Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 15 January 2020 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
15 JANUARY 2020

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 - 14)
To approve the minutes of the meeting of the Committee held on 27th November, 2019.

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

7. Neighbourhood and Primary Care Network Update (Pages 15 - 28)
Report of Nicki Doherty, Director of Delivery, Care Outside of Hospital, NHS Sheffield CCG.

8. Locality Social Care and South East Neighbourhood Working Update (Pages 29 - 54)
Joint Report of Sara Storey, Interim Director, Adult Services and Dawn Shaw, Director, Libraries, Learning, Skills and Communities.

9. Work Programme (Pages 55 - 62)
Report of the Policy and Improvement Officer.

10. Date of Next Meeting
The next meeting of the Committee will be held on

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

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

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 27 November 2019

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

Non-Council Members (Healthwatch Sheffield):-

Lucy Davies

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Lewis Dagnall.

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 Councillor Angela Argenzio declared a personal interest in Item 6 – Sheffield Continuing Healthcare – Collaborative Service Development Update – as her employers own a residential home and the report contains a lot of information about care homes and continuing care.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 16th October, 2019, were approved as a correct record.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 The Chair, Councillor Cate McDonald, stated that the NHS representatives had declined to attend the meeting due to it being held in the pre-election period before the General Election and the sensitivity of the items to be discussed. Councillor McDonald expressed her dissatisfaction at this, given that the Scrutiny Committee is a statutory body, and the Committee agreed that a letter should be sent to the Clinical Commissioning Group (CCG) expressing their disappointment. The questions asked will be forwarded to the CCG or the appropriate NHS body for their response.

5.2 **Question from Rita Brookes**

5.2.1 Paragraph 70 of the National Framework for NHS Continuing Healthcare states:
"Assessments of eligibility for NHS Continuing Healthcare and NHS-funded Nursing Care should be organised so that the individual being assessed and their representative understand the process and receive advice and information that will maximise their ability to participate in the process in an informed way. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike".
One of our frequent complaints has been that Sheffield CCG does not take any steps to ensure that there is compliance with this requirement. This results in individuals and their representatives being severely disadvantaged throughout the process.
At present there doesn't seem to be any improvement to this position. What has Sheffield CCG done specifically to address this problem?

5.3 **Questions from Sue Harding**

5.3.1 Page 12 of the CCG slide pack (Page 24 of the agenda pack for this meeting) shows that 91% of appeals had the original decision upheld at a local level from April to September 2019. This would seem to be a questionable measure of success to use.
How many people were refused continuing healthcare funding during this period and how many of those refusals turned into an appeal? This is an important indication of the health and accessibility of an appeals system.
The small numbers involved (22) could indicate that the system is not easy for a lay person to navigate. People could be dissuaded from appealing for a whole variety of reasons, some of which we have experienced.
When considering the number of appeals upheld, a high percentage (91%) could be an indication of bias on behalf of those handling the appeals.
There is national concern regularly reported in newspapers about why almost the entire appeals process sits within the NHS. A recent article in a national newspaper stated
"There should be some kind of independent body that regulates or oversees this process because at the moment the NHS is the judge, jury and gatekeeper".
Is the Scrutiny Committee content to rely on such a flawed procedure as a measure of improvement?

5.3.2 Page 17 of the CCG presentation (page 17 of the agenda pack) refers to the results of the "How did we do" questionnaire.
The satisfaction levels shown on this slide are impressive but there must be some concern about how this survey was conducted.
How many of the 60% plus people shown as satisfied were people who had been refused CHC funding?
When were the questions asked? During the process or afterwards when the result of their assessment was known?
How were the questions asked? In person? By phone?
What questions were asked? Were participants simply asked "were you satisfied?" or were they asked more specific questions like "what was done to prepare you for the DST assessment?" "How helpful was that?"
"Did you understand what was said during the Assessment?" "Was jargon used

and if so was it explained?"
I could expand further……
Were the questions asked vetted by any sort of professional who is trained in the science of asking unbiased, non-leading questions in surveys?

Without this sort of detailed explanation, is the Scrutiny Committee content to rely on these satisfaction indicators as any true measure of the quality of the assessment process which affects several hundred people in Sheffield every year?

5.4 The Chair said that she could only answer all three questions in part, and some might form part of the presentation during the meeting.

5.5 **Question asked by Andy Hiles**

5.5.1 Mr. Hiles stated that he was addressing the Committee to bring to their attention certain employment practices which have crept into the NHS. He referred to a lady who was in attendance at the meeting and said that she was "bank" staff and called into question the practices of the NHS and how they treat "employees" and "bank staff"

5.5.2 The Chair said that she would take advice on the role of the Scrutiny Committee on such an issue, and would respond in writing to the question raised.

5.6 **Question asked by Joanne Arden**

5.6.1 This question relates to the proposal to change the way the Council pays care home fees currently paying the net contribution to care homes changing to gross contribution.

