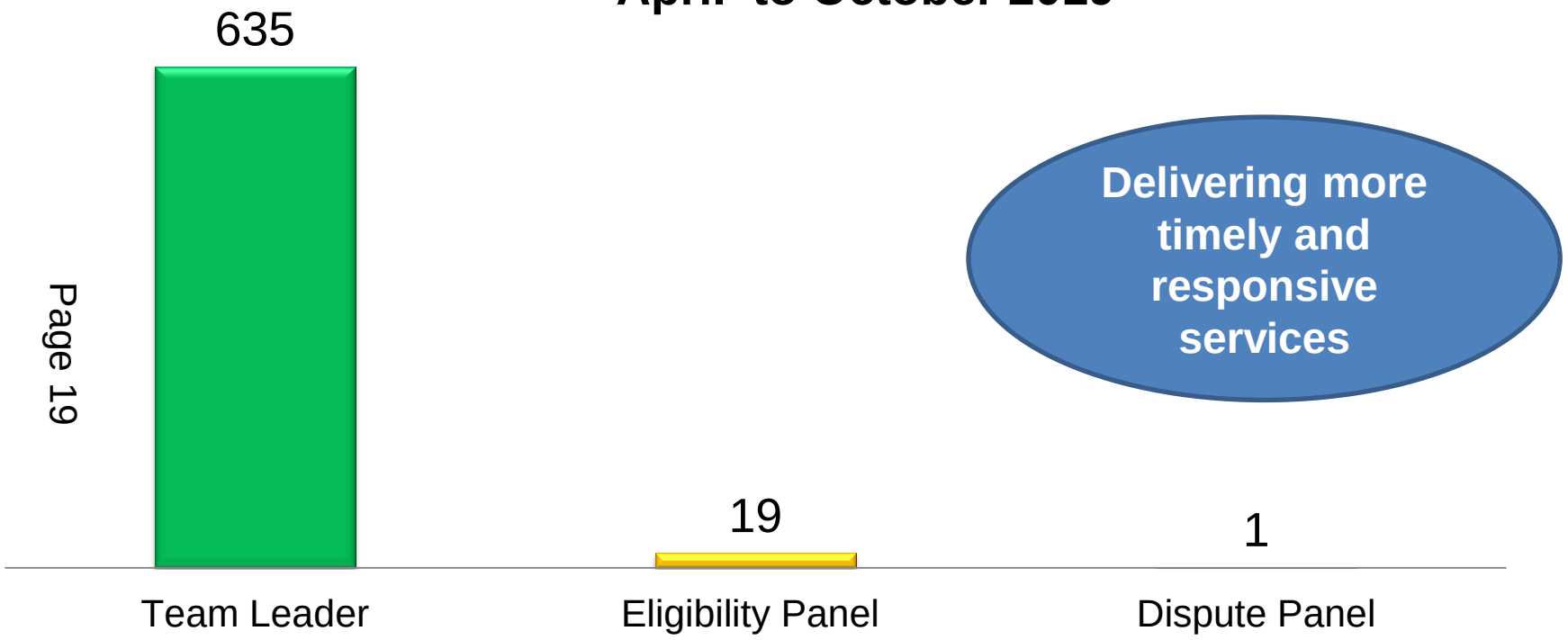
The actions we have taken	How this is benefitting people in receipt of services
Continuing Healthcare Operating Procedure CHC Operating Procedure We have collaboratively developed our new procedure which has been launched through a series of integrated awareness events aimed at our workforces.	Services are delivered in a consistent manner compliant with the national framework for Continuing Healthcare. A reduction in the number of cases sent to eligibility and dispute panels is resulting in more timely and responsive services. Social workers are attending more Decision Support Tool assessments which contributes to delivering better outcomes for people.

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

The majority of eligibility outcomes are now signed off by the CCGs Continuing Healthcare Team Leaders

655 Decision Support Tool Assessments signed off April to October 2019



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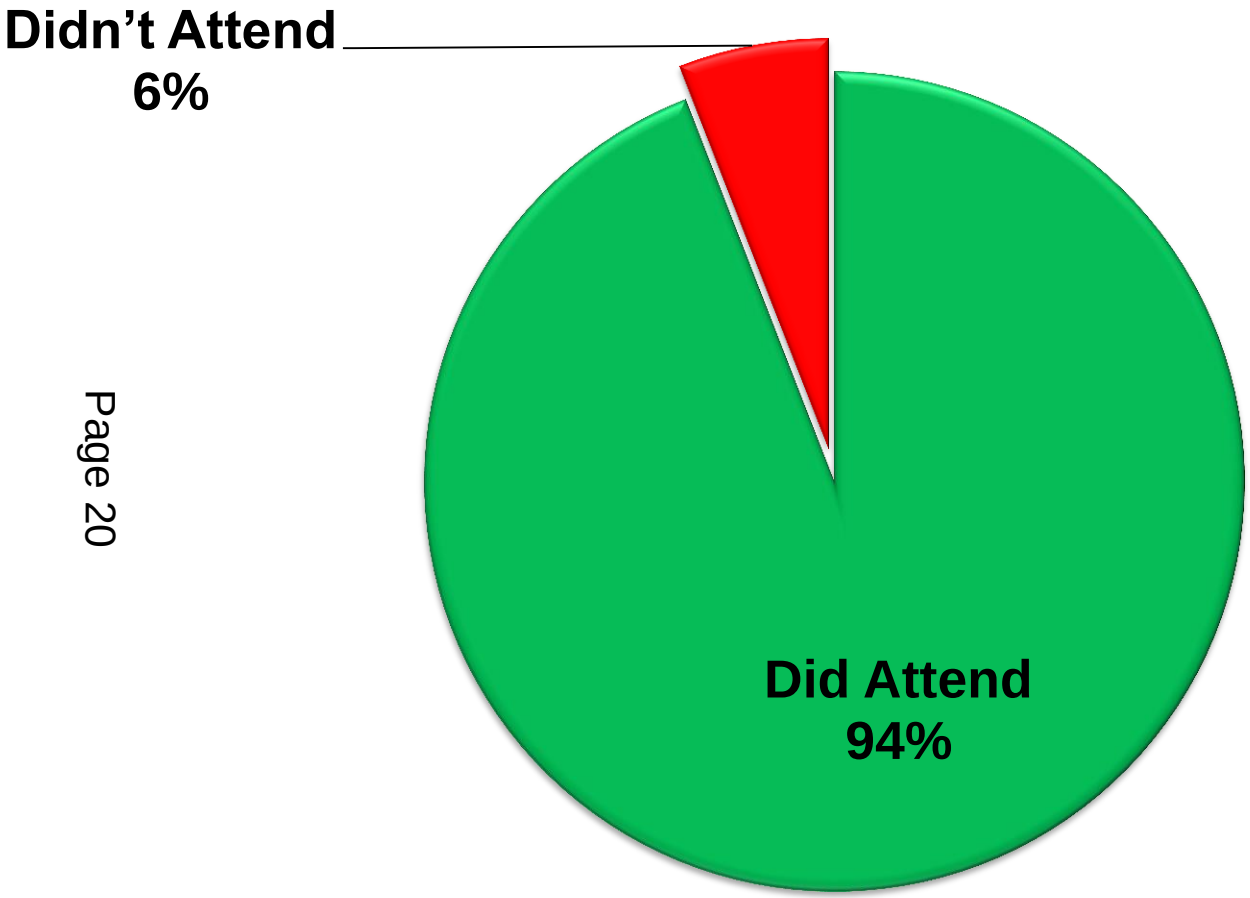
NHS Sheffield Clinical Commissioning Group

We are currently unable to provide year on year comparisons. The planned move to a new digital capability will enhance our reporting.

Decision Support Tool Assessments attended by Social Workers April - October 2019



Greater collaboration will deliver improved service quality and better outcomes for people in receipt of care

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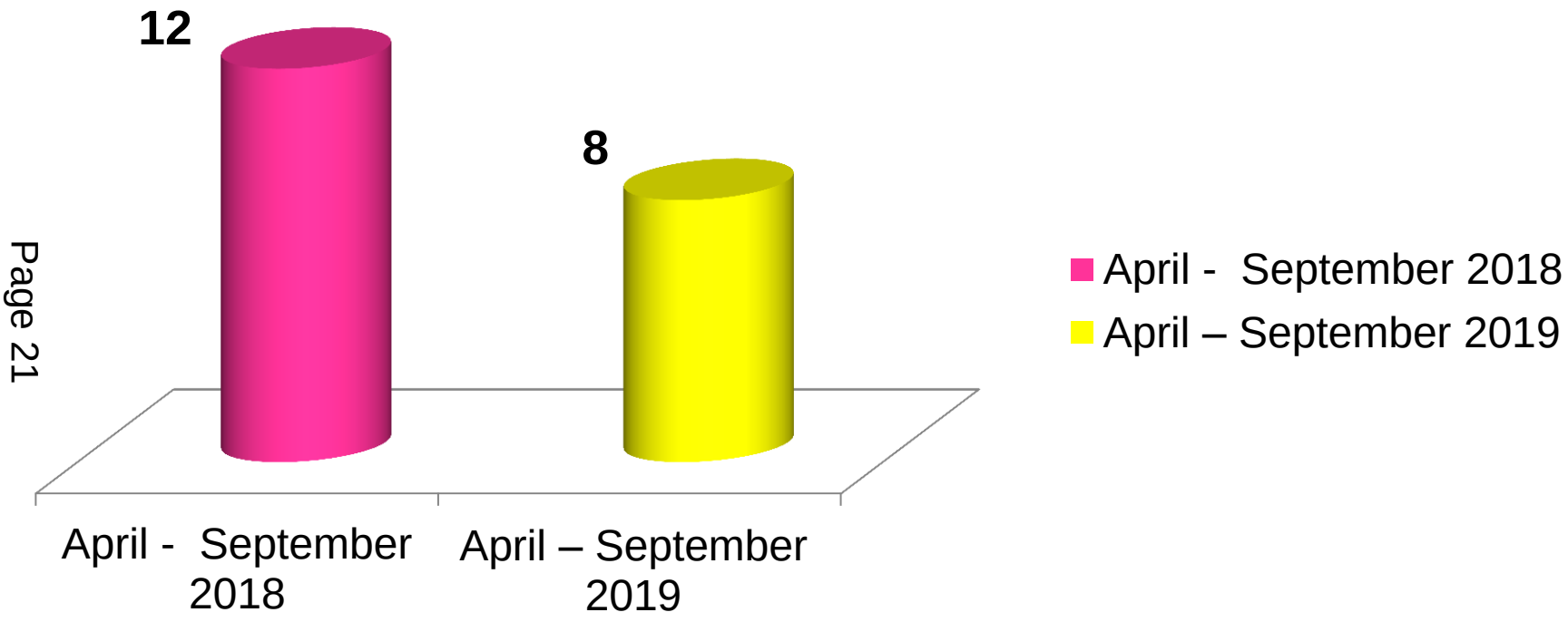
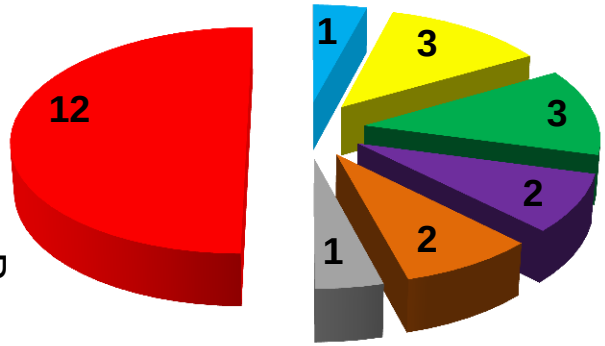
NHS Sheffield Clinical Commissioning Group

We are currently unable to provide year on year comparisons. The proposed move to a new CHC digital platform will enhance our reporting capability

The number of complaints relating to Continuing Healthcare has reduced

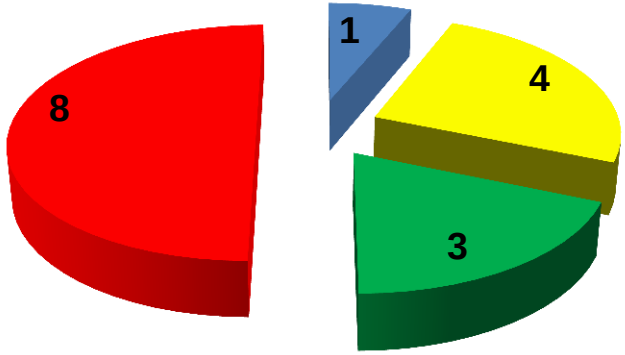


Complaint Themes



- Attitude & Behaviour
- Assessment
- Communication
- Funding
- Clinical Treatment
- Care Package
- Total

April to September 2018



- Attitude & Behaviour
- Assessment
- Communication
- Total

April to September 2019

Nil returns Funding/Clinical Treatment/Care Package

Independent Appeals Management

- Having listened to feedback from people in receipt of care and their representatives we have transferred the responsibility for managing Appeals to NHS Doncaster CCG, to ensure that the process is independent.

- The new appeals arrangements came into effect from the 1st September 2019

Sheffield - Continuing Healthcare Appeal Outcomes

74% (30) of appeals concluded between April – September 2018 had the original decision upheld at a local level

91% (22) of appeals concluded between April – September 2019 had the original decision upheld at a local level

91% (14) of NHS England Independent Reviews January to September 2019 were deemed as sound

The actions we have taken	How this is benefitting people in receipt of services
Continuing Healthcare Disputes Resolution Policy We have collaboratively developed our new disputes resolution policy which has been launched through a series of integrated awareness events aimed at our workforces.	CHC Disputes Resolution Policy When disputes occur they are resolved consistently and expediently between organisations without having a detrimental impact on people in receipt of services.

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The actions we have taken	How this is benefitting people in receipt of services
Monthly Continuing Healthcare integrated Benchmarking and Learning Events Reviewing collaboratively how we deliver services in line with the framework and practice principles: Considering the role of the multi-disciplinary team and the role played by the person and family. How we record the needs against the domains.	Developing a joint understanding of roles and responsibilities is supporting the delivery of a more consistent higher quality service experience. People will benefit from services delivered in a manner that reflects our new practice principles.

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NHS Sheffield Clinical Commissioning Group

The actions we have taken	How this will benefit people in receipt of services
CHC Digital Discovery work completed to build and agree the case for change. Investigated options including health and social care systems. Stakeholder benefits analysis complete. Successful application to be one of 7 NHSE CHC Digital Pioneers.	A more consistent approach to process and working practices will improve the quality and service experience for all. A more timely responsive and communicative service will improve quality/experience. Greater transparency and accountability of the services delivered supported by auditable care records which evidence decision making.

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NHS Sheffield Clinical Commissioning Group

The actions we have taken	How this is benefitting people in receipt of services
Joint Commissioning Single contracted Care at Night Service Single contracted Somewhere else to Assess Quadrant	People in receipt of care receive person centred seamless services and as a result do not have to move care provider when their eligibility changes. Improved value for money. The right care is provided at the right time in the right place delivered by a 'Team around the person' model of care.

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NHS Sheffield Clinical Commissioning Group

Ongoing service improvement

- **A more collaborative approach across the community**
  Supported by an increasing ambition to integrate health and social care services to improve working arrangements, which place the individual at the centre of the care. Developments will continue to be informed through strong engagement with people in receipt of care and our workforces.

- **Joint Workforce Development Plan**
  Integrated approach to workforce development to deliver a consistent high quality service experience.