As the owner and operator of Cairn Home at Crosspool we are concerned about the negative cash flow implications of this change. Currently we collect our fees from the resident by weekly direct debit but the Council pays every four weeks, two weeks in arrears and two weeks in advance. Whilst this will have a negative impact upon our cash flow, this will be minor compared to what happens when a new resident is admitted, frequently it taking many months before any payment is received from the Council. In the last year we have had one resident where it was over six months before a payment was received. Under the current system, at least we have the money from the resident coming in each week.

From the Council's perspective, you are looking at an annual cost of £715,000 to implement this change at a time when the Council is under severe financial pressure, and if this money is available we would suggest that it could be more effectively spent on increasing the gross care home fees, not making a negative impact on the cash flow of care homes.

Please can this be reconsidered?

5.6.2 The Chair said she would respond in writing to the questions raised.

6. SHEFFIELD CONTINUING HEALTHCARE - COLLABORATIVE SERVICE DEVELOPMENT UPDATE

6.1 The Committee received a report and presentation by Sara Storey, Interim Director of Adult Social Care, Sheffield City Council, providing an update on how the changes that have been implemented through the Collaborative Service Development, are impacting on the people in receipt of ongoing long term care and their representatives.

6.2 She said that the Council's Ongoing Care Service was committed to working to improve services by looking at barriers, challenges and difficulties faced by families and how the Service can be improved. The Service had agreed to sign up to the values and principles and was working in partnership with the Clinical Commissioning Group (CCG) to deliver helpful, responsive and timely support to those in need.

6.3 She referred to the "How did we do" questionnaire which gave people in receipt of care services, the opportunity to share their experience of the services they received. Gathering feedback from the questionnaire was still in the development stage, however Sara Storey felt that the questions that had been asked were the right ones, and had been supported by Healthwatch, in terms of setting up focus groups as to ascertain what type of questions were the right ones to ask of those people who had previously been in receipt of care from the Council and those currently receiving care and what was their experience and support received in terms of their long term needs. Data had shown that not everyone was able to get their views across for a number of different reasons, i.e. not everyone was able to fill in a form; some people do not answer their phones; some are not able to answer questions online or are uncomfortable at answering questions about themselves in any format and that the offer of help was there to those people who need support in accessing advocacy. It was important to engage with people using the service, as well as the frontline staff, voluntary sector organisations and carers delivering the service and that a clear process needed to be put in place, particularly when a complaint had been received regarding the level of care someone was receiving.

6.4 She said that a process was in place to resolve issues when the City Council's Social Workers disagreed with Continuing Care Nurses about the level of care and support someone was receiving, there needed to be a clear process in place to identify someone's needs by talking to each other, by working better together, although there was more work to be done to resolve these disputes. If managers were unable to find an amicable solution, the dispute was then escalated to a higher level, but this had only happened in a small number of cases.

6.5 Sara Storey said that the number of complaints relating to continuing care had reduced and that responsibility for managing appeals had recently transferred to NHS Doncaster CCG to ensure that the process was independent. She believed that a more integrated approach to workforce development would deliver a consistently high quality service experience.

6.6 Lucy Davies, Healthwatch representative, stated that with regard to the questionnaire shewelcomed the fact that the Sheffield Clinical Commissioning Group (CCG) had taken steps to gain feedback from service users, however she felt that feedback scores only related to specific parts of the process. She referred to a case study and said that his version of the level of care he had received differed vastly from that of the CCG and his experience doesn't reflect the care outlined by the CCG. She had two questions to ask, firstly, how was the CCG measuring the impact of the new set of values and behaviours put in place when they hear stories similar to the one she had outlined and what are they doing to unpick how to do things differently. Secondly, does the Social Care Service feel assured that when someone is moved from Social Care to Continuing Health Care (CHC), is the Service assured that the person has adequate care management and also that their social care needs are going to be met.

6.7 In response to the comments made by Lucy Davies, Sara Storey stated that each person was individually case managed. There are on average up to 11,500 adults in social care and that for every complaint received by the City Council, the correct procedure was put in place to deal with it. Ms. Storey stated that what was working well was the care at night service, which were formally undertaken by two separate services, one commissioned by the City Council and the other by the CCG. If someone was identified, via the district nurse or social worker, as having care needs during the night, they would have to go through a lengthy process, and if change to that care was required, they would be passed from one provider to another. Through joint commissioning, a more efficient and effective service was being provided.

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

- Adult Social Care (ASC) in the past was extremely process driven with targets and tick boxes and constraints caused by austerity. There used to be a 24 page assessment form and this has been reduced, by working with people, listening to them and finding out what was happening to them, we feel we are now in the position where we have a vision and strategy how to deal with people. It was accepted that the Service was not getting it right all the time, but now have more of an understanding of what was needed to be done and what the staff and workforce need to get it right.

- The decision to move the Continuing Health Care (CHC) appeals service to Doncaster CCG was taken by the Sheffield CCG and was not a Council decision.

- With regard to digital capacity, one of the problems experienced was that the Council and the CCG have completely different information and data capturing systems, so there was no method or way of capturing and holding information on people who go through a full process, in a way that enabled the Service to compare year-on-year the care being provided, but information from previous years to compare with was unavailable. The ASC Service was looking at how the current case management system can be changed to incorporate all documents and information into the same

system. The aspiration was to have one system so that City Council and the CCG can look collectively and staff don't use two systems to log, store and move information around. The current system the City Council uses was Liquid Logic, and a module was being developed around continuing health care, but it was felt that an interim system should be put in place to reduce duplication and capture information across the board, so work for this was going out to tender, but there was still a lot of work to be done in that area.

- With regard to reassessments, it was felt that this had definitely improved. More social workers were given more notice to attend meetings, the problem in the past being that they were given short notice that a meeting was going ahead and therefore the Service would be struggling to release Social Workers to attend meetings to support people or they would be struggling to find someone who knew the person well enough to provide the personal element required. It was not known, at present, what timescale would be considered appropriate, whether it was days or weeks. The Service would be interested in people's views on the process to express what they would consider to be timely for them.

- In response to questions about Members not being confident that the appeals process was independent, it was felt that there should be a level of knowledge and understanding about nursing care needs, health care, social care needs etc. and that a level of professional experience on the Appeal Panel when making those decisions was necessary.

- When asked whether people are being signposted appropriately, it was noted that the Council has been looking at benchmarking data in other areas to try and get an idea of whether the staff that normally fill in the initial healthcare checklist, are filling it in properly and talking to people to direct them to the best care available. Looking at Sheffield numbers, its good to know whether we're doing enough or not enough and reminding staff on a regular basis wherever possible, to always bear in mind is this person eligible for continuing healthcare.

- The Service would like to raise expectations. It is, to a certain extent and more particularly the CHC, tied to the NHS national set of guidance, criteria and casework assessments etc. and has limited ability to influence what they look like and how they are set up. The Service is looking at introducing an initial "Welcome to the CHC Service" contact with people, for those who are able to communicate initially over the phone, looking at rolling out the customer satisfaction feedback reviews, looking at how to get in touch with people early on and supporting and managing their expectations and to be clear with people as early as possible of what they can expect in adult care.

- The figures regarding the value for money of the night care service were not to hand at the meeting, but the figures will be made available to Members of the Scrutiny Committee.

- There hasn't been any difficulties recently in recruiting social workers into

adult social care, although children's services have not always had the same issues as adults. There had recently been a round of recruitment of Social Work Prevention Officers and Care Managers on a similar grade and 150 applications for the post of Social Work Prevention Officer had been received. The Service had changed its approach to recruitment. In the past, it had always recruited newly qualified workers to a lower grade, however there had been an increased number of Social Work Apprenticeships and Occupational Therapy Apprenticeships and the Council were recruiting at higher grades to encourage more experienced Social Workers and thereby creating a good mix of skills. There had been a good response from people prepared to work across the board. The City Council was very clear about what was expected from its workforce and was working with HR colleagues to make sure job descriptions were up to date.

6.9 The Chair stated that a number of questions had been asked at the meeting and she was preparing to submit them to the CCG to provide answers, and she would request that the CCG attend a meeting of the Scrutiny Committee in February, 2020, the focus to be on the person centred approach to CHC and the appeals process.

6.10 RESOLVED: That the Committee:-

(a) thanks Sara Storey for her contribution to the meeting; and

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

7. WINTER PLANNING

7.1 The Committee received a report of the Interim Director of Adult Social Care (SCC) on Winter Planning which gave details of the 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.

7.2 Present for this item was Sara Storey, Interim Director of Adult Social Care, Sheffield City Council.

7.3 Sara Storey stated that the last year had been very challenging with regard to delayed transfers, particularly during the winter months, but there had been notable improvements. She said that the real focus had been on getting people home after a stay in hospital and Sheffield Teaching Hospitals Trust was still under a lot of pressure to make this happen. She added that the city has a good home care network and support agencies were working well together.

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

- With regard to the documents that were embedded within the report, it was

confirmed that links to those documents would be made available.

- The City-Wide Care Alarm Scheme (CWAS) is now offering support similar to the Community First Responder (CFR) scheme in other areas operated by the Yorkshire Ambulance Service, where volunteers are trained to use life-saving skills in their local area; the CFRs are volunteers based within the community). Now, if someone calls 999 or 111 and has fallen but is not injured, CWCA can attend. Even if an alarm is not activated, they may only be a minute or two away from a medical emergency and very often their role is to simply provide vital reassurance to patients and their families.

- Even if someone doesn't have a city-wide alarm, they can be redirected to the service.

7.5 RESOLVED: That the Committee:-

(a) thanks Sara Storey for her contribution to the meeting; and

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

8. CQC LOCAL SYSTEM REVIEW ACTION PLAN

8.1 The Committee received a report setting out the progress made since the Care Quality Commission's Local System Review on Older People's Care in Spring, 2019.