- **Care provision**
  Working in close partnership with care providers to ensure we have high quality services which meet the needs of our citizens

Sheffield City Council

NHS Sheffield Clinical Commissioning Group

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Story of difference - Case Background

Workers embracing the new Practice Principles collaboratively developed between Sheffield City Council and the CCG

Andrew

- Moved from Sheffield to live in Scotland
- Has a joint package of care between health and social care
- Has complex autism and support needs
- Family relocated to be near him in Scotland
- Received a Fee uplift in line with Scotland
- Had a disproportional funding split between Sheffield City Council and the CCGs Continuing Healthcare Service

Story of difference - Case Background

Involve

- Andrew took part and was involved in the meeting
- A joint review and DST assessment was planned around the families availability
- Andrew was encouraged to give his feedback in his own way
- Acknowledged Andrew is at the centre of the information we both needed
- Honest and open discussion with provider about fee uplift held separately
- 3 conversation model focuses on the individual and what makes a good life and links to information within the DST – seamless between health and Social Care

Story of difference - Case Background

Empathy

- Family anxiety about repatriation back to Sheffield

- Health and Social Care acknowledged Andrews personal development and the progress he had made. We both gave reassurances it would not affect his living arrangements if funding changed

- Listened to provider and rationale for requesting uplift

Story of difference - Case Background

Collaborative

- Seamless approach to eligibility and care package review for Andrew and his family.

- Discussion with providers to ensure the correct package was in place and funding was correct.

- Working together with commissioning colleagues on our return to Sheffield to ensure the paperwork was completed in a timely manner and all parties were kept up to date.

Care at Night

Feedback from people in receipt of care captured from 6 weekly Telephone Surveys

November 2019

Question One

Are all the agreed tasks being completed while the care and support workers are with you at each visit?

100% of responders confirmed that the agreed tasks were being completed.

Comments:

- ❑ Yes, they complete all the tasks that I want them to during each visit
- ❑ Yes, if there are any problems I will tell them
- ❑ Yes, they do everything I need

Question Two

Are there any changes to the tasks required, and do you feel the staff have enough time?

100% of responders confirmed that they did not require any changes to the tasks, and felt that the staff had enough time.

Comments:

- No, they manage to do the tasks in the time allocated
- No, they are all good staff

Question Three

Do you have a regular care team, if so are you happy with them?

100% of responders confirmed that they had a regular care team that they were happy with.

Comments:

- ❑ Yes, I am happy with them
- ❑ Yes, they are regular and friendly
- ❑ Yes, they are smashing.

Sheffield Children's NHS Foundation Trust
Sheffield Clinical Commissioning Group
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

Overview and Scrutiny Panel

Winter Planning

27th November 2019

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Sponsor	**Sara Storey - Interim Director of Adult Social Care Sheffield City Council.**

1. Purpose

To provide assurance regarding the development of Sheffield's winter plan by detailing governance structures and citywide partnership working along with a summary of key developments with regard to patient flow in order that Delayed Transfers of Care (DTOC) do not increase and become a significant issue as in previous winters.

2. Introduction / Background

Providers and Commissioners across the Sheffield health and social care system develop individual winter plans on an annual basis. Sheffield's Clinical Commissioning Group coordinates the development of an overarching plan for the city. The overarching plan (attached) is formally signed off on behalf of the health and social care system by the Urgent and Emergency Care Transformation Delivery Board.

3. Is your report for Approval / Consideration / Noting

Noting.

4. Recommendations / Action Required by the Overview and Scrutiny Committee

The OSC is asked to note the attached winter plan with its supporting governance structures and the addition actions in place to support and sustain patient flow and discharge over the winter period.

Overview and Scrutiny Panel

Winter Planning

27th November 2019

1. Purpose

The purpose of this paper is to provide assurance regarding the development of Sheffield's winter plan by detailing governance structures and citywide partnership working. In addition, the paper will summarise key developments with regard to patient flow in order that Delayed Transfers of Care (DTOC) do not increase and become a significant issue as in previous winters.

2. Introduction

Providers and Commissioners across the Sheffield health and social care system develop individual winter plans on an annual basis. Sheffield's Clinical Commissioning Group coordinates the development of an overarching plan for the city. The overarching plan is formally signed off on behalf of the health and social care system by the Urgent and Emergency Care Transformation Delivery Board (see below).

The overarching plan (see appendix 1) builds on individual partner's plans and lessons learned from previous winters (with actions to address). It ensures timely additional focus and support from city wide partners at times of increased demand and system pressure by additional ongoing improvements and developments over the year to support system resilience, system wide communication over the period, capacity planning, risk management, and escalation processes (along with system leads).

3. Governance

Governance is provided through the Urgent and Emergency Care Transformation Delivery Board (UECTDB). The board is chaired by the Chief Executive of Sheffield Teaching Hospitals with senior representation from health and social care partners from across the Sheffield system.

The board is supported by two formal sub-groups providing additional operational focus and opportunity for joint working. These provide scrutiny of, and support to, partners across the local system especially at times of high demand and pressure.

The first of the sub-groups Why Not Home Why Not Today board, supported by system executive directors focusses on ensuring timely discharge of patients. This group enables timely and formal discussions between partners in order to ensure continuation of patient flow, especially at times of high demand and by doing so avoiding high local levels of Delayed Transfers of Care seen in previous years. The executive sponsors, have oversight of programmes that ensure the transfer of care for all patients is effectively managed. Currently this is effectively managed through a daily Multi disciplinary TASK meeting, weekly Delay Tranfers of Care weekly report, that is discussed in a weekly Flow meeting attended by all partners, and weekly director level call, with escalation to CEO's if needed.

The second sub-group the Operational Resilience Group (ORG) focusses throughout the year on supporting performance with regard to the timely flow of patients potentially requiring acute care both through traditional care pathways accessed via Accident and Emergency departments and by ambulance. In addition, the group focusses on the development and consistent use of appropriate alternative care pathways and direct admission into hospital specialties to ensure patients receive the right care at the right

time, reducing pressure on key elements of local urgent care pathways and services such as the emergency department at the Northern General Hospital.

During the winter period the ORG's primary focus is to provide a forum for operational discussions of emerging pressures across the whole patient pathway (including patient flow and discharge) between system wide partners and the agreement of mitigating operational actions with escalation to the UECTDB as appropriate.

In addition to the formal structures outlined above the developing relationships and trust between peers across the health and social care system ensure timely additional support at times of system pressure.

4. Delayed Transfers of Care

Delayed Transfers of Care have been historically been a challenge for the Sheffield System particularly during the winter period. However, there have been notable improvements which have built on successful partnership working and development of relationships over a number of years. Key developments and actions to support resilience over the winter are detailed below.

Throughout the winter period governance and scrutiny will continue to be provided by the Executive Directors, WNHWNT board, ORG and UECTDB (detailed above). The additional winter pressure funding provided to Sheffield City Council is allowing for resilience and sustainability to be built into services and ensure that seasonal capacity added during 2018/19 can be maintained and effectively utilised flexibly as required.

The system has identified that additional secondary care capacity is not a solution and that investment needs to be embedded within the prevention services before urgent care services are required. Allocations have included increasing capacity within the Community Equipment and Adaptation Team to ensure people are safe and independent within their own homes and assessed in a timely manner to avoid transfer. Additional social workers, allied health professionals and prevention workers have been recruited to ensure active admission avoidance is in place. Last year Sheffield CCG invested additional funding in the Voluntary and community sector to strengthen the range of alternative provision available to people upon discharge and to prevent admission. During this year these schemes have been evaluated along with existing schemes with recommendations going forward for continuing these services in future years. The voluntary sector have embraced the opportunity and established strong relationships with the Acute provider and SCC Homefirst provision to provide a range of support to ensure individuals are supported.

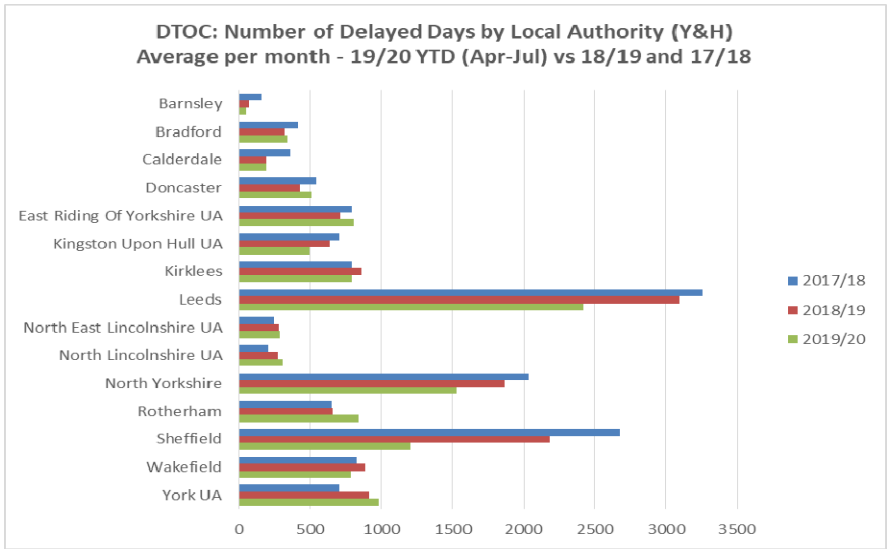
Where admissions are unavoidable the Community Equipment and Adaptation Team's additional capacity will be used to enable pace of discharge and ensure that facilities meet the needs of the patients on return to home. The Hospital to Home team has been enhanced and integrated with the Trusted Assessor Scheme to ensure people can return to their usual place of residence as quickly as possible if admitted from a care home.

During winter of 2018 the system supported the commissioning of step down beds to support flow for patients not requiring long term residential care but unable to return home immediately. This resource has been integrated for 2019 with the At Risk of Admission Front Door Response Team and GP Collaboration to prevent readmissions wherever possible. During 2019, this will continue with funding for the beds agreed outside of the Better Care Fund, however the social care support to assess individuals in the beds will be funded through funding provided by the Secretary of State for Health.

5. Recommendations

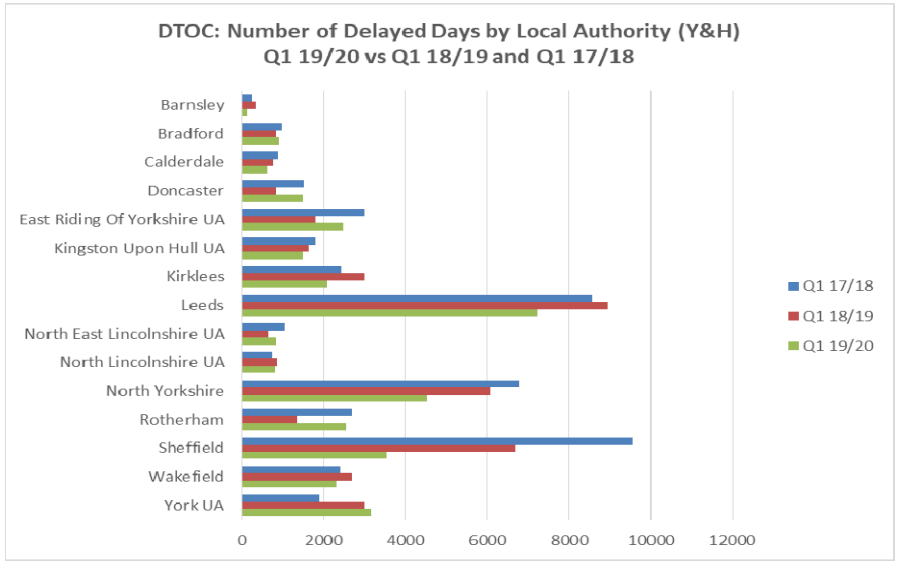
The OSC is asked to note the attached winter plan with its supporting governance structures and the addition actions in place to support and sustain patient flow and discharge over the winter period.

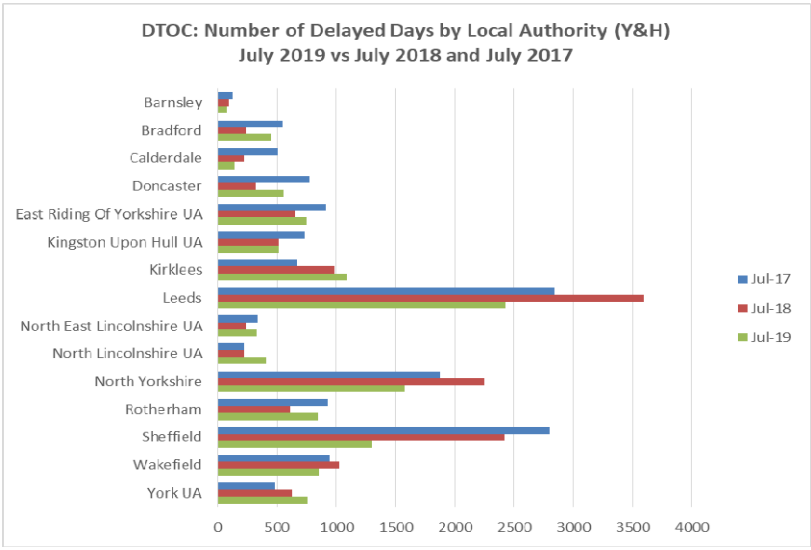
COMPARED TO OUR REGION



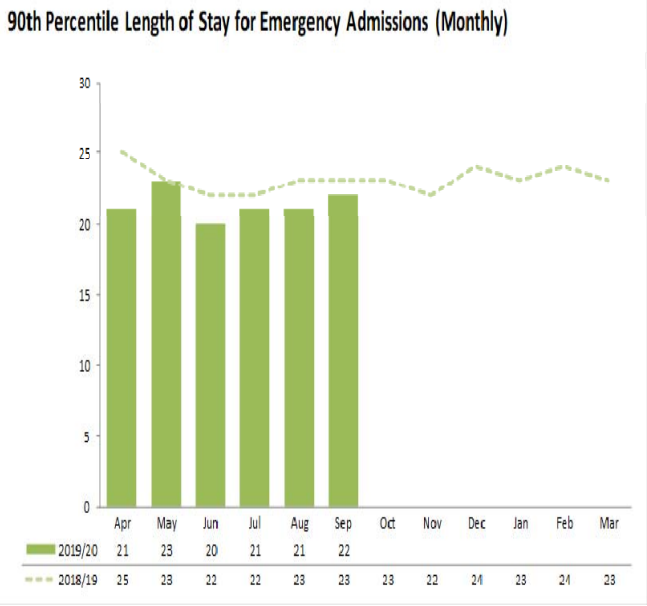
Sheffield's improved DTOC position between 2017/18, 2018/19 and to date for 2019/20 compared to other regional Local Authorities.

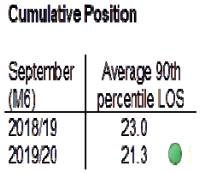
Comparisons made over a year, a quarter and a month.

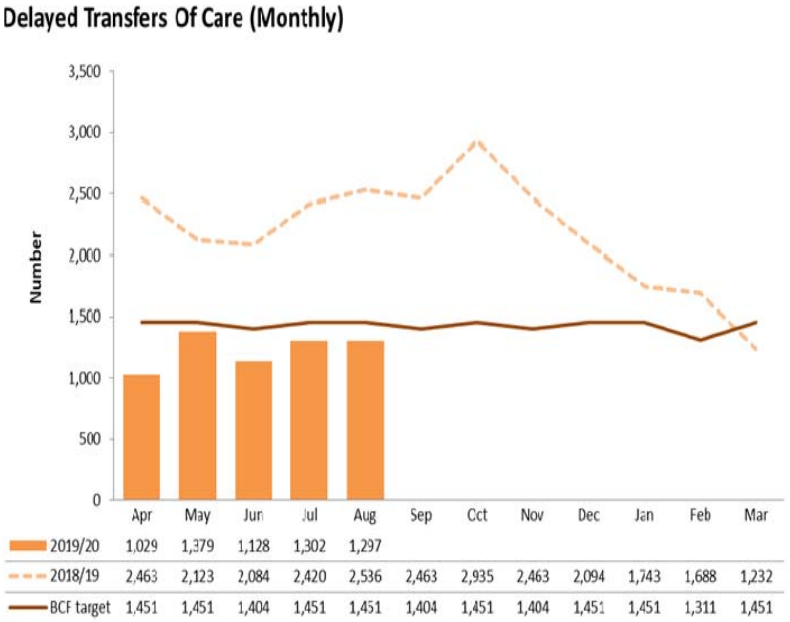




IMPROVEMENTS MADE IN SHFFIELD







Length of Stay (LOS) for Emergency Admissions (Over 65s)

In 2019/20 (April to July 2019) the average length of stay was 21 days, compared with an average of 23 days for the same period in 2018/19.