8.2 Present for this item was Jane Ginniver, Deputy Director (Development), Accountable Care Partnership.

8.3 Jane Ginniver referred to the achievements to date, the work in progress and the challenges still to be met. The most significant achievements made was a marked improvement in Delayed Transfers of Care and a sustained reduction in the number of people being admitted to care homes across the city.

8.4 RESOLVED: That the Committee:-

(a) thanks Jane Ginniver for her contribution to the meeting;

(b) notes the contents of the report; and

(c) expresses satisfacion that progress is being made in implementing the action plan.

9. WORK PROGRAMME

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

9.2 RESOLVED: That the Committee approves the contents of the draft Work Programme 2019/20 and requests that an additional meeting of the Committee be

scheduled for 26th February 2020, to consider the draft Mental Health Strategy.

10. DATE OF NEXT MEETING

10.1 It was noted that the next meeting of the Committee will be held on Wednesday, 15th January, 2020 at 4.00 p.m., in the Town Hall.

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Report to January Scrutiny & Policy Development Committee 15 January 2020

Report of: **Nicki Doherty Director of Delivery, Care Outside of Hospital, Sheffield CCG**

Subject: **Neighbourhood and Primary Care Network Update**

Author of Report: Sarah Chance, Neighbourhood Development Manager

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Summary:
This report gives an update of the neighbourhood transformation monies and an overview of the current position since the introduction of the Primary Care Network Direct Enhanced Service (PCN DES)

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:

The Committee is asked to note the developments within Sheffield primary care.

Background Papers:

The link below looks at service specifications for the Network contract Direct Enhanced Service for PCNs covering the 5 new specifications.

https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/

Neighbourhood Transformation Specification

Category of Report: OPEN

Report of the Director of Nicki Doherty Director of Delivery, Care Outside of Hospital, Sheffield CCG

Neighbourhood and Primary Care Network Update

1. Introduction/Context

In 2016 Sheffield CCG introduced a Locally Commissioned Service (LCS) to encourage practices to engage in a Neighbourhood way of working. This LCS saw 16 Neighbourhoods begin to engage with this approach and build foundations to mature and to identify the extent of their ambition.

> *"Neighbourhood is Health, social care and all statutory and voluntary sector stakeholders working together to coordinate health and social care for people in their local area, and consider how to make the best and most effective use of local services. Each Neighbourhood has a set of priorities based on the health and social needs of their particular area. There is also a strong focus on preventing ill health, reducing unnecessary hospital admissions and supporting people to gain control of their own health and wellbeing"*
>
> *Sheffield Neighbourhood Definition*

It was envisaged by Sheffield CCG that neighbourhoods would be a key vehicle for the delivery of health and social care services working within the Accountable Care Partnership.

Since then the NHS Long Term Plan (January 2019) has set out an ambition for a new service model fit for the 21st Century; a model that complements the Sheffield neighbourhood model and its ambition. The Long Term Plan sets out an ambition in relation to a multispecialty community provider approach, and describes a model of Primary Care Networks with community services working to the Primary Care Network footprints.

2. Current Position:

2.1 Primary Care Networks

In January 2019, NHS England published Investment and Evolution, a five-year framework for GP services. One of the most significant changes in the contract was the introduction of the network contract as a Directed Enhanced Service (DES).

"PCNs are groups of GP practices working more closely together, with other primary and community care staff and health and care organisations, providing integrated services to their local populations" Sheffield Network Definition.

The Network DES is designed to enable general practice to take a leading role in every Primary Care Network. The contract went live on the 1st July 2019. It is an extension of the core GP contract, which must be offered to all general practices and sees the Network being paid rather than individual practices.

The Network DES introduces:

- The role of a Clinical Director who can be a clinician from within the network practices. The role of the Clinical Directors is to develop relationships and work closely with peers and clinical leaders from across primary care, health and social care.

- Over the five year contract the networks are funded to develop their workforce with new roles, in year one networks receive funding for a social prescribers and a pharmacists, others roles from 2020 include a physiotherapist, paramedic and physician associate

    - Within Sheffield 14 out of15 Networks have recruited their link worker through a local voluntary organisation some choosing their local People Keeping Well partners whilst others have chosen Door 43 to do focused work on teenage mental health. The network without a link worker is Universities who are currently liaising with the University as there are plans to create new posts for 'student wellbeing' so the network want to be sure the roles do not duplicate but that aims are aligned.

- Each network will receive recurrent funding of £1.50 per patient for network development and for £1.45 per patient for extended hours

- Networks will benefit from an 'Investment and Impact Fund' up to the value of £300m by 2024 however no further details have been released on this.

- Additional new services from 2020

- A key component of the network DES will be the development and implementation of seven national service specifications which have just been published in draft format, the seven service specifications will be for:

1. Structured medication reviews and optimisation;
2. Enhanced health in care homes;
3. Anticipatory care;
4. Supporting early cancer diagnosis;
5. Personalised care (as part of the NHS comprehensive model);
6. CVD prevention and diagnosis; and
7. Tackling neighbourhood inequalities

- From 2021 it is currently intended that Networks will also receive £6 per head for Improving Access, this is currently the money invested in to the hubs managed by Primary Care Sheffield

As Networks are at the early stages of development and capacity-building NHSE will phase-in service requirements in a way that is commensurate with the capacity available to PCNs through the contract and the support available through wider system.

Initially Networks will be required to deliver two of the five specifications (Structured Medication Reviews and Optimisation and Enhanced Health in Care Homes) in full from 2020/21, phasing in the requirements of the Anticipatory Care, Personalised Care and Early Cancer Diagnosis specifications over the period from 2020/21 to 2023/24.

Each network will be provided with a network dashboard. The outline service specifications illustrate the proposed metrics that will be reported via the new network dashboard. The dashboard will help PCNs to understand their position and support peer learning and quality improvement.

The introduction of the network DES gave Sheffield neighbourhoods the opportunity to explore their population and geography, and a number of practices chose to realign to different neighbourhoods. Sheffield now has 15 networks/neighbourhoods, each with an identified Clinical Director(s) and Managerial Lead.

An illustrative map of the Networks/Neighbourhoods is provided in Appendix 1

2.2 Neighbourhoods

The commitment to neighbourhood working saw a number of initiatives taking place across the city, the organisation of neighbourhood steering groups and joint learning events across providers have further developed integrated relationships and ways of working.

In 2018, NHS Sheffield Clinical Commissioning Group (SCCG) invested £718k to fund six neighbourhood transformation bids as part of plans to deliver city wide development to transform care across Sheffield.

The implementation of some of the small scale projects has taken much longer than initially anticipated. However, all of the six sites are now successfully mobilising their plans. Each neighbourhood is now providing monthly highlight reports and are presenting at the Neighbourhood Development Group to update and raise any risk or issues that need escalating.

There have been a number of issues in relation to the recruitment of staff and additional issues around the impact of VAT. The implementation of the Primary Care Network Direct Enhances Service (DES) has supported the neighbourhoods to overcome some of these issues by providing additional clarity. The challenges identified for this stage were considered in both the specification created for phase two and the support that was provided.

Phase one has seen various successes in the building of relationships across organisations, new service design and expansion of the primary care workforce

It was the expectation of the successful neighbourhoods that time would be allocated to producing evaluations of their projects. Phase 1 transformation projects have some allocated resource to funding for evaluation but it is the view of the Neighbourhood Development Group that they would benefit from support to initiate the work. Sheffield CCG have recently commissioned Co:Create to deliver a half day workshop to all project leads of both phase one and two to explore a suite of methods, tools and approaches to gathering data which each Neighbourhood team will be able to easily use to capture progress against shared outcomes

Continuing with Sheffield's ambition to further support and mobilise neighbourhoods as delivery mechanisms and to support their ongoing development the CCG invited neighbourhoods to submit business cases for the second phase of transformation funding. The main criteria for phase two was that the model be for a change or a new way of working based on the priorities set out in the Long Term Plan to meet the needs of their population. It was a key requirement that the business cases be a change involving multiple partners focusing on a cohort of patients prominent in the neighbourhood. As a result bids were submitted with Age UK, Manor and Castle, Door 43, Stocksbridge Leisure Centre and Heeley Development Trust. A summary of the transformation projects for both phases can be seen in the matrix Appendix 2.

The ACP Neighbourhood Development Group shaped the service specification in August 2019 this was then sent to neighbourhoods inclusive of partner organisations. Submissions were received from 10 neighbourhoods. A panel of Accountable Care Partnership representatives then evaluated and scored each

submission against the scoring criteria. Of the ten submissions, seven neighbourhoods have been awarded a share of £600,000.

2.3 Relationships and Engagement

Underpinning the success of the neighbourhoods and their role in the Sheffield care system is strong leadership. As a city we have invested heavily in this through Liminal Leadership programmes for neighbourhoods, Practice Manager training, GP mentoring, nurse training and development, to mention a few. This continues to be a priority and we are working as ACP partners with the neighbourhoods to continue to identify and support development and training needs.

Previously neighbourhoods identified a number of services that would benefit from facilitated development in order to ensure positive progression to a fully integrated neighbourhood approach.

As a result several Neighbourhood Learning Network (NLN) events, jointly hosted by Primary Care Sheffield and Sheffield CCG, have been run. A number of services have been invited to the learning events, which have facilitated open discussions about individual Neighbourhood issues and desired improvements. In addition the NLN and The People Keeping Well Learning Event have been hosted jointly; there are plans to do this in 2020 around areas such as the contracting of the different sectors.

Most neighbourhoods are now supported by the integrated community care team, the PKW leads, CSW's and in some areas social care and IAPT.