Delayed transfers of Care

In 2019/20 to date (April to July 2019) total delayed days were 4,838, compared with 9,090 days for the same period in 2018/19. This represents a 46% improvement over the same period in 2018/19.

Sheffield Urgent and Emergency Care Transformational Delivery Board

Winter Plan 2019/20

September 2019

Contents

1. Introduction

This Sheffield system plan sets out local governance arrangements supporting system resilience over the coming winter and contains the following elements:

- Lessons learned with actions and progress in the current year
- Additional key programmes supporting A&E performance, patient flow, length of stay reduction and support for care homes
- Flu
- System wide communications over winter
- Surge planning
- Managing Risk
- Escalation process - including triggers and actions (individual and system)
- Daily Roles & Responsibilities Over Peak Holiday Period
- Key contacts over the winter period

2. System Governance

Overarching system governance will be provided through the Urgent and Emergency Care Transformation and Delivery Board (UECTDB). The board is chaired by the Chief Executive of Sheffield Teaching Hospitals and has senior representation from health and social care partners from across the Sheffield system.

The board will be supported by two sub-groups providing additional operational focus and scrutiny. The Why Not Home, Why Not Today (WNHWNT) board will continue to focus on ensuring timely discharge of patients in the same way as last winter and the recently formed Operational Resilience Group (ORG) providing additional scrutiny and support to front end performance (see lessons learned below).

With regard to supporting day to day operations, the Sheffield FLOW group (attended by operational leads from health and social care partners) will continue to meet on a weekly basis ensuring that any emerging issues are resolved. In addition, the FLOW Overflow Group (FOG) has undertaken an operational review of the last eight months with the findings informing winter planning. Further support will be provided by ECIST and this will focus on reducing length of stay and optimising ward processes.

In addition the System Wide Transport Group (attended by operational leads from health and transport providers along with facilitation by the CCG) will meet as

required over the winter period to ensure any issues surrounding patient transport are addressed in a timely manner. Both groups will escalate any issue as appropriate to ORG, WNHWNT and UECTDB

With regard to UK EXIT system partners and EPRR leads will escalate any emerging issues to ORG, WNHWNT and UECTDB as appropriate (see appendices for individual provider plans).

3.1 Lessons Learned from Winter 2018/19, Actions & Progress

What Worked Well	Actions and Progress
Action cards with system wide responses agreed in advance of escalation enabled a timely and more co-ordinated response at times of pressure.	Cards have been reviewed by all system partners to ensure they reflect all key actions (both internal and supporting partners). (See section 3.5)
All urgent care providers sharing detailed forecasting demand and available capacity over the Christmas period enabled a shared understanding of key pressure points across the system.	Detailed demand and capacity forecasts have been developed for an extended period to cover December and January. (See section 3.5) Forecasting will be reviewed and updated on a regular basis as winter approaches, this will also include wider system pressure and capacity planning, which will support with identifying pinch points and where uplifts in capacity and additional mitigating actions may be required.
Single contact sheet for named leads across all system partners (both in and out of hours) over the holiday period supported more timely access to partners at times of pressure (particularly during the holiday period when colleagues were covering for A/L).	This winter the system contact sheet will cover an extended period (mid-December to mid-January). (See section 4.4)

What Could Have Worked Better	Actions and Progress
Better system integration – particularly routine usage of community pathways and alternatives to ED.	A gap analysis of the local directory of services has been undertaken which has identified a number of areas for development. Following this the Emergency Care Practitioner service has now been included. In addition, significant developments have taken place with regard to Social Care (Home First), Mental Health and Learning Disabilities services and these will be reflected in the local DOS in time for winter. Direct booking: • Profiles of urgent primary care out of hours services have been ranked enabling maximum usage of hub capacity. • The 111 service can now book into the Walk in Centre (254 bookings in June) with the potential to expand further. A standard operating procedure has been agreed enabling YAS crews to directly refer to community pathways (routinely and consistently) via SPA (health) in order to avoid conveyance and support patients to remain in their own homes. Emergency Care Practitioners: • A new contract agreed with 25% of capacity now formally supporting care homes to avoid admissions and support core YAS crews to link in with SPA and community pathways and alternatives to ED. • Direct links have been established between ECPs and Home First service (ECPs can now refer patients for social support). • ECPs are now able to refer into Care Home medication optimisation team in order to

	support patients to remain the community. Minor injuries Unit: • The most recent urgent care review highlighted a number of communities who were not aware of the Minor Injuries Unit. As part of our new Urgent Care improvement programme, and in particular improving knowledge and information, we will be undertaking targeted outreach engagement to help improve access to information about what services are available. This will be in two parts – as part of our winter communications plan but also looking to see what else we can do over a longer time period to ensure that the public feel confident in knowing what services including MIU are available. Out Of Hours Pharmacy: • The Wicker Pharmacy is an established, well-known late night & extended hour's pharmacy that dispenses both NHS and private prescriptions. At least one pharmacist is always on duty during opening hours to supervise the dispensing of prescriptions and to offer help and advice when required. The pharmacy carries a wide range of medicines in stock. Community nursing teams have been trained to verify deaths (expected) leading to significant reduction of workload of ECPs and GPs (both in and out of hours) enabling release of capacity to provide urgent care and support admission avoidance.
Pre-agreed protocols for requesting/accepting diverts of patients (specialty level and ED) and repatriation of patients from/to neighbouring acutes would have enabled	The potential to develop protocols across SYB agreeing the operational pre-requisites for divert and a repatriation request is being explored.

more transparent and consistent working across SYB at times of high demand and pressure.	
Clearer system understanding of key cohorts of patients where greater system integration could reduce conveyance to hospital.	Audits have been undertaken by YAS and the STH's Front Door Response Team which provide clear evidence to inform focus of current and future programmes of work supporting system redesign/transformation and resilience.
During winter STH was required to decant six inpatient wards due to a fire prohibition notice being issued. This provided a significant operational challenge with a number of services operating out of a reconfigured bed base in a period of the year which already presents increased operational challenges. This required the development of a revised winter plan to decant all six wards, (housing 168 inpatient beds). As a result all baseward beds were re-provided alongside an additional 28 offsite community beds for patient awaiting other non-acute services and in turn to support better acute flow.	In response to the reduced bed capacity with the Trust new patient flow models were put in place enabling patients to be supported in a community rather than acute setting.
Inter Facility Transfers (IFTs)	Historically IFTs have been a significant issue in Sheffield due to local operation of hot and cold sites. In order to mitigate issues with IFTs the Sheffield system is undertaking an analysis of historical demand. In addition, this year, forecasting is linking into the YAS hour by hour demand tool to map key points of significance and highlight the need for additional transport within pressured days rather

	than in the past simply identifying 24 hour periods of increased demand.
Enabling patient transport services access to bus lanes enabled more efficient use of transport particularly over the peak period.	The approach has been reviewed (no significant issues highlighted) and will be in place over the coming winter period.

3.2 Ongoing Improvements to Systems Resilience

Additional programmes are in place across the Sheffield system delivering service improvement and transformation. A number of key programmes are focussing on ensuring additional support in the community and pre-hospital pathways in order to reduce avoidable admissions, improve A&E performance (ambulance handover and 4 hour target) and patient flow and also ensure timely discharge.

It is anticipated that these work streams will complement the additional actions highlighted above to support individual partner and system resilience over the winter period.

As a system we recognise the importance of supporting our Accident and Emergency department with efficient and effective unscheduled care being developed in a local area by working across primary and secondary care to respond to the needs of patients and carers. Supporting systems include the utilisation of six Primary Care Extended Access Hubs; direct booking in to the Walk in Centre and our A&E GP Streaming which supports the wider CCG strategy around Urgent Care in Primary Care with aim to ensure that wherever possible, practical and appropriate patients requiring urgent primary care receive this in a non-acute setting.

With every patient being able to access timely high-quality unscheduled care services that are safe, effective and caring, that promote good health and wellbeing and that reduce the impact of illness on the patient and carers.

A summary of the key programmes of work are as follows:

3.2.1 Delivery of the national standards for ambulance handover and four hour system performance

Given the current challenges around consistent and sustainable delivery of the national standards for ambulance handover and four hour system performance, the system has focussed on system integration (particularly with regard to adult patients) and the local opportunities to increase usage of alternatives to acute care.

An over view of the system plan can be found in the following document:

4 Hour System Improvement Plan 12

The main achievement to date has been the development of a Standard Operating Procedure agreed enabling ambulance crews to refer directly to community pathways. See below:

SSPA SOP Version 2.docx

Further work to improve ambulance handovers, ensure the DOS is accurate and complete for key conditions, ensure effective and routine use of community pathways and where appropriate direct conveyance of patients to acute specialities is ongoing. This supports the ED and flow based work streams as part of the overarching system plan to improve four hour performance.

The Urgent Care workstreams for 2019/20 will review direct conveyance opportunities, ensuring appropriate pathways are in place and that these are streamlined and routinely used.

There are four key areas are:

- End of Life
- ENT
- Mental Health
- Urology

This work will positively impact on ambulance handover by reducing volumes and improving process.

The SPA/YAS SOP will be live for winter; paramedics will have the ability to refer directly into SPA for community health and social care pathways.

See Front Door Plan and System Overview plans below:

Front Door Plan (UECTDB) 21.08.19.p

UECTDB_System Improvement Plan Ov

3.2.2 Extended access to primary care (including direct booking from 111)

The Sheffield system has established fifteen Primary Care Networks supporting greater collaboration across practices. With regard to providing directly bookable appointments into urgent primary care providers out of hours significant numbers of appointments are currently offered across the city by four community hubs and the GP out of hours service (along with two additional hubs delivering extended access). These appointments for urgent primary care are directly accessible by the 111 service with the option to increase capacity at times of high patient demand and system pressure.

In addition, the walk in centre is also now able to accept referrals from the 111 service (both in and out of hours) and also has the potential to increase capacity over winter to support periods of system pressure.

Finally, in line with the new GP contract all practices across the city are beginning the process of enabling direct access booking from the 111 service during core hours. In terms of timescales whilst the national deadline for completion is the end of the financial year the local system is aiming to start the process of implementation from the middle of August. In order to support system resilience it has been agreed that practices surrounding the Northern General Hospital will be prioritised (data shows that this area of city is a disproportionately high user of ED services and also an area of high deprivation).

3.2.3 Support to care homes

With regard to care homes there is a comprehensive programme of work in place implementing a range of initiatives with key areas of focus supporting the care home workforce and avoiding hospital admissions.

Examples of key areas of development:

- NHS mail for care homes is currently being rolled out across the city (currently 75% of homes now live). This will provide secure communication to support safe and proactive discharge from acute care.
- Project ECHO (supporting end of life care) is in place across the city's nursing homes and from September will also extend into residential and domiciliary care.
- The care homes capacity tracker continues to be utilised and work is taking place to raise its profile to support acute sector discharges.
- A clinical educator post will be in place over the coming winter supporting care home staff to recognise deterioration in patients earlier

in order that additional clinical input can be provided in a more timely manner (as so avoid potential admission to hospital).

Details of the above schemes and the wider work being undertaken can be seen in the care homes programme plan below:


care homes transformation updat

3.2.4 Implementation of Same Day Emergency Care (including frailty pathways)

With regard to supporting resilience in adult care STH is working towards a more robust medical workforce model across the summer ahead of a move to Single Assessment and SDEC implementation ahead of winter. STH are developing the ambulatory care model and pathways which include Same Day Emergency Care (SDEC). The STH SDEC pilot ran for one month between June - July 2019 and early findings show that clinicians within the trust were able to discharge 82% more patients home on the same day. The final report once completed will be shared with key stakeholders along with supporting implementation plans.

(See STH winter and Action 95 Plan for more details).

3.2.5 Long length of stay reduction, discharge planning and roll-out of SAFER bundles

With regard to supporting timely discharge of patients the following key developments have been implemented in adult care:

- Board rounds have been established on the 16 wards experiencing the highest levels of delayed transfers of care along with standardised approaches within geriatric stroke medicine and the remaining 10 elements of SAFER flow to support earlier in the day discharge.
- Following a joint procurement a new model (Somewhere Else to Assess) supporting discharge in the community has been put in place.
- Given the risks associated with staffing surge beds, the Trust is reviewing options to maintain the 28 Offsite Community Beds as in winter 2018/19. Discussions are ongoing with the system regarding funding.
- The recently implemented seasonal commissioning model for intermediate care beds is designed to provide additional capacity to cater for increased demand over winter. In the event of high-levels of intermediate care bed occupancy and corresponding high-volumes of delayed transfers of care, support will be sought for the allocation of funding to support the purchase of

additional intermediate care bed capacity to facilitate increased discharge volumes and reduce the number of medically fit patients in acute beds.

- 21 LoS reviews are being led by the lead nurse for clinical operations. The trends themes and lessons learnt will be reported monthly and shared with the wider system at the flow working group.
- The WNHWNT transformation programme continues to impact on care home sector capacity and further supporting integration which is leading to improving decision making and day to day responsiveness.
- For additional actions supporting delayed transfers of care see OPEL action cards.

(See STH winter plan for more details).

3.2.6 Divert and repatriation arrangements between local places across SYB

In Sheffield and across SYB at times of system pressure repatriations can be a significant issues and impact on patient flow. However recognising these issues links local systems.

The potential to develop SYB wide protocols for divert (A&E and specialty) and also repatriation is currently being explored with the aim of agreeing a range of operational pre-requisites and escalation actions before diverts are requested or repatriations potentially delayed.

(Note policies will be included when agreed across SYB.)

3.2.7 Developments within mental health, learning disabilities and autism

- There is a ‘core 24’ mental health liaison service (in line with the national definition) that is able to gate-keep individuals into a Psychiatric Decision Unit (PDU). The PDU is a new service that went live in July 2019, and is able to provide care, support and treatment to individuals who require urgent mental health care. It is based on the Northern General Hospital site.
- The Integrated IAPT service has now been fully implemented, and based on our forecast we should see a reduction in 551 non-elective admissions and 1,413 ED attendances during 2019/20. This service involves the delivery of psychological therapy interventions alongside physical health care, across 10 individual pathways of care.
- The CCG’s Mental Health Integrated Commissioning team are in the process of designing and implementing a revised and extended crisis resolution and home treatment offer (in line with the NHS Long Term Plan) for both adults (including older adults) and children and young people. Both developments

will be complete during 2019/20, and new services will therefore be in place, as a minimum, during the winter period (although ideally before).

- There will be an extended offer for those women in need of perinatal mental health care and support. This will be in place before the winter period and will therefore positively impact on the number of new mothers who require crisis and emergency health care.

- The CCG's Mental Health Integrated Commissioning team are at the very early stages of implementing a new model of community mental health care, which will in the first instance (i.e. during 2019/20) be aligned to 4 primary care networks. Although not yet validated, the working hypothesis is that through the provision of open access early intervention services, this will reduce those who need crisis and emergency care. The first phase will be in place in December 2019 and January 2020.

3.2.8 High Intensity User Programmes and Social Prescribing

Sheffield Teaching Hospitals continue with the existing work taking place with High intensity User Groups in A&E; this is led by A&E's Clinical Director, supporting the long term strategies.

Single Point of Access are able to manage and coordinate crisis response and GP's in Sheffield now have the ability to log in to a secure portal which recognise patients who are frequent attenders to A&E, in order for them to undertake targeted work.