Within the South East of the city the CCG are supporting Sheffield City Council with the implementation of the HUB providing the "Team around a Person" approach to care.

2.4 Integrated Care System Support

Recognising the importance of successful PCNs as the cornerstone of health systems, the ICS will be supporting their development by investing c.£7m across SY & B between 2018/19 – 2019/20. This is to support and enable primary care transformation and to deliver an organisational development programme for networks and their Clinical Directors.

As part of the network development the Integrated Care System has issued a matrix to monitor network maturity; each network self-assessed themselves from foundation to level 3 in the following areas.

- Leadership, planning and partnerships
- Use of data and population health management
- Integrating care

- Managing resources
- Working with people and communities

These were submitted to the ICS and summarised to identify key themes and opportunities to offer support and development at various levels of scale including ICS/System, CCG/Federation, PCN/Practice, bespoke individual or professional group.

Following on from this, each network identified key areas that they would be focusing on to develop the maturity of their network. Details of this can be seen in the matrix (appendix 2). Each network was allocated development monies to support them in meeting their identified development needs.

The role of the network Clinical Directors is new and comes with multiple challenges and opportunities to address real change. Sheffield Clinical Directors have begun meeting regularly, have secured leadership training through Robert Varnam PhD MSc MRCGP is the Head of General Practice Development at NHS England and coming together to develop the Sheffield network vision and development plan.

As part of the Clinical Director development with the support of PCS and the CCG a “Big Tent” will be held in March. The aim of the event is to invite partner organisations to present an overview of their service with opportunities for integration and to develop quality patient care.

3 What does this mean for the people of Sheffield?

The Network DES aims to reduce inequalities and strengthen partnership working at a Neighbourhood level by delivering integrated models of care. In particular the five network specifications are centred on the most vulnerable groups, with a clear overlap, in particular care home patients, frail and elderly and people with multiple Long Term Conditions.

It is important to recognise the significant opportunity of the system working collaboratively to support networks with the implementation of these specifications; a good example of this will be the realignment of community services to the network foot print and wider MDT working in practices.

Whilst the network DES is evolutionary and aims to alleviate the workforce pressures on general practice it is a complex change which needs support from the system. This includes considering how to build on the established collaboration for the implementation of the service specifications whilst ensuring the appropriate management is available to ensure existing pressures are not exacerbated.

Consideration needs to be given to:

- Sheffield CCG are currently in discussions with STH as to how community services can further integrate with Networks to meet the expectations set out on the Long Term Plan and with regards to the implementation of the specifications during 2020/21

- The role of the CCG in the co-ordination and support for delivery of the specifications
- CCGs should work with PCNs, community service providers and LMCs to support transition of existing service to meet the new requirements.

- Following the election, the CCG are keen to explore how councillors can engage with and support the Network/Neighbourhoods way of working.

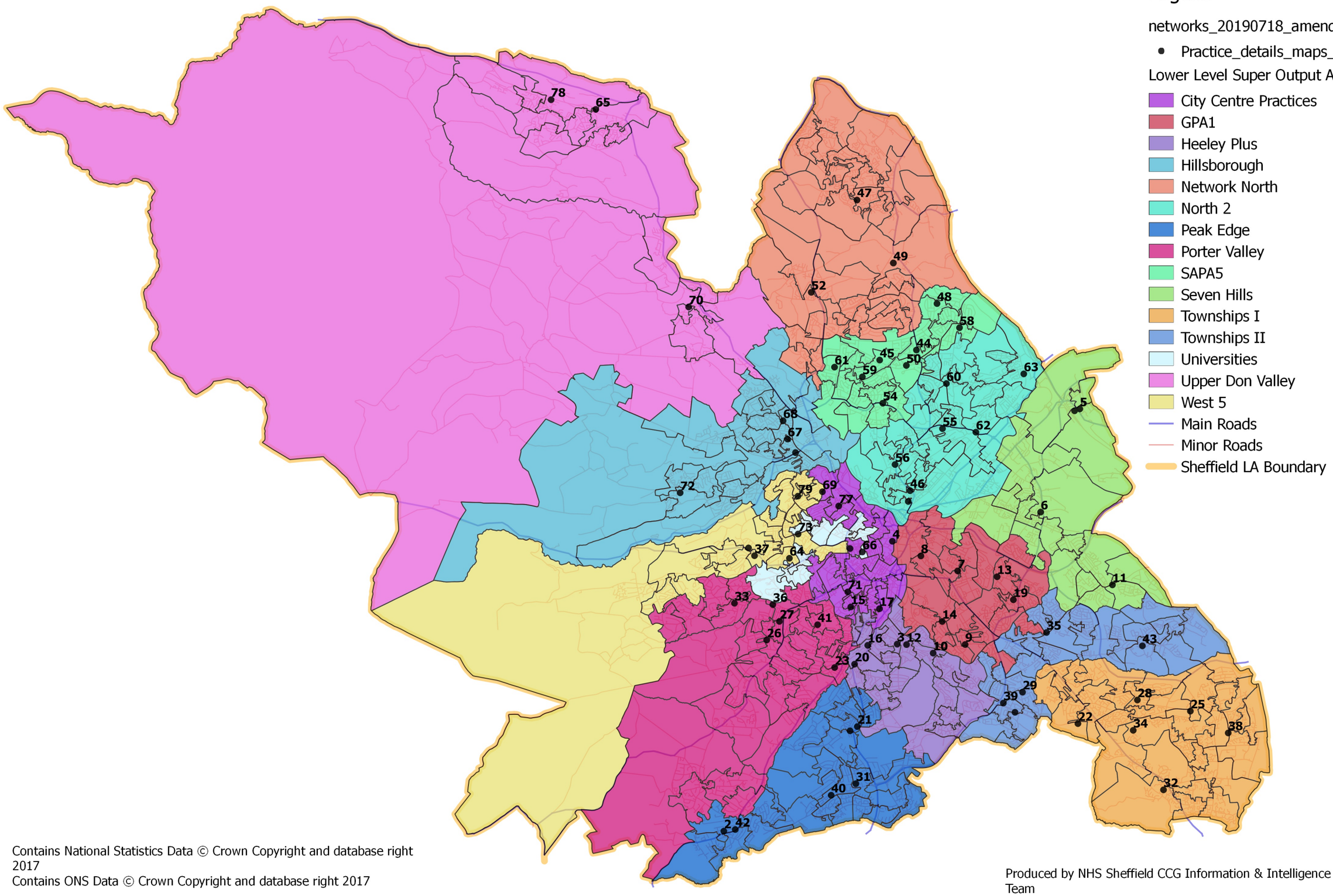
- Due to the requirements of the Network DES each network will begin to form Network Patient Participation Groups to be engage with the local population.