Those individuals, who are identified as frequent attendees to ED, can be referred to community nursing by clinicians within the acute trust for a review and consideration of an 'OK to Stay plan' for long term care management plan.

The support the Sheffield Social Prescribing provides can help prevent and delay people needing to access health and social care services. Sheffield's main approach to Social Prescribing is resolving social issues and connecting people to 'things that matter to them' locally which will reduce the risk and/or decline of poor health and wellbeing. This will enable people to be more protected and resilient and able to access timely help to manage long term conditions.

Additional work commenced with SYB key stakeholders, CCG's and acute trust.

3.3 Flu & Infection Control

Intelligence shared from the southern hemisphere suggests that the prevalence and impact of flu this year may be higher than in previous years and flu plans have been requested from all partners system wide.

Given these concerns there will be greater oversight and scrutiny of the implementation of local plans with flu being added as a standing agenda item for

ORG meetings. In addition, a representative from the citywide Vaccination and Immunisation group will attend ORG meetings over the winter period.

Point of care testing (PoCT) remains a key tool for the early identification of patients with influenza. This early identification supports clinical decision making regarding discharge and where admission is required, supports early application of infection control principles to help minimise spread of the infection. The PoCT kit has previously been sourced on an adhoc funding basis annually through winter funding; following support from STH's business planning team a tender exercise is currently underway to support a more sustainable approach to delivering the service.

With regard to vaccinating housebound patients this will led and delivered by practices and neighbourhoods. In addition a citywide communications group is being led by STH to support uptake by patients and the public across the city.

In order to ensure the maximum numbers of staff are vaccinated across the local health and social care system a task and finish group will be put in place to share learning and best practice.

To support GP practices in their delivery of flu we have arranged sessions for reception staff/ back room staff to attend immunisation updates in which there will be attendance from Public Health England.

Sheffield CCG have provided practices with access to e- learning updates or a face to face update at the University for Registered Health Care Professionals.

In regards to Health Care Assistants Sheffield CCG have organised a number of update sessions in which they can attend, HCA's must attend a basic 2 day training course prior to administering the vaccine.

With regard to system assurance the ORG will receive information on the number of housebound patients in practice and so ensure plans are in place to ensure timely vaccination. Escalation if required will be to the UECTDB.

We recognise as a system that diarrhoea and vomiting has been an issue over the summer. In order to address this issue the CCG's Infection Prevention and Control team and the acute trust are meeting to ensure plans are in place with system wide assurance provided to ORG.

Finally, assurances regarding implementation from individual partners will be provided to the ORG ensuring a system wide understanding of any issues and agreement of mitigating actions (if required) with updates and escalation to the UECTDB as appropriate.

See individual partner's plans below (note in many cases flu plans are included within winter plans):

Yorkshire Ambulance Service:

Copy of Flu Campaign Project Pla

SCH:

SCH Flu Plan (2019-20).docx

SHSC:

Winter Flu Plan 201920.docx

Yorkshire and Humber Screening Programme:

Flu Update September 2019 Fina

3.4 System Communications over the winter period

NHS Sheffield CCG will be developing a local winter communications plan on behalf of the Sheffield system. The plan will be based on the national NHS and Public Health England 'Help Us Help You' campaign – Help Us Help You is a unifying overarching campaign that includes Stay Well this Winter, NHS 111 and GP extended hours.

The campaign aims to ensure that people who are most at-risk of preventable emergency admission to hospital are aware of and, where possible, are motivated to take, actions that may avoid admission this winter. Local communications will be in line with these messages.

Communication leads will work together closely over the winter period to ensure that messages are consistent system wide with co-ordination of delivery as required. In addition, there will be representation by the members of the CCG's communication team at the ORG throughout the winter period ensuring the timely sharing of messages and escalation of concerns if required.

For information see the system communication plan:


Winter 2019-20 comms plan.docx

SHSC:


Winter Communications Plan

(Note additional plans from providers to be included following internal signoff although in some cases will be part of wider winter plans.)

3.5 Surges in demand/capacity planning

Recognising how useful this shared understanding of key periods of pressure was last year (particularly for out of hours providers of urgent primary care who rely on the same workforce) the Sheffield system has expanded the period covered to include all of December and January rather than just over the core holiday period.

The embedded document below identifies the expected pressure points and potential surges during the period, either due to high levels of anticipated activity and/or due to challenging levels of staffing. It is anticipated that this shared understanding will be used to inform through discussion whether specific actions within the System Action Cards (see below) need to be enacted in advance of pressures in order to mitigate them.

See capacity plan below (note still being developed by a number of partners and a fully completed version will be included in the final draft).


Capacity & Demand Modelling Winter 201

(Note key peak days will be highlighted and referenced in this section once all partners have submitted their forecasts.)

3.6 Managing Risk

As outlined above there are a number of programmes in place delivering service improvement and transformation which will help to ensure robustness of local services and pathway during periods of pressure. However, increased demand for care during the winter period is likely to put local services under significant additional pressure and a number of risks to the Sheffield system have been identified.

Overview, governance and agreement of additional mitigating actions will be provided by the ORG and WNHWNT with escalation to the UECTDB as required.

Key risks to the Sheffield system focus on:

- System performance (particularly delivery of the 4 hour target, timely ambulance handover and ensuring flow and timely discharge).
- Successful continued implementation of local service developments (particularly those supporting greater integration of care provision and pathways).
- Ensuring robust plans are in place with regard to mitigating the potential impact of significant disruption by high prevalence of flu (both staff and vulnerable patient groups).

See embedded document for full details of the risks identified along with their mitigating actions.

Risk Log:

Risk Register 12.09.2019.xls

4. Surge Management

4.1 Escalation Process

Each system partner's individual OPEL level is set by an agreed set of triggers. These have been reviewed and this year have been amended to include Sheffield's local Clinical Advice Service (CAS) – STH's SPA (in hours) and the GP Collaborative (out of hours).

See system triggers document below: (note additional triggers for GP OOHs and SPA currently being signed off internally and will be included in the final draft.)

System Triggers 23.08.doc

Taking the learning from last winter the System Action Cards have been reviewed by all system partners to ensure they reflect all key actions (both internal and supporting partners) and have also been amended to include Sheffield's local Clinical Advice Service (CAS) – STH's SPA (in hours) and the GP Collaborative (out of hours).

See system action cards below:

System Action Cards
V3- OPEL 28.08.2019

The overall Sheffield OPEL level is determined on an overview of all of the organisations' positions. Normally this is based on a review of key indicators from the previous day and conversations as and when needed between CCG leads and senior operational managers.

In order to support this process a set of daily key performance indicators are shared by email across the local system which provide an overview of system performance and pressures over the previous 24 hours.

See example of Sheffield daily KPI email below:

Urgent Care
System-wide Escalatio

During the peak Christmas period (16th of December – 6th of January) the following processes will be followed:

Week Days:

- STH lead will ring the CCG lead each day following the 8am bed meeting. The purpose of the call is for STH to share the current operational position and expected OPEL level for the rest of the day and agree whether to trigger the 10am Sheffield System Local Conference call. The call will only be triggered if the system is deemed to be at Level 2 or above.
- All other partners should contact the CCG lead by 9.15 if they feel that their OPEL level is likely to increase the overall system level.
- If the call is required, an email will be circulated by 9.15 to the ORG representatives confirming that the call is required, the anticipated system level and the seniority of attendance required on the call (see OPEL action cards for more details regarding attendees required).
- The purpose of the 10am call is to confirm the system level OPEL and to agree which actions on the System Action Cards (embedded in section below) will be enacted to support the system and reduce the OPEL level. The CCG will host the call (see section 4.3 Daily Roles & Responsibilities over Peak Holiday Period below for contact details).

Weekends/Bank Holidays (if necessary):

- The 10am call will take place on weekends/bank holidays if required by STH. If one of the partners feel that their OPEL level is likely to increase the overall system level they should contact the STH first on call director.
- If the call is required a message (text or phone) will be circulated by 9.15 to the in hours on call contact for each organisation confirming the call is required and the anticipated system level and also Brian Hughes Deputy Accountable Officer for the CCG (see section 4.4 for the named leads for the period).
- The purpose of the 10am call is to confirm the system level OPEL and to agree which actions on the System Action Cards will be enacted for the relevant level (see Daily Roles and Responsibilities Over Peak Holiday Period).

Live Test:

In order to ensure that the system is prepared for the core Christmas period a live test will be undertaken on the 16th of December and this will take place regardless of the system OPEL level.

- If the system is at level 1 scenarios will be described on the call and representatives will be required to confirm that they could enact the relevant actions on the System Action Cards.
- If the system is at level 2 or above the System Action Cards will be enacted as necessary and the live test will be replaced will be for real.

4.2 NHS England Exception Reporting

NHE England requires all CCGs to complete a standard escalation template and for this to be submitted to the Yorkshire and Humber mailbox (england.yhwinter@nhs.net) by no later than 12.00 (both weekdays and weekends).

During week days the local acute trusts are required to submit their reports (when required) to the CCG by no later than 11.30 in order that combined system response can be submitted (CCG to lead on behalf of Sheffield System).

During weekends and bank holidays STH will lead this process and submit exception reports directly to the NHSE North: england.northwinter@nhs.net on behalf of the Sheffield system (also copying the NHSE local team england.yhwinter@nhs.net and the CCG).

Pro-active management of pressures by using Tableau, enabling users to interact with performance charts, reports, and dashboards in real-time. The advanced analytical techniques will also support local trusts to undertake prediction modelling, predict surges in demand and plan for better bed and staff capacity.

Details of the local escalation triggers are contained in the document below:

NHSE Exception Reporting agreed Sys

4.3. Daily Roles & Responsibilities Over Peak Holiday Period

During the key holiday period (16th of December – 13th of January) in order to support citywide working and resilience a number of regular communications and meetings will take place both within the Sheffield place and with NHSE.

Details of all key meetings/communications (routine and during periods of system pressure/escalation are set out on a day by day basis in the document below (note this document contains a summary of the local elements (both week days and weekends) and may be subject to change to reflect additional requests from NHSE).

See document below for details (note this will be continually updated over the period to reflect NHSE calls etc.)

DRAFT Daily Roles & Responsibilities Over

4.4 Key Contacts

As in previous years in order to ensure a shared understanding across the Sheffield system of partner leads (both in and out of hours) a key contact sheet for the period 16th of December until the 10th of January.

Details of the system leads can be found in the document below (note rotas and A/L have yet to be finalised and so last year's document has been included to give an indication of the level of detail):

System Contacts Christmas and New Y

Appendices: (embedded documents)

Supporting documents from system partners.

1. Winter plans

   (Note a number of local plans are in the process of internal signoff and will be included as soon as available.)

2. UK Exit plans.

Individual partners across the Sheffield system have developed EU Exit plans; in addition system partners have been asked if they have identified any further system wide risks.

No further risks have been identified, however if any are identified these will be escalated to the UECTDB for discussion and agreement of mitigating actions as appropriate.

(Note a number of local plans are in the process of internal signoff and will be included as soon as available.)

SCH EU Exit Actions

SCH EU Exit Actions 07.08.19 .xlsx

Route 2 Beds

Patient & Relative Interviews

Arthur

Support at home before hospital stay

- I Live with my wife
- Had no support in place before hospital
- Had carers helping at home after another recent hospital stay

Health

- I've had 2 hospital stays in the last couple of months
- I was diagnosed with bladder cancer

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

Nothing.

What has been good/best about the care and support you have had?

Getting to know lovely people here and the hospital. We are very fortunate.

Have all the different people involved in your care worked well as a team?

Yes, but need better communication.

1. Reason for hospital stay

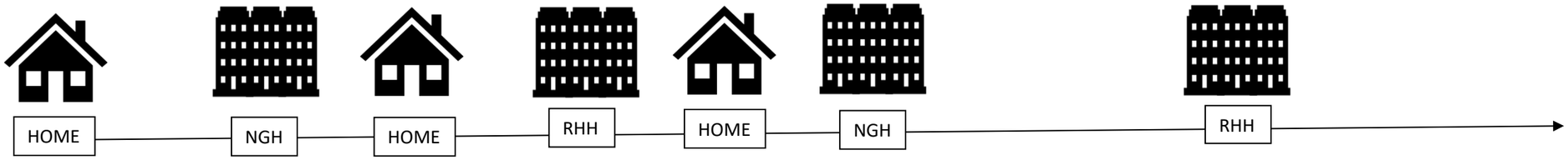
It was my water works, I didn't do anything because I didn't think it was serious, then started passing blood.

My wife rang 111 and was advised to go to A & E.

3. Then weeks later I ended up at the Hallamshire Urology Wards.

5. But I got an infection and had to go back in. I'm not sure what kind of infection it was.

- 6. I had to go to A & E and then to the Hallamshire. We live far out from the hospital and had to go through the whole thing with my [wife] coming out the hospital to go home at 3am in the morning, I found that distressing.
- The only criticism I can make is that they said I had to go back to A & E. I found that a bit funny, that I couldn't go straight back to the Hallamshire. It has knocked the legs off me and my wife. We were so independent. I worry about her.
- I was sent too early to be transferred to the Hallamshire. I had to wait a long time; it was about 5 hours to transfer from A & E to the Hallamshire.



2. The doctor at A & E thought it was an infection so gave me antibiotics and sent me home.

4. I was in there for a week or so then got sent home.

Experience in hospital

- On arrival I don't think they explained what would happen next, but I might have not heard.
- They looked after me well, I can't complain about the care they gave me; from care workers to doctors they were all supportive.

  They talk to you and keep you relaxed when they're washing you and when taking you to the toilet. They don't stop in [the toilet] with you, they stand and wait outside and ask if you are alright; that shows respect and keeps your dignity.

- At first you don't know what is going off and what you can and can't do. I wasn't aware I could use the pads that I normally use until I saw another patient getting them out the draw. It would have been good to know.

Feelings about going to a nursing home

Fine.

Feelings when told

Pleased because my wife didn't have the responsibility of seeing to me.

Was the stay wanted?

I think this is the best thing [being at the nursing home].

Communication in hospital about stay in R2 bed

When told about R2 bed stay

A few days before.

Towards the end of my stay I was told I was coming here [nursing home]. My main concern was my wife and I asked if she could have help, so she has a carer in the morning and evening. She was in hospital at the same time as me at one point, because she had [condition], but she was in the Northern General. We couldn't even speak to each other.

Thoughts on reason for the stay

Waiting for care to be set up at home and a slot for radiotherapy. I know it's an interim thing.

Information given in hospital about what would happen next

When asked directly, Arthur said:

- The reason for going to a nursing home had been explained.
- He was given the right information at the right time
- He had enough information:

It was all explained; I had enough information; I don't question a great deal.

- He didn't want any additional information about anything else
- He thought the information given was easy to understand, however went on to say:

Too many technical words but it was the general thing of having too much of everything all at once. I couldn't absorb it all; it can be too much at once. Written information would be good. I got to a stage where it was too much, and I wanted people to leave me alone. It can be too much; you nod and say yes but you've not taken it in. It's partly because you want them to go away and get it done with.

- He had not seen the R2 information leaflet.

Experience at R2 bed nursing home

Is staying at the home how you expected it to be?

Yes. It was what I expected.

Thought and feelings about being at the home

Fine, I was pleased with my room – its en-suite, but I don't see anybody much in-between time. I have trouble talking to people because of I'm hard of hearing, some accents can be difficult.

Quite content at the moment. I was worrying about medication. Lack of communication with things like medication, and they've not passed things on. I rely on professional staff completely, so you trust them.

At the Hallamshire, I got pain relief when I wanted but here you have to wait ages for it. In hospital, they come round with meds and say 'are you in pain?' They would give me [pain relief medication] and that would help me til the evening.