4. Recommendation

4.1 The Committee is asked to note the update provided and are asked to consider the following;

1. Consider and review the information in this update and provide views and comments
2. Consider how can we collectively engage with Sheffield citizens regarding Neighbourhoods to ensure consistency of messages
3. What will the impact of mature PCNs be on the rest of the system?

15 Networks Across Sheffield City



Legend

networks_20190718_amended

- Practice_details_maps_20190703

Lower Level Super Output Areas

- City Centre Practices
- GPA1
- Heeley Plus
- Hillsborough
- Network North
- North 2
- Peak Edge
- Porter Valley
- SAPA5
- Seven Hills
- Townships I
- Townships II
- Universities
- Upper Don Valley
- West 5
- Main Roads
- Minor Roads
- Sheffield LA Boundary

Produced by NHS Sheffield CCG Information & Intelligence Team
18/07/19

Number	Practice Name	NETWORK_NAME
4	Clover City Practice	City Centre Practices
66	Devonshire Green and Hanover Medical Centres	City Centre Practices
69	Harold Street Medical Centre	City Centre Practices
71	Porter Brook Medical Centre	City Centre Practices
77	Upperthorpe Medical Centre	City Centre Practices
7	Dovercourt Group Practice	GPA1
8	Duke Medical Centre	GPA1
9	East Bank Medical Centre	GPA1
13	Manor and Park Group Practice	GPA1
14	Norfolk Park Medical Practice	GPA1
19	The White House Surgery	GPA1
1	Abbey Lane Surgery	Heeley Plus
3	Carrfield Medical Centre	Heeley Plus
10	Gleadless Medical Centre	Heeley Plus
12	Heeley Green Surgery	Heeley Plus
15	Sharrow Lane Medical Centre	Heeley Plus
16	Sloan Medical Centre	Heeley Plus
17	The Mathews Practice	Heeley Plus
20	Veritas Health Centre	Heeley Plus
42	Totley Rise Medical Centre	Heeley Plus
67	Dykes Hall Medical Centre	Hillsborough
68	Far Lane Medical Centre	Hillsborough
74	Dr Milner and Partners	Hillsborough
75	Tramways Medical Centre (O'Connell)	Hillsborough
47	Chapelgreen Practice	Network North
49	Ecclesfield Group Practice	Network North
52	Grenoside Surgery	Network North
53	Mill Road GP Surgery	Network North
46	Burngreave Surgery	North 2
55	Page Hall Medical Centre	North 2
56	Forge Health Group	North 2
57	Sheffield Medical Centre	North 2
59	Southey Green Medical Centre	North 2
60	The Firth Park Surgery	North 2
62	Upwell Street Surgery	North 2
63	Wincobank Medical Centre	North 2
2	Baslow Road, Shoreham Street and York Road Surgeries	Peak Edge
21	Woodseats Medical Centre	Peak Edge
31	The Meadowgreen Group Practice	Peak Edge
40	The Avenue Medical Practice	Peak Edge