Nursing home Vs care in own home

I would prefer to be at home, but I don't want to put the onus on my wife.

Views on having enough of the right care to help recovery

Yes [I have enough of the right care], but I've only been in here for a day.

Knowledge of what would happen next

No, [I don't know what is happening next] not in detail.

Thoughts and feelings about going home

Thoughts on having enough support when back home

Yes, [I will have enough support] I'll have carers visiting. One in the morning and one in the evening.

I had them before but for some reason it had to be discontinued. After I had been in hospital before, it was going to be for 6 weeks, but I ended up back in hospital before that, so I lost my care and have to reapply.

Beth

Support at home before hospital stay

- I live alone, I'm very independent, rely on my neighbour and nephew
- I get help with shopping and cleaning my house.
- My nephew comes every night and my neighbour pops in every day. I've got a stair lift and bath with a chair, and a commode, and bed downstairs and a big fridge full of food.

Health

- I've got a stoma bag; I empty it myself.
- No, not really [had enough support to manage my health], I didn't want it, I'm independent.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

If I could just go home, I want familiar surroundings.

What has been good/best about the care and support you have had?

It was better in hospital; very nice and kind. They knew just what I wanted.

Have all the different people involved in your care worked well as a team?

I don't know.

Reason for hospital stay

I had a swollen, painful tumour in my intestine. It was a blockage, so I had an operation; keyhole surgery.

I stayed in hospital a long time ago, about 7 or 8 years ago for the same thing.

Experience in hospital

- Not so bad, I didn't eat a lot, but they got used to me and didn't put as much on the plate as they do [at this nursing home]. They were very good, they were lovely. You couldn't wish for anything better, everyone called me [by my first name]; it was home from home, they said I was a model patient.
- On the ward I got an infection, I don't know what kind, they wouldn't tell me, and they took a lot of bloods. They put me in my own room, it were a bit lonely. I got a bit bored, there was no one to talk to but I liked the en-suite.
- I was in for about 4 weeks. I was in the little room for about two weeks, then I came here.

Moving wards

Yes [I stayed on the same ward].

Feelings about going to nursing home

Feelings when told

Not very good; I thought it's gonna be nice, but I've changed my mind.

Was the stay wanted?

I would rather have been at home. I enjoyed being in hospital, but I'm not thrilled at being here. I rang the bell, but nobody comes for ages. They just put a big plate of food in front of you.

Transfer from hospital to R2 nursing home

I came here in an ambulance, it went alright.

Experience at R2 bed nursing home

Thoughts and feelings about being at the home

Not thrilled, having to wait for the bell and there is no choice, they just bring you food. They have said I can go down to the lounge after two days.

Nursing home Vs care in own home

Yes, I'd prefer to be at home with them coming in.

Views on having enough of the right care to help recovery

Yes, I'm a lot better. In hospital I couldn't get up and walk around so I lost the strength in my legs. I have physio in here; it's helped me a lot. I couldn't stand up when I first came, I can go to the bathroom on my own now.

HOME — NGH — NURSING HOME — HOME

Communication in hospital about stay in R2 bed

When told about R2 bed stay

They told me the night before I came, I asked them to call my nephew.

No, I didn't mind [being told then].

Thoughts on reason for the stay

- There wasn't enough information; I was just told you're going into this care home, to build me up.
- I'm here because they are trying to get a carer for me, I've had a letter. I'd be a lot better off at home. I miss it.

Information given in hospital about what would happen next

When asked directly, Beth said:

- The reason for going to a nursing home had been explained
- She was not given the right information at the right time
- She did not feel she had enough information
- There was something else she would have liked to know:

What it was gonna be like [at the nursing home]. If I'd known what it was gonna be like I'd have asked to be straight home. I'd rather have stayed in hospital, but they need the beds.

- The information given was not easy to understand:

No [it was not easy to understand], I feel neglected and taken for granted.

- She had not seen the R2 information leaflet

Knowledge of what would happen next

No, I don't know. I feel quite well. I've always been independent. Everyone is nattering at me to have a carer. They'll come for 20 minutes 4 times a day and then it'll go down to once.

Thoughts and feelings about going home

I've got all that convenience.

Thoughts on having enough support when back home

I've got a chair that tilts and a 41-inch TV [at home].

Clare

Support at home before hospital stay

- I live with my sister, and daughter who has [condition].
- I just prefer to be independent. My sister is very good, we all look after each other.

Health

- I've got a heart valve and epilepsy, but only ever had two fits, and blood pressure.
- I've been in hospital two or three times in the last 18 months to two years.
- I have a tummy problem. My catheter goes through my stomach. Other hospital stays in the past have been because of my catheter.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

I don't know.

What has been good/best about the care and support you have had?

Some are better than others in hospital.

Reason for hospital stay

I had pneumonia. I'd been off colour for a little while; I knew I wasn't myself. I didn't go to the doctors because I have problems with my legs so I can't. I just thought I would get better. I was poorly at home for two weeks.

My sister rang an ambulance and I went to the Northern General.

Thoughts on whether the hospital stay could have been avoided

Doctors wouldn't have helped they are always so busy, so you think I'm not gonna bother. I've had phone appointments before.

Experience in hospital

- [It was] alright just as you expect; good meals. I was so determined, I thought I'm gonna throw a brick out the window, I was desperate to get out. I got someone to keep an eye on me.
- I had a letter saying I'm gonna have a camera down to look at stones quite soon. The doctor in hospital didn't know I was gonna have the procedure and asked me to bring the letter in; I think he didn't trust me.

Moving wards
I was on two different wards. The last one was Osborn.

Feelings about going to a nursing home

Yes. I was alright about it [going to the nursing home].

Feelings when told
Alright.

Was the stay wanted?
Well I have to be [alright about being at the nursing home], I'm going to get better.

Transfer from hospital to R2 bed nursing home

Ambulance transport was ok when I came here. I was waiting a long time, from early til late but I didn't mind. They were busy with emergencies and I just think that could have been me.

Happy with discharge?
Yes, I was told I was going tomorrow.

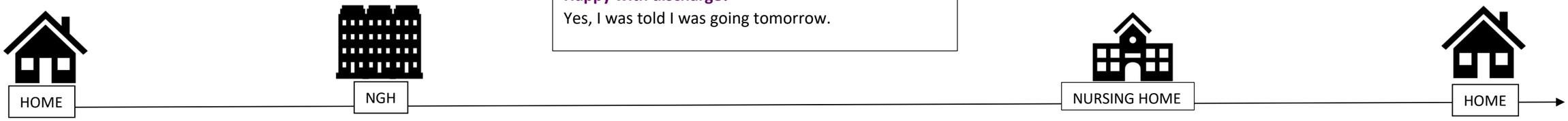
Experience at R2 bed nursing home

Is staying at the home how you expected it to be?
Yes.

Thought and feelings about being at the home
They are short of carers in [the nursing home], they work very hard but there just isn't the amount.

Nursing home Vs care in own home
I would rather be [at the nursing home], I don't want carers. At the moment we don't have any, but it will probably come to that.

Views on having enough of the right care to help recovery
Yes [I have enough of the right care]. I couldn't wash myself properly when I was poorly, but now, I can wash myself again. You try and help yourself don't you.



Communication in hospital about stay in R2 bed

When told about R2 bed stay
It was mentioned a few days before and then the day before they said it will definitely be tomorrow.

Thoughts on reason for the stay
I came here because I was off colour, I can't remember it all.

Information given in hospital about what would happen next
When asked directly, Clare said:

- The reason for going to a nursing home had not been fully explained:

I was not really told no. I'm not sure why I can't go home, I assumed I'm not well enough.

- There was something she would have liked to have been done differently:

Yes, I was told I was coming here because I was getting better. They didn't say why I couldn't go home, and I was coming here instead but I'm not bothered. The nurse said they couldn't understand it.

- She was given the right information at the right time
- She had enough information
- There was nothing else she would have liked to know
- Information given was easy to understand
- Had not seen the R2 information leaflet:

No written info was given to you about what would happen.

Knowledge of what would happen next

- I'm going home tomorrow. I've been here just under 2 weeks.
- Carers might be coming [when I go home]. I've no idea how many times.

Thoughts and feelings about going home

Great.

Thoughts on having enough support when back home

Nothing else really [is needed in terms of support].
I'm sure I will do [have enough support], the phone is handy.

Daniel

Support at home before hospital stay

- I'm a carer for my wife who has dementia. She had carers coming in, getting her up and ready, washed and dressed, and making her breakfast. We made a sandwich at lunch and then carers came at 5pm. I was often already cooking by then, but they offered.
- We pay for the [carers] but get an allowance for that, but only Monday to Friday for my partner. The council send theirs at the weekend. You never know the time they're coming. They came at 1:30pm for a morning visit. That were no good was it? The very first time they were a bit late and the next day was a Sunday, I wanted a lie in. I was in bed and heard them shouting up to me at 7:30 in the morning. I told them not to come again but they did. One said they have no travel time, they had to fit five people in half an hour including travel time.
- My son works but my daughter has finished work. They are both very good. They always phone and say, 'do you want any shopping?' They arranged respite in a care home for my wife.
- District nurses were coming before. You never knew who was coming.
- I would have liked more support with my wife. One of my children has taken over the finances and the other has taken over with my partner.
- It would have been nice to have had a day out more than what we did.

Health

- I've got a hernia, my prostate, and my circulation is bad but that's no problem. They can't do anything about that it's my heart.
- I've got cancer; lymphoma.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

No [nothing], I'm very lucky.

What has been good/best about the care and support you have had?

couldn't wish for a better service in hospital or in here.

Have all the different people involved in your care worked well as a team?

I'm sure they would be.

Reason for hospital stay

- …I felt a bit tired, so I went to bed early, about 7pm. It didn't go very well, my partner was shouting up the stairs to me, wondering where I was, what I was doing. The next morning, I couldn't get up, her carers rang the GP and demanded a home visit. The next thing I knew there were paramedics and police stood by the bed. They took me to the Northern General.
- I was treated for pneumonia; lack of oxygen…

Thoughts on whether the hospital stay could have been avoided

If the doctor had seen me. I'd over done it looking after my wife. You have to get through the receptionist, what's that about? You tell the receptionist; say the most private information and they pick out a doctor from what you've said. The doctor didn't even come out then, they said to get the paramedics out.

Experience in hospital

- I wasn't with it. It was 50 /50 whether I made it, but they did something right and got me as fit as they could do.
- At hospital they were as good as good can be, you couldn't wish for being looked after any better.
- I had 3 visits from St Luke's when I was in hospital, it was good; they'd sit and talk.

Moving wards

I was in hospital for 2 weeks, stayed on one ward for one day and then was moved to another. I was there for a fortnight.

Feelings about going to a nursing home

It was a case of finding somewhere. They tried to get me in the same home as my wife but there was no room, so I ended up here.

Feelings when told

[I felt] alright; one place is as good as another. It was always on the books. The family didn't think it was a good idea for me to go home to an empty house with nothing put in place.

Was the stay wanted?

I would have come here if I'd had a choice, because if anything happened to my wife, I wouldn't be able to do anything. I can't lift her. We've both had falls. We have city alarms, both of us. Last time she fell we used them.

Experience at R2 bed nursing home

Is staying at the home how you expected it to be?

Yes.

Thought and feelings about being at the home

Nursing home Vs care in own home

See 'Was the stay wanted?'

Views on having enough of the right care to help recovery

Yes [I have enough of the right care].

Transfer from hospital to R2 bed nursing home

Getting here went smoothly, I came in an ambulance.

Happy with discharge?

Yes, there was no problem.

HOME — NGH — NURSING HOME — HOME

Communication in hospital about stay in R2 bed

When told about R2 bed stay

- I didn't know when it was gonna be then it happened quickly. They said, 'you're off, get yourself together'. They told me on the day. It was alright [that it happened quickly].
- They came one morning and said, 'with a bit of luck you'll be out of here today', and then later they said 'get your stuff'; I had about an hour.

Thoughts on reason for the stay

- In hospital they wanted the beds and I was as fit as I ever could be, I was just taking up room. No, it didn't feel like that [like I was just taking up room].
- There was some talk of bringing me here to see how I could manage; whether I'll be able to able to stand to cook a meal.

Information given in hospital about what would happen next

When asked directly, Daniel said:

- The reason for going to a nursing home had been explained:

They explained well. In hospital and here, it was good as good could be, you couldn't wish for being better looked after.

- He was given the right information at the right time
- He had enough information
- There was nothing else he would have liked to know
- Information given was easy to understand
- He had not seen the R2 information leaflet
- There was nothing he would have liked to have been done differently

Knowledge of what would happen next

- It depends if they get hold of my daughter.
- I don't know. Today they talked about going home but me and the children didn't want [my wife] to be left in a care home once I'm home. The family don't want me at home and her to be left there. They have fetched her every day to visit.
- I've been here 3 days. I might be going today or tomorrow. It'll be a case of getting carers sorted.On the off chance, my son doesn't work [today] so he could get carers organised.

Thoughts and feelings about going home

I'm ready.

Thoughts on having enough support when back home

I'm sure I will [have enough support] but we've got to get carers organised. We'll use the same company as before. We just have to see how I could manage on my own, making meals.

Edith

Support at home before hospital stay

- Just lost my husband
- I have got a son and his family
- I've got a care alarm

Health

- Fell on first night home from hospital
- Walks with a frame

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

It's all been good.

What has been good/best about the care and support you have had?

They have all been nice to me.

Reason for hospital stay

I've Just lost my husband. I had been in hospital and had equipment put in in case of accidents. It was night when I came out. My son and his family were on to me to stop at theirs, but I wanted to stop in my own house.

I settled in for the night and put the kettle on and thought how can I walk with my frame and a hot drink so I had a cold drink instead. I couldn't work out how to carry the drink. I pulled the care alarm around my neck and they soon came. My son came and an ambulance, and they took me to hospital.

Nothing was broken, my leg was just swollen and bruised. I have to use a frame. Everyone says I've done marvellous, but I'd rather walk on my own.

I felt alright but I must have gone straight on my leg. I was at the Northern General for 6 weeks and learning to walk with a frame.

Thoughts on whether the hospital stay could have been avoided

It was just one of those things, I'd already got the equipment, the alarm.

Experience in hospital

Yes, it was alright. It was lovely people chatting to you.

Moving wards

Yes [I stayed on] the same one.

Feelings about going to nursing home

Because I'd been here before I knew I'd be alright.

Feelings when told

I've been here before. [Name of son] arranged it though, not the hospital. I thought I was doing so well then all this happens. Kids can't have time off from work, they've got kids and mortgages.

Was the stay wanted?

I wanted to come here, not carers. I don't want carers, if you have them Monday to Friday, they just make you a cup of tea or wash your face, they aren't there long. I'd rather be in sheltered housing.

Transfer from hospital to R2 bed nursing home

[My son] brought me here. He works out of town but always rings me in the mornings.

Happy with discharge?

Yes.

Thought and feelings about being at the home

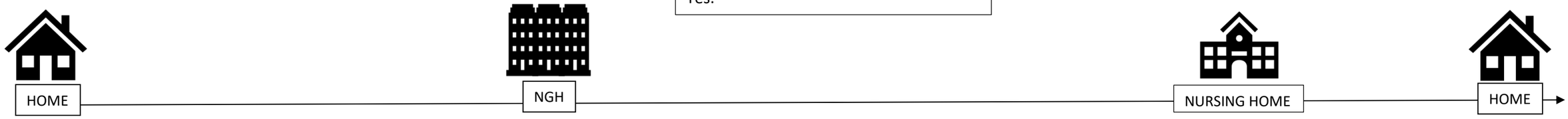
- I'd rather be here than in hospital.
- I've been here for this week.

Nursing home Vs care in own home

I don't know [which I would have preferred] because I've heard that many bad remarks about carers. I don't want to start worrying about it. They say they come at 8pm so it doesn't give you a choice. (Also see 'Was the stay wanted?')

Views on having enough of the right care to help recovery

Yes [there is enough of the right care].



Communication in hospital about stay in R2 bed

When told about R2 bed stay

I knew all the time; it wasn't a surprise.

Thoughts on reason for the stay

There is nowhere else to go. I'd rather come here; I'd be in the house on my own because my kids are both working.

Information about what would happen next

When asked directly, Edith said:

- She was given the right information at the right time
- She had enough information
- There was nothing else she would have liked to know
- Information given was easy to understand
- She had not seen the R2 information leaflet

Knowledge of what would happen next

I'm not sure [what will happen next].

The place I'd like to go is sheltered housing. They have lovely staff and they ask if you want owt fetching. I'm not sure where to go. I stayed there after a fall. It was supposed to be for two weeks, but I ended up staying longer.

Thoughts and feelings about going home

I'm not sure about it. My family need to be with me, I want help with what to do.

Thoughts on having enough support when back home

I don't know. I don't know who I'll end up with.

Frank

Support at home before hospital stay

- Neighbour helps and had carers.

Health

- Had 4 strokes.
- Has trouble walking and with his hand. He can't use all of the fingers on one hand.
- Has walked with a stick for 20 years.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

Not being here because of the bed.

What has been good/best about the care and support you have had?

They are alright the nurses, but the experience [of being stuck on the bed] was not nice.

Reason for hospital stay

Frank did not remember why he was in hospital but thought it might be due to a stroke.

Experience in hospital

Everyone has been nice to me.

Experience at R2 bed nursing home

- It helps you being here.
- The carers do what they want, they don't ask me what I want. If you ask them, they will do it for you. You don't want them telling you what to do all the time; it's probably for your own good. If I walk down the corridor, they send you back. You could wobble and have a fall. I've got my stick and that [pressure] mat. They're always monitoring.
- It's alright here except getting stuck in the bed.
- Frank said he had been stuck on the bed at the nursing home. He had been able to put their legs over the side of the bed but couldn't get up. He said:

Carers came and helped me; it was quite frightening. I'm scared now of the bed. I couldn't get out of the bed for two days.

Views on having enough of the right care to help recovery

Yes [there is enough of the right care].

Knowledge of what would happen next

No [I don't know what is happening next].

I don't know when [I am leaving the nursing home].

Thoughts and feelings about going home

I want to go home, I miss it. They help you and all that but it's not the same. You've got to ask them for everything.

Thoughts on having enough support when back home

No [I won't need any other support], I can manage.

They are doing the house up so I can go back. It will be scary at first, there are steps, down to the toilet. I have a rail so I could go down them but can't now because of my hand. I nearly had a fall. They are paralysed my fingers from the stroke I had, from the first stroke.

Hilary

Support at home before hospital

- I do my own housework and cook.
- I live with my son in a bungalow, he helps.
- My husband died and daughter is estranged.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

No, its home from home, this [nursing home] is like a hotel, everyone has been nice.

What has been good/best about the care and support you have had?

99% of staff are all excellent. One is a bit rough at moving me.

Reason for hospital stay

I've got a built-in wardrobe. I was on my hands and knees to get something out and I couldn't get back up, so I rang my son [who I live with]. I'd fallen and was on the floor. They rang the doctors and they sent two ambulance people and they took me to the Northern General. I was unwell as well as the fall. I take tablets for my heart, for blood pressure.

Thoughts on whether the hospital stay could have been avoided

It was my own fault for having a fitted wardrobe and the bottom drawer was a bit stiff.

Experience in hospital

It is relaxed, everybody is family. There's food, drinks and doesn't matter if night or day staff, they're the same. They make sure you're alright.

I could get to the toilet using my frame. That's why they need me here. We're all the same in my family – very determined.

Moving wards

[I stayed on] the same ward, it was like home from home, they were all very friendly. They couldn't have been better.

Feelings about going to have a nursing home

Feelings when told

Fine because I knew it was a step forward.

Was the stay wanted?

- Yes, I knew I wasn't ready at the time.
- I was sorry that they moved me but it's nearer for my son and they are overloaded at the hospital aren't they.

Transfer from hospital to R2 bed nursing home

Happy with discharge?

Yes, but I'll tell you one thing. They didn't inform my son; they took his mobile number. He went to the Northern General to see me. The nurse must have completely forgotten to tell him. When he went to the ward my bed was empty and he asked, 'where's my mum?' I don't like complaining but if you see an empty bed – he'd think I'd gone to the mortuary.

Experience at R2 bed nursing home

Thought and feelings about being at the home

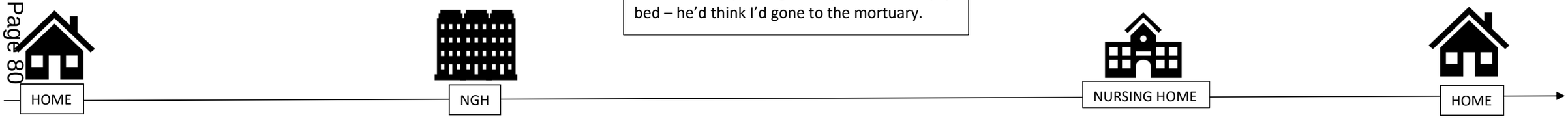
This is like the best hotel in London. It's like a holiday camp.

Nursing home Vs care in own home

It's a bungalow but I don't want to be a burden, my son needs to work.

Views on having enough of the right care to help recovery

Yes [there is enough of the right care].



Communication in hospital about stay in R2 bed

When told about R2 bed stay

Days before, that was okay, they said it's nearer to home.

Thoughts on reason for the stay

- I've only been here a couple of days. They said it was another step and nearer where I live. I think the idea was to get me more mobile, my son works in the day. It is very comfortable. It is nice.
- They said it was a step nearer to getting home.
- They did come and explain. The doctor was good.

Information about what would happen next

When asked directly, Hilary said:

- The reason for going to a nursing home had been explained.
- She could not remember whether she had been given the right information at the right time
- She had enough information
- There was nothing else she would have liked to know
- Information given was easy to understand
- She had not seen the R2 information leaflet

Knowledge of what would happen next

No [I don't know what is happening next].

They said it wouldn't be long until I go home, if I have a carer for two weeks or something. Going home is important.

Thoughts and feelings about going home

I'm quite content here, but I know I've got to go home when I'm mending.

Thoughts on having enough support when back home

Nothing [no other support needed], we both do cleaning and cooking. I can ring shopping in.

Irene

Support at home before hospital

- I Live on my own, with no help.
- I'm completely independent.
- My two children help out.

Health

- I've a bit of arthritis, indigestion and hearing aids.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

Very noisy at night in hospital and in [the nursing home]. I have my door open because I don't want to be shut off. Bells are always ringing.

What has been good/best about the care and support you have had?

In [the nursing home], the staff and some of the young ones are really, really pleasant and meals are very good.

.

Reason for hospital stay

I was shopping at [name of area] and took my shopping trolley but didn't have a lot of shopping in it. I went to the supermarket and stepped onto the escalator. My legs shot up in the air and I fell on my back; I went flying. I broke my ankle, got plates and screws now. I had to ask someone to phone an ambulance and family, and they met me at the Northern General. Ambulance crew turned my ankle to put it straight, but they'd not done it right, so then I had an overnight plaster on and an op the next day.

Thoughts on whether the hospital stay could have been avoided
If I'd not gone shopping [it could have been avoided].

Experience in hospital

All the staff were very good, and the surgeon even came to see me after the operation. The operation went well but the reason I've not been allowed home is that they put a pot on after the op; it was just temporary in case my leg swelled up. The second one was a bandage, they wet it and massage it and it goes rock hard. I've got a great big blister that the second plaster cast caused. So, they took that pot off and dressed the blister and gave me a bandage and a boot. I still can't put this foot on the floor.

I'm non-weight bearing. I have to go to hospital to have the dressing done at clinic. They put fresh dressings on. I don't mind, I'd rather go to hospital, they have doctors there.

Moving wards
After my operation I think I was moved to another ward. I think I was in from [gave dates; was in hospital for 10 days]. I didn't mind moving wards. It was alright.

Feelings about going to have a nursing home

Well I had to be alright, I couldn't do owt about it. It was the first free place they'd got.

Feelings when told
I had to be alright because I knew I couldn't go home. They took me to a kitchen in the hospital and I couldn't do anything.

Transfer from hospital to R2 bed nursing home

I was transferred here with the first pot on after 11 days in hospital. I didn't get discharged, just moved here, I'm still under the hospital.

Hospital appointment during nursing home stay
The ambulance takes me to hospital from here. The time before I had a four hour wait for an ambulance back. They looked after me though, they gave me a cup of tea and sandwich.

Experience at R2 bed nursing home

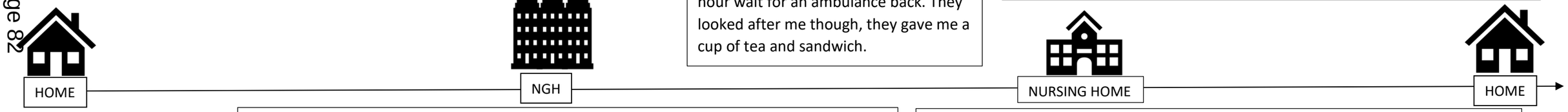
Is staying at the home how you expected it to be?
I suppose so, my Mum was in a home.

Thought and feelings about being at the home
Only thing I can do is watch television and go to sleep. I've not been in the communal rooms. I get the opinion that a lot of people are older than me and it would upset me.

I've no complaints about the staff, they are all nice. They come with cups of tea and check on you a lot

Nursing home Vs care in own home
No. When I think about it, I'd rather come here until I can walk on two feet.

Views on having enough of the right care to help recovery
Yes, they are amazed how well I've done. I do what any professionals and doctors tell me. I've got an appointment in 3 weeks at hospital. The ambulance is booked but it doesn't say what it's for.
Irene showed her appointment card which displayed no detail about the appointment other than the time.
I don't know if I'll have physio later, once I'm weight-bearing. When I'm in my own surroundings I'll be a lot better off. I can walk around the room at home. I can't in the corridor here, my legs get tired and then I can't get back.



Communication in hospital about stay in R2 bed

When told about R2 bed stay
I think they told me the day before.

That was alright [being told the day before]. They were checking how I was doing with my frame. I was doing alright, and they were waiting for a place here.

Thoughts on reason for the stay
It's been explained to me. It's because I'm not capable of looking after myself, when I go home, I'd be hopping on one leg. They are worried about making tea and stuff. I suppose it's all for my own benefit. They 've warned I might get scalded.

Information given in hospital about what would happen next
When asked directly, Irene said:

- The reason for going to a nursing home had been explained
- She was given the right information at the right time:

Yes. I ask if I want to know.

- She had enough information:

I've had 3 leaflets from here. One about what I can and can't do, that was from the hospital.

- There was nothing else she would have liked to know
- Information given was easy to understand
- She had not seen the R2 information leaflet

Knowledge of what would happen next

I thought I would be home the next day, but they must have changed their minds. I don't know why. It might be because I've got plates and screws even though I'm younger than some. I suppose I can't weight bear.

Most people go the next day, maybe it's my age, and they've said I've got brittle bones. I've got a frame for the toilet and frame to walk with. I don't know how long I'll be here, that's what they are trying to sort.

My son offered to do tea for me. My daughter wants someone to come in the morning to make a sandwich for lunch – a carer. Thought I'd best try it and see how I go on. They said I'll probably have to pay for carers, but I thought the first 6 weeks is free and you pay after that, so I'm not sure. I don't think I'll need 6 weeks. For safety I'll walk with a frame. I'm in a flat but there are steps up and down to it.

Thoughts and feelings about going home

I'm ready but I'll feel safer once I can put weight on my leg. I'm more confident here that if I fall there are people around.

Thoughts on having enough support when back home
Not really [any other support I need]. My daughter and son are a good help. I only have to phone up. My family will help me shop and wash.

Jack

Support at home before hospital

- I have a 3-bed house, and a cleaner.
- I live on my own.
- My son chauffeurs me about a lot and my grandson helps with the shopping.
- No carers.

Health

- Prostate cancer, and its spreading. It's in my kidneys and bones, my glands. I should have had an op 2-3 weeks ago. They did a urine test but it was dodgy so they couldn't do it. It's a procedure where they put tubes from my kidneys to drain away into my bladder, so I don't have to change bags. It is supposed to be happening Friday. The staff told me. My son didn't know either. There is supposed to be a letter coming. I go as an outpatient and go home the same day. I don't think I will do though. I had something similar a few months ago and they had to keep me in because of the after affects. They had to stop because of my blood pressure.
- Yes, [I had enough support to manage my health], I could cope, I was doing alright. Its old age.
- This was the second time [staying in hospital]. Its 2 and a half years ago since, it was for the same thing, for convalescence.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

No, I'm quite happy with it. I'm happy with all the hospital experiences, I've had quite a few, for my hips, lung cancer surgery and 2 hernias.

The only thing I didn't like; I've got 3 urine bags. They [care workers at the nursing home] come at 5:30am to change bags. They didn't come today though so I asked a carer.

What has been good/best about the care and support you have had?

I can't fault them. They have been very friendly and welcoming.

Have all the different people involved in your care worked well as a team?

Yes.

Reason for hospital stay

I fell in the bedroom. It did hurt; I had my hips replaced about a month ago. My son rang the doctor the next day. The doctor said I'd better go to A & E. I had an x-ray and they said they would keep me in for a few days. I'd not broken anything.

They said I was run down.

Thoughts on whether the hospital stay could have been avoided

Yes, it was my fault. I was going up to bed and switched the landing and bedroom lights off, but I'd not put my reading lamp on so there was no light. I fell over something. I rang my son and he came and got me into bed. It knocked the stuffing out of me. My head hit the ground but there was no bruising.

Experience in hospital

Alright, I was quite satisfied.

Moving wards

I didn't move wards.

Feelings about going to a nursing home

Feelings when told

It didn't bother me because I had experience previously when I was at Beech Hill.

Was the stay wanted?

Yes, I was quite satisfied. I'm on my own all the time at home.

Transfer from hospital to R2 bed nursing home

Happy with discharge?

It worked out okay. They provided an ambulance; it all went smoothly.

Experience at R2 bed nursing home

Is staying at the home how you expected it to be?

Yes.

Thought and feelings about being at the home

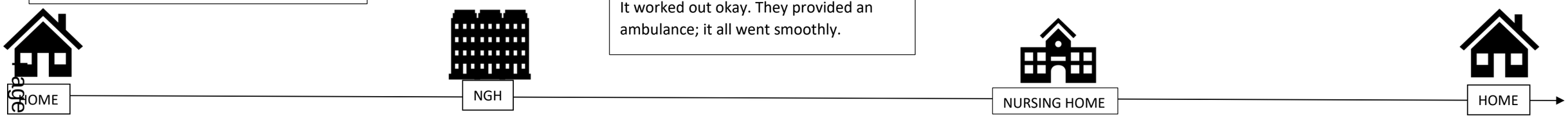
I've been content.

Nursing home Vs care in own home

I don't know. My neighbours are very good and help me. They were my wife's friends.

Views on having enough of the right care and treatment to get better

It's queer this. It was the same thing at Beech Hill. You don't get a lot of mobility treatment. Sometimes they walk you down the corridor and back. They say I'm mobile enough.



Communication in hospital about stay in R2 bed

When told about R2 bed stay

Can't really say, I'm not sure if they told me or my son. I didn't find out until the last minute.

Thoughts on reason for the stay

They didn't actually [explain why] no, but it turned out it was convalescence; mobility really. I'm not good on my feet, I walk with a frame.

Information given in hospital about what would happen next

When asked directly, Jack said:

- He had not been told why he was going to a nursing home:
- He was given the right information at the right time:

No, they didn't tell you a lot. If you ask questions, I don't think they knew.

- He had enough information:

Yes. It was the same as 2 and a half years ago.

- There was nothing else he would have liked to know
- Information given was easy to understand
- He had not seen the R2 information leaflet
- There was not anything that he would have liked to have been done differently:

No [there wasn't anything], I was satisfied.

Knowledge of what would happen next

- I'm going home today at 9:30am, its 10:55am now.
- No [I've not been told why the transport is late].
- It will be [hospital transport] yes. If it's this morning my son will be there when I get home. He's got to work though this afternoon.
- … I've not spoken to a care worker about what is happening at all, they've spoken to my son. I would have liked to have spoken to them. Perhaps they think I'm past it.
- They said they are arranging carers four times a day.

Thoughts and feelings about going home

- I'm not really bothered but it's a bit lonely. There's still all those hours on your own.
- Yes, alright [feelings about having carers]. It's my age. It'll be a bit of company. They're always run off their feet

Thoughts on having enough support when back home

Yes, I think so. I've not really thought about it [what other support I would like]. It's a bit of company.

Katherine & daughter

Support at home before hospital

- Lives alone
- Carer twice a week from Age UK for companionship and to take me shopping. Yes [it is useful].
- Two other relatives come too.

Health

- Alzheimer's, pernicious anaemia, high blood pressure, MGUS (protein in blood, so needs observation. It could turn into Myeloma), underactive thyroid and trigeminal neuralgia and depression.
- Yes, [I get enough help to manage my health] until the fall I felt alright.
- Except she was very fed up of being at home and wanted to move into a care home. But she's changed her mind now and can't wait to get home. We had a memory clinic appointment made to change medication for anxiety. Mum was worried about food and generally anxious.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

Perhaps if they told you a little bit more but how they've looked after me, I can't fault it. They could have looked after you a bit better in the discharge lounge. Nobody spoke to you. You didn't know what was happening. They fetched me just after breakfast.

Everything has been done as it should. I think in hospital it was a timing issue. If we had been half an hour later in A & E, they couldn't get through the doors with ambulance trolleys.

With social services, before hospital, they had a tick list of physical health criteria, but it is hard to access care you think you need. Mum comes over as being more with it than she is. The nurse said she didn't pick up on it whatsoever. It's harder when its mental not physical.

What has been good/best about the care and support you have had?

How people have been so nice. I can't fault them at all. They come in and see if I'm alright. They don't pester me, they are there.

The professionalism of staff throughout has been outstanding, combined with a great level of empathy and kindness for people.

Have all the different people involved in your care worked well as a team?

The handover from the Northern General to here was good. They were on the ball straight away with checking blood pressure.

Reason for hospital stay

Mum had a collapse at home on the kitchen floor. She pressed the alarm around her neck, and they ordered an ambulance and rang me up. I live 10 miles away. When I arrived the neighbour and ambulance were already there.

She had been ill the week before. I rang an ambulance and it came it 20 minutes. We had been at A & E the week before. We were at the supermarket and she was suddenly sick. I took her home and she was breathless and had chest pains. I'd made a GP appointment, but it escalated, and I rang an ambulance. [Paramedics] found she had got an irregular heartbeat when they did the ECG; otherwise they wouldn't have taken her. I think a lot of it was panic, but she calmed down. The paramedics were fantastic, very professional.

Thoughts on whether the hospital stay could have been avoided

It was just one of those things.

I don't know. She had a 24-hour ECG thing and high blood pressure. They couldn't get to the bottom of it. I wonder if she could have taken her meds twice. She rang me before because she didn't know if she had taken them, or twice. There is a box for them with days of the week on, but she doesn't always know what day it is.

Experience in hospital

I got to know people when I walked about. I could please myself.

Staff on the ward worked hard. They never slacked off.

[At A & E] triage was very busy, but we had a 3- or 4- minute wait for triage then after 15 minutes transferred to a room with a bed. A proper room with a door not curtains. They took bloods. An Assistant Practitioner asked for more blood tests, they were really good, kept us informed. People brought refreshments every couple of hours. Everyone was really nice despite it being manic. When treating you they didn't appear to be rushed. After the final blood test, they admitted her because she had been at A & E twice in a week and they needed to get to the bottom of it. After 5 hours we were transferred to Brearley. She had a chest x-ray.

Brearley really make an effort. There is a day room where people can have lunch together with a tv and books. She was in for 10 or 11 days to keep an eye on her and gave her a blood thinner so were waiting for blood to get back to normal. Her blood pressure was high, so she had tests, it took a while to organise the ECG, and she had a scan of her heart.

Moving wards

Initially she was admitted to the Frailty Unit then they transferred her to Brearley after a 1-night stay. It was fine moving. Everyone was really professional, had time for us, they couldn't have been nicer.

No [I didn't want anything done differently], they were very good they were. I could do things for myself and they didn't mither me. I could walk as much as I wanted to.

Feelings about going to a nursing home

I can't say I was overjoyed, but realised I'd got to, I couldn't go home straight away.

Was the stay wanted?

That is one of the issues; social care takes so long, but on the other hand it's a period of convalescence. She looks so much better and got some food inside her. The delay might not be a bad thing.

Transfer from hospital to R2 bed nursing home

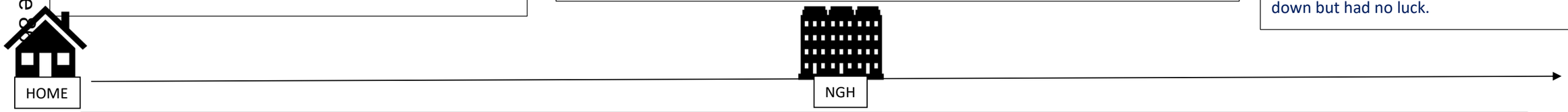
Happy with the discharge?

We were waiting all day in the discharge lounge. I was the first one to go in and the last one to go out at night.

She arrived after 5pm, I kept ringing up. I knew she was coming here so I rang here.

Katherine's relative confirmed she was not given the phone number. She had looked it up.

They lost her walking stick [in the move from hospital to nursing home]. We tried to track it down but had no luck.



Communication in hospital about stay in R2 bed

When told about R2 bed stay

They phoned and told me and said they would say when they got a bed. That was about 8 days before, then a couple of days before the move they rang and told me.

They didn't tell me where; I knew I was going somewhere.

Thoughts on reason for the stay

I wasn't capable of going home and wanted something in-between.

Information given in hospital about what would happen next

- She was unsure whether the reason for going to a nursing home had been explained:

. I can't remember. I don't think they did. I had no idea.

- She was not given the right information at the right time:

No, they didn't tell you a lot. If you ask questions, I don't think they knew.

- She had enough information
- There was nothing else she would have liked to know
- Information given was easy to understand
- Katherine's relative said she had not seen the R2 information leaflet before and that it was possible her mum had been told things but forgotten them.

How to improve how information is given

Written information for people like mum who can't remember things. Particularly when they don't understand the meaning. I understand a lot, but the public don't know the names of test and things.

Experience at R2 bed nursing home

Was being at the home what you expected?

I didn't really know. I would have gone home but it was what I needed.

Thought and feelings about being at the home

I can't fault them.

When I walked in the first day and saw the battered room, I thought how can she stay here? but then realised how clean it is, how many staff, and how good they are. She stayed at a private care home for respite, but this is better. They are all professional; physio, nursing staff, social care, it's all here. It must cost a fortune. The cleaner was cleaning one of the rooms when someone had left, and they were so thorough. Everything is perfect, the food, you can go down for lunch, they work so hard.

Nursing home Vs care in own home

I'd come here, can't fault them at all.

The difference in how you look. It's like an old-fashioned convalescence.

Views on having enough of the right care and treatment to get better

Yes definitely. I'm walking the full length of the corridor each day.

Yes, particularly the good nutrition, hydration and physio.

NURSING HOME → HOME

Knowledge of what would happen next

…I'm going home and having carers.

There will be meds visits am and pm then twice a week a visit so she can get showered. The social worker has organised it. We'll change the Age UK hours to help. In the evening they'll get a meal ready and lunchtime to take her tout to church group or morrisons for her lunch every week. If I'm at home, I'll go once a week or more. We go away a lot in the summer. We've got a key safe and citywide alarms. The social worker told us she can have hot meals brought in twice a week and then there's microwave meals. One collapse happened when she was using the oven.

Thoughts and feelings about going home

Looking forward to it.

Thoughts on having enough support when back home

Yes [will have enough support].
We've got aids everywhere from when my father was alive. All the physical stuff is in place. We've not been using it but will do. There is a trolley to use for carrying food through. I think we'll have a whiteboard to write down who comes and when, what meals on what day and write what we want Age UK to do. We need to be more disciplined, less ad hoc.

Martha

Support at home before hospital

- No help at all. I didn't need any help [to manage my health], I was fine then.
- My daughter lives near me.

Health

- A heart condition.
- Overnight [hospital stays] sometimes with palpitations and then home the next day. That is going back a few years.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

No, nothing.

What has been good/best about the care and support you have had?

It's been excellent, all of it.

Have all the different people involved in your care worked well as a team?

Oh yes, they did yes.

Reason for hospital stay

I fell and broke my hip. I was at home, it's sheltered accommodation. I pulled the alarm round my neck. The ambulance came and took me to the Northern General. I went in on [date] and had an operation on [2 days later]; a hip replacement.

Thoughts on whether the hospital stay could have been avoided

If I didn't have breakfast, I can faint and fall. I was just about to get breakfast but got up to go to the toilet. I started sweating, in the bedroom and I knew I was fainting but couldn't stop myself.

Experience in hospital

They were ever so good to me. Staff were good and it was all lovely.

Moving wards

I think I might have moved I can't remember. In the finish I was on the surgical ward. I didn't mind at all, they moved me in my bed.

Feelings about going to have a nursing home

Feelings when told

I knew I wasn't fit to get back to my flat, so I could see the physio here.

Was the stay wanted?

Yes.

Transfer from hospital to R2 bed nursing home

It went okay. In an ambulance.

Happy with discharge?

Yes, everything was fine.

Experience at R2 bed nursing home

Was being at the home what you expected?

Yes, physio and everything like that.

Thought and feelings about being at the home

I feel very happy. I'm nice and comfortable and got my own room. The staff are lovely and very good.

Nursing home Vs care in own home

I'd choose to go home if there were nurses every day. When I go home, I will have carers anyway.

Views on having enough of the right care and treatment to get better

Yes, physio is good, and everything has been.

HOME → NGH → NURSING HOME → HOME

Communication in hospital about stay in R2 bed

When told about R2 bed stay

I can't remember. I was happy when they told me.

Thoughts on reason for the stay

…they told me to get well enough to go back to my flat.

Information about what would happen next

- The reason for going to a nursing home had been explained.
- She was given the right information at the right time
- Had enough information
- There was nothing else she would have liked to know
- Information given was easy to understand
- Had not seen the R2 information leaflet

Knowledge of what would happen next

I'm going home as soon as carers are arranged and done. It can be four times a day if I need them or just tell them if I don't need them.

Thoughts and feelings about going home

Yes, it will be nice to be back home.

Views on having enough support when back home

Yes, I don't think there is anything more I could have.

Relative telling Nelly's story

Support at home before hospital

- She was quite independent. I went three of four times a week to help with housework, shopping, taking care of her money.
- She lives on her own in a flat.

Health

- She suffered a stroke in 2006. Her mobility isn't that good. She shuffles instead of walking. She started having falls, I don't know when it started because she didn't tell me, she got herself up.
- I don't think there was anything she needed [in terms of support to manage her health]. She has regular 6-month reviews, and the GP at home is very supportive.
- Only the stroke when she's been in hospital before.

Overall experience

Thinking about your whole experience from going into hospital until now, what would have made it better?

More information about the financial side of things and the sooner the better.

What has been good/best about the care and support you have had?

Everybody being so kind and considerate, that is important.

Have all the different people involved in your care worked well as a team?

I think so.

Reason for hospital stay

This time it was a fractured pelvis. She was at home when she fell. I was on holiday, but my daughter and niece were going so it was my niece rang and then rang my daughter and got her to go round. She rang 999 and they sent an ambulance who took her to A & E, and she stayed at the Northern General.

Thoughts on whether the hospital stay could have been avoided
She just went.

She has got a walking stick by the bed, but she won't use it. I asked her to have a frame, she said no, or a wheelchair, she said no. She said no to an alarm, she says she can always get up,' it's no use for me'. She knows her own mind.

Experience in hospital

- … they were really good with her.
- It happened on the Friday; they were gonna send her home on Saturday. Then we said she can't walk and insisted she can't come home. Then she admitted that she was in pain, had an x-ray.

Moving wards

- She went from A & E to Frailty Unit for one night.
- …Then they moved her to Huntsman and then to [nursing home]. On Friday she had the fall and on Wednesday came here.

Feelings about going to a R2 bed nursing home

Was the move wanted (by you)?

I think so, yes.

Transfer from hospital to R2 bed nursing home

Fine, it was in an ambulance.

Happy with discharge?
Yes. It took a long time. Got here between 4 – 5 o'clock, but we thought it would be just after dinner[lunch].

Experience at R2 bed nursing home

Was the stay at the home as expected?
It was what I expected.

Thoughts and feelings about Nelly being at the home
I think it has been good.

She was upset and crying and wanting to go back to hospital. She can't cope with change. She quite likes it now. She knows she's going home.

Nursing home Vs Care in own home
Definitely here. It's been really helpful. She wouldn't walk with me but will with the physio.

Views on having enough of the right care and treatment to get better
Yes. The physio making her walk. I think she'd of given up more. They've been really good and strict.

Hospital stay during R2 bed stay

When she had an assessment [at the nursing home] she was sick so went back to hospital to check she as okay, it was back to A & E, on the Tuesday morning. She was waiting for an ambulance from here. At 11am she was sick, and it was 4pm when we arrived at A & E. At 8:30pm the doctor said she could go home here [nursing home] or stay the night. I told her she'd have to come back again if she was sick with blood again. She stayed then came back here the next day. We were on Red Bay [at A & E]. It was very late when they took her to a normal ward.

HOME — NGH — NURSING HOME — NGH — NURSING HOME — HOME

Communication in hospital about stay in R2 bed

Thoughts on reasons for the stay
I spoke to a couple of nurses, asked about the procedure. They explained that when she was medically fit, she could go home. I said she will need carers, then they sent her here to be properly assessed.

Information given in hospital about what would happen next

- The reason for going to a nursing home was explained.
- She was given the right information at the right time
- Had enough information in some ways:

Yes, when I asked about mum not eating in hospital the doctor came as soon as I got there. They were really good and told me what happened. When I was concerned about her eating the doctor came again.

- There was some other information she would have liked to know:

…They were asking the woman across what she had got at home; in depth. She'd got lots of things, but they didn't ask my mum. If [they did not ask] because she was coming here, I don't know. Why is it different because she is having an assessment here? She [the other woman in hospital] had physio but they said my mum was having her assessment here [nursing home]. They don't ask the family enough. When you've not had carers before, you'd have thought you would have been given more information earlier about how it works, and I could explain to my mum about the package. I asked here [at the nursing home], what will happen with care and the medical side. They gave me a form for medications. I'm worried she'll not get funding. I would have liked more information earlier, and about the financial side. It would have eased my mind a lot.

- Had not seen the R2 information leaflet

Knowledge of what would happen next

I got a phone call this morning. Financially I don't know if we could have borrowed the money. I've got it all, aids and adaptations, a key safe.

I presume the care is funded because she was gifted pension credit, I'm not sure but its free for 6 weeks.

No [I don't know when she is coming home]. They want all these things in place. They get to know the day before or a few days before that they've got care in place. I think when you've not had care before you should be given at least a couple of days' notice. I've got to start arranging to be there.

Thoughts on going home

I always worry about if she falls.

Thoughts on Nelly having enough support at home
I don't think so [there is nothing else needed].

CQC Local System Review Action Plan

Date: 27th November 2019

Author(s):	**Jane Ginniver, ACP Deputy Director (Development)**
Date:	**5th November 2019**

1. Purpose

This paper identifies progress made since the CQC Local System Review (LSR) on Older People's Care in Spring 2018.

2. Introduction / Background

The action plan following the CQC LSR on Older People's Care was approved by the ACP Board in July 2018, and quarterly updates tracking progress against this action plan have been regularly completed and reported back to both the ACP Board and the Health and Wellbeing Board. This review is more in-depth than these previous quarterly updates, and refers back to the original CQC recommendations, noting what achievements have been made over the intervening period, what work is still in progress and continuing challenges.

The report identifies significant achievements made over the past 12-18 months, including:

- A marked improvement in DToC figures; this stood at 34 for w/c 8th October 2019, compared with 99 for w/c 23rd October 2018. This is the result of concentrated working at system and organisational levels, which has become embedded in many areas, and with new processes now being established to ensure that this is sustained
- A sustained reduction in the number of people being admitted to care homes in the city. This stood at 988 per 100,000 population in 2015/16, reduced to 824 per 100,000 in 2016/17, then again to 750 per 100,000 in 2018/19
- Co-production and public engagement in the development of new services and pathways are becoming increasingly viewed as the 'norm' at system level. This has been seen across the work of the Mental Health and Learning Disabilities Board, during the development of both Shaping Sheffield and the ACP Workforce Strategy and in the establishment of the 'Integrated Accountable Care Forum' – the ACP's public advisory body run by Healthwatch
- Progress in embedding the voluntary sector as a key strategic partner. They have joined the ACP as a formal partner, now have named members of all workstreams and the ACP's EDG has approved funding of £50,000 to further embed this work
- A comprehensive workforce strategy was approved by the ACP Board in October 2019. Systems leadership development work completed covers various levels and roles of staff across the sector
- The establishment of the Joint Commissioning Committee will simplify and strengthen

commissioning across the city around frailty and other areas
- A system level focus on mitigating winter pressures, including the engagement of voluntary sector services.

Some challenges continue. These primarily relate to information sharing arrangements and technologies. While these are being addressed through the ACP's Digital Workstream, they are not quickly resolvable and are likely to continue for some time.

Almost all of these work activities are now embedded within the project plans of various groups and projects across the ACP and more widely:

- The ACP workforce strategy
- The ACP contract with Healthwatch
- The Ageing Well Board
- The informal 'Strategy Hub' – a meeting of the organisational Strategy Directors and equivalents
- The Primary Care Board
- The Digital Transformation Board
- The Better Care Fund
- Joint Commissioning Committee

We plan to continue monitoring this consolidated CQC Local System Review action plan for at least another 6 months. We will need assurance that the actions identified are having (or are highly likely to have) the required impact on support for Older People across Sheffield before these activities are subsumed within 'business as usual'.

3. Is your report for Approval / Consideration / Noting

Noting

4. Recommendations / Action Required

The Scrutiny Committee is asked to note the contents of this report

5. Other Headings

N/A

6. Are there any Resource Implications (including Financial, Staffing etc)?

No

Review of the Action Plan following the CQC Local System Review on Older People's Care

1. System leaders must continue to engage with people who use services, families and carers and undertake a review of people's experiences to target improvements, bringing people back to the forefront of service delivery.		
Achievements to Date	**Work in Progress**	**Challenges**
• A lot of engagement work done by the ACP on the development of key strategies over the past 12 months. Eg extensive consultation during the development of Shaping Sheffield and the workforce strategy. • The importance of involving Sheffield citizens in service design and delivery is embedded within our leadership development programmes. • A cross-organisational group has been established to collaboratively investigate and address system-level complaints, with learning being shared to establish a common process to be used by all ACP partners. • A contract with Healthwatch has led to the establishment of the 'Integrated Accountable Care (IAC) Forum'; a public advisory group with whom the ACP and its workstreams have consulted on the development of numerous pieces of work.	• A longitudinal study tracking a number of patients from the ward for a period of 6-9 months, to review experiences across their patient pathway. • Continued investigation of system-level complaints to ensure that new ways of working become embedded. • A recent workshop facilitated by Healthwatch brought together ACP workstreams with members of the public, the outputs from which will create some principles around public engagement for ACP partners to use when developing new work.	• Data sharing restrictions have inhibited the extent to which information can be shared across the ACP with a view to improving people's experiences.

2. System leaders must work together to create the required culture and conditions to support integrated care delivery.		
Achievements to Date	**Work in Progress**	**Challenges**
• A vision for the Ageing Well Board is articulated within Shaping Sheffield, with a shift in focus to 'prevent, reduce and delay multi-morbidity', rather than frailty or older age. This is appropriate and in line with the wider system prevention and integrated focus. • The Joint Commissioning Committee has identified frailty as one its 3 priorities. • Work to develop a person-centred city is progressing at pace. For the first time, a system-wide approach to 'What Matters to You' day was adopted in 2019, and STH held a dedicated personalised care conference. The person-centred city group has commissioned research into how we embed person-centred approaches and this is integral to the ACP workforce strategy, with £60k secured from HEE for cross-system frontline staff training. • 'Leading Sheffield' is our system leadership development programme which is now in its second cohort. An ACP Shadow Board has been funded through the NHS Leadership Academy. 'Collaborate' is a frontline-staff equivalent of Leading Sheffield led by	• Work to develop a shared Quality Improvement (QI) language is progressing, with Sheffield City Council staff now engaging with the microsystems approach. More work needs to be done to embed this and to ensure that the wider system benefits from shared QI approaches. This is captured within the ACP workforce strategy.	• Limitations around digital interoperability inhibit integrated working. This is being addressed to some extent through the digital workstream but this will take time to be implemented. • Individual organisational policies around access to premises, staff inductions and staff access also inhibit the opportunities for integrated delivery.

the community group SOAR, with plans to extend this more widely across the city. • The workforce strategy includes 'culture' as its primary theme, with an organisation development focus to enable the development of the culture required to support integrated care and delivery.		

3. Health and social care leaders across Sheffield should work together to align their transformation delivery programmes and strategies. Health and social care must be equal partners in the system transformation programme and strategic direction.		
Achievements to Date	**Work in Progress**	**Challenges**
• System wide improvement programmes have been applied to the End of Life (EoL) and CHC pathways. EoL is a priority within the city's Health and Wellbeing Strategy and is embedded within the ACP Ageing Well priorities. • Governance arrangements of the Health and Wellbeing Board and ACP Board changed to ensure separate chairing arrangements. • The Shaping Sheffield Plan developed to outline the priorities and delivery intent of the ACP workstreams. All workstreams now have clear membership and leadership arrangements. • The successful bid for NHS England funding to	• An EoL needs assessment is progressing at pace • CHC processes are a key part of the ongoing care programme • The development of clear action plans for all ACP workstreams • Investment through the Social Outcomes Fund currently being finalised to support the Ageing Well Board priorities. • A draft integrated model of care has been developed. This is now in the process of wider consultation across the ACP workstreams and the IAC Forum prior to implementation.	

transform community mental health provision was a result of sustained and embedded partnership working within the Mental Health and Learning Disabilities team.		

4. System leaders should undertake evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.		
Achievements to Date	**Work in Progress**	**Challenges**
• The 'Operational Resilience Group' (feeds into the ACP's Urgent and Emergency Care Board) have progressed a range of activities in this area. This includes the daily dashboard, winter resilience planning and pathway reviews.	• This needs to be on ongoing action following all periods of escalation.	

5. System leaders should plan more effectively for winter and demand pressures throughout the year, ensuring lessons are learned and applied when planning for increased periods of demand.		
Achievements to Date	**Work in Progress**	**Challenges**
• EMG agrees the utilisation of winter funding, in line with plans agreed by the Operational Resilience Group following a review of learning from the previous year/s.	• A process is currently being established, reporting directly to the relevant Chief Executives to embed this learning and to ensure we are more strategic and proactive in managing periods of increased demand.	

6. System leaders should continue to implement the recommendations of the Newton Europe review and evaluate their effectiveness. This needs to inform strategic planning and delivery.		
Achievements to Date	**Work in Progress**	**Challenges**
• The Local Government Association (LGA) has recently evaluated the 'Why Not Home, Why Not Today' programmes, and hosted a seminar to feedback the outcome. • The task, flow and COO escalation process has been reviewed to ensure it remains fit for purpose. • Weekly charts are shared with system leaders and operational staff to ensure a clear understanding of all levels of flow and delays.	• Further actions are recommended to maintain grip on the system and to ensure the reduction in DToC is sustained (to link with the action in 5 above).	

7. System leaders should develop a more proactive approach to market management in adult social care. They should continue to focus on domiciliary care to ensure that the proposed changes are effective. Strategic conversations must take place with people delivering services when these services are being recommissioned to establish the impact on service delivery.		
Achievements to Date	**Work in Progress**	**Challenges**
• Remodelled contracting and commissioning service to provide clearer focus on brokerage and quality assurance in independent sector, plus restructured team to better support. • Draft propositions on outcome based homecare	• Ongoing development of links between housing and care at SCC • Capital requirements for housing being developed. • Joint development of supported housing	

developed which will help develop a different longer term approach.	focusing on key schemes where health, housing and care can be better aligned.	

8. System leaders should develop a workforce strategy across health and social care and include providers in the VCSE sector to ensure a competent, capable and sustainable workforce.		
Achievements to Date	**Work in Progress**	**Challenges**
• A workforce strategy has been developed in consultation with all ACP partners, including voluntary organisations and members of the public. • £60k funding from HEE secured to support the implementation of training for frontline staff on person-centred approaches. • £370,000 secured from HEE to support innovation in the development of training placements across Sheffield, plus an additional £50k each to STH, SCH and SHSC to support organisational placement initiatives.	• The strategy now needs to be developed into a comprehensive implementation plan. • 5 priorities identified within the strategy for 2019-20 action are underway.	

9. To ensure there is robust evaluation supported by data to inform commissioning decisions, system leaders should have a more coordinated approach to running pilots and developing innovations; it should be clear how they will fit in with the wider strategic plan and how quality information will be used to evaluate them against identified focuses for improvement.		
Achievements to Date	**Work in Progress**	**Challenges**
• The 'Why Not Home, Why Not Today' (WNHWNT) Board delivered 7 programmes of transformation, including the off-site beds initiative. The programmes were evaluated and plans are in place to progress those that are successful. • BCF funded schemes are evaluated and continuation considered on an annual basis.	• Work is progressing to undertake a deeper dive of all services that support flow in order to support the 20/21 BCF planning process • The Joint Commissioning Committee will hold officers to account to ensure joint commissioning intentions support new models of care and better patient experience. • The Joint Commissioning Committee will be supported by EMG to establish a joint commissioning plan to deliver new models of care and support the shift in investment focus to prevention.	

10. The discharge process should be evaluated incorporating the views and experiences of people using services, their families and carers. During this process system leaders must consider the multidisciplinary approach, clarity of the process, the three routes to discharge from hospital, the choice policy and the quality and consistency of the information provided. Following this evaluation, revised processes must be implemented and evaluated.		
Achievements to Date	**Work in Progress**	**Challenges**
• Services commissioned from the voluntary sector to engage with patients on the wards and to provide support to carers with choices on discharge. • The 3 routes out of hospital and all of the services available within these routes have been mapped. Staff were engaged with to share this information, gaps have been identified and work is progressing to add capacity in these areas. • The WNHWNT Board ran a therapy programme, ensuring that all patients are offered a core assessment and that a triage tool is on all wards. • The WNHWNT 'Safer' programme implemented gold level ward rounds on all high DToC wards. • 'Red to green' is embedded on elderly wards and is providing intelligence on delays to support flow.		

11. There must be a review how people flow through the health and social care system, including a review of pathways so that there are not multiple and confusing points of access. Specific focus should be given to prevention, crisis and return. Pathways should be well defined, communicated and understood across the system.		
Achievements to Date	**Work in Progress**	**Challenges**
• Links to the achievements under recommendation 10, specifically the review around the 3 routes out of hospital and the services commissioned from the voluntary sector. • A CCG-funded pilot run by Age UK Sheffield, the Sheffield Carers Centre and SCCCC to support the quality of transfers, focusing on mitigating winter pressures.	• Link with the action in 5 above.	• Improving the sharing of information across organisations to improve the flow of patients and to ensure they are accessing the most appropriate services.

12. There must be an evaluation of health and social care professionals' skills in communication and interaction with people to establish where improvements are needed.		
Achievements to Date	**Work in Progress**	**Challenges**
	• Developing this training, particularly aimed at frontline staff, is a stated priority for 2019-20 within the workforce strategy and we have secured £60k from HEE to implement it.	

13. Housing support services should be included within multidisciplinary working, especially in relation to admission to, and discharge from, hospital, to enable early identification of need and referrals.		
Achievements to Date	**Work in Progress**	**Challenges**
• Closer relationships between housing and ASC leading to better delivery of equipment adaptations		

14. There should be a review of commissioned services to consider outcomes, design and delivery to improve the effectiveness of social care and CHC assessments.		
Achievements to Date	**Work in Progress**	**Challenges**
• The 'Ongoing Care' programme has evaluated the CHC process, values and integrated work.	• New values are currently been embedded. Plans are progressing to agree integration in the longer term.	

15. There should be a review of the methods used to identify carers eligible for support so that they are assured that carers are receiving the necessary support and have access to services.		
Achievements to Date	**Work in Progress**	**Challenges**
• The CCG has invested in a range of voluntary sector services to support carers, this included a particular service to work with carers in hospital to provide	• Work is ongoing with carers' organisations through the workforce strategy implementation work, as carers are included within the remit of	

advice and support prior to discharge.	this strategy.	

16.The trusted assessor model should continue to be embedded.		
Achievements to Date	**Work in Progress**	**Challenges**
	• This work is being continued – this will be an ongoing action.	

17.The criteria for the re-ablement services should be evaluated and reviewed.		
Achievements to Date	**Work in Progress**	**Challenges**
	• A single specification for this service is being developed for implementation in 2020/21	

18.There should be a specific focus to bridging the gap between the single point of access and First Contact, community and acute preventative services and rehabilitation. Social care providers should also be part of this process to align services and develop collaboration between all system partners.		
Achievements to Date	**Work in Progress**	**Challenges**
	• A draft integrated model of care has been developed and it is going to be a particular focus for Chief Executives and the Executive Delivery Group of the ACP . This is now in the process of wider consultation across the ACP workstreams	• There will inevitably be ongoing challenges with this as we implement a more integrated model of care – some foreseen, others not.

	and the IAC Forum prior to implementation.	

19.Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation.		
Achievements to Date	**Work in Progress**	**Challenges**
• VAS was made a formal partner of the ACP in 2018. • Several services were piloted with the voluntary sector to support flow during winter 18/19 and summer 19/20. Inclusive of a project to review all existing schemes and recommend services for the future. • VCF representatives have been identified for all workstreams. • The benefits of working together in the workstreams has been evidenced through MH and access to funds this way. Likely to be further opportunities coming down from ICS / NHSE in this way.	• Commitment of £50k made in summer 2019 through EDG & Board, and acknowledged this is just a starting point.	• Still need to work on developing the strategic position of VAS within the ACP.

Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee Wednesday 27 November 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 15th January 2020 4pm Locality Working		
Working together in Localities	To consider how we are working in localities with a focus on Primary Care Networks and Social Work Locality working - what is the ambition, where we are now, what do we need to do to achieve the ambition, and evaluate how joined up things are in practice – with a focus on impact.	Nicki Doherty CCG Sara Storey, Tim Gollin, SCC Dawn Shaw, Lorraine Wood, SCC
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*
Mental Health Strategy	*To consider Development of the Mental Health Strategy*	*SCC*

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