Number	Practice Name	NETWORK_NAME
23	Carterknowle and Dore Medical Practice	Porter Valley
26	Falkland House Surgery	Porter Valley
27	Greystones Medical Centre	Porter Valley
33	Nethergreen Surgery	Porter Valley
36	Rustlings Road Surgery	Porter Valley
41	The Hollies Medical Centre	Porter Valley
44	Barnsley Road Surgery	SAPA5
45	Buchanan Road Surgery	SAPA5
48	Dunninc Road Surgery	SAPA5
50	Elm Lane Surgery	SAPA5
54	Norwood Medical Centre	SAPA5
58	Shiregreen Medical Centre	SAPA5
61	The Health Care Surgery	SAPA5
5	Clover Group Practice	Seven Hills
6	Darnall Health Centre (Mehrotra)	Seven Hills
11	Handsworth Medical Practice	Seven Hills
18	The Medical Centre	Seven Hills
22	Birley Health Centre	Townships I
25	Crystal Peaks Medical Centre	Townships I
28	Hackenthorpe Medical Centre	Townships I
32	Mosborough Health Centre	Townships I
34	Owlthorpe Surgery	Townships I
38	Sothall Medical Centre	Townships I
24	Charnock Health Primary Care Centre	Townships II
29	Jaunty Springs Health Centre	Townships II
35	Richmond Medical Centre	Townships II
39	Stonecroft Medical Centre	Townships II
43	Woodhouse Health Centre	Townships II
72	Stannington Medical Centre (Shurmer)	unassigned
76	University Health Service	Universities
65	Deepcar Medical Centre	Upper Don Valley
70	Oughtibridge Surgery	Upper Don Valley
78	Valley Medical Centre	Upper Don Valley
30	Manchester Road Surgery	West 5
37	Selborne Road Medical Centre	West 5
64	Broomhill and Lodge Moor Surgeries	West 5
73	The Crookes Practice	West 5
79	Walkley House Medical Centre	West 5

Appendix 2 - Primary Care Network Maturity

	PCN Set up and Support		Organisational development and change		Leadership Development and Support		Supporting collaborative working (MDTs)		Population Health Management		Social Prescribing and asset based community development	
	Current	Planned	Current	Planned	Current	Planned	Current	Planned	Current	Planned	Current	Planned
GPA1	F	1	F	1	F	1	1	2	F	1	1	2
North 2	1	2	F	1	1						F	1
West 5	2	3	1	2	2	3	2	3	1	2	2	3
Townships 1	1	2	F	1	F	1	F	1	1	2	F	1
Townships 2	1	2	F	1	F	1	F	1	1	2	F	1
Seven Hills	F	1	F	1	F	1	F	1	F	1	F	1
Heeley Plus	F	1	F	1	F	1	F	1	F	1	F	1
Peak Edge	F	1	F	1	F	1	F	1	F	1	F	1
City Centre with Students from SHU	F	1	F	1	F	1	F	1	F	1	F	1
SAPA5	F	1	F	1	F	1	F	1	F	1	F	1
Network North	2	3	2/3	3	2	3	2	3	1	2/3	2	3
Hillsborough	F	3	F	1	F	1	F	2	F	3	1	3
Upper Don Valley	F	1	F	1	F	1	F	1	F	1	F	1
UoS Student Network	F	1	F	1	F	1	F	1	F	1	F	1
Porter Valley	2	3	2/3	3	2	3	2	3	1	2/3	2	3

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Appendix 2 - Neighbourhood Matrix - Network Summary

N	Practices	Size	Manager Lead	Clinical Director	Transformation Phase One	Transformation Phase Two	Leading Sheffield	Time for Care	PCC	Current Partnership	Shared Network Staff	Link Worker	Identified Development Needs
GPA1	Norfolk Park Medical Practice White House Surgery Duke Medical Centre Dovercourt Surgery East Bank Medical Centre Manor Park Medical Centre	41,746	Paul Wike	Helen McDonagh Tim Hooson		To develop an enhanced multi-organisation, multi-service Dementia Holistic Care Pathway working with all partners to meet the needs of this cohort of patients.						Manor + Castle	Support to be ready for wider network membership Sheffield Clinical director support and development Managerial support and development Network data resource, expertise and knowledge Support with the development of resource for network PPG Support with venues and facilitators for network engagement workshops Funding for OD and change management Backfill for staff to attend meetings/training
North 2	Pitsmoor Surgery* Upwell Street Surgery The Flowers Health Centre* Firth Park Surgery Wincobank Medical Centre Burngreave Surgery Page Hall Medical Centre Sheffield Medical Centre Southey Green Medical Centre	56,256	Karen Zaman	Jenny Joyce	To develop a Neighbourhood Pain Management Model To implement a small scale MDT to work across the Care Homes in the Neighbourhood to conduct a feasibility study to design a cost affective care home model. To enhance HCA into care navigation role, supporting patients at high risk of admissions to manage health and social needs.		*	*		SOAR	Health and Wellbeing Worker GP Neighbourhood Coordinator	SOAR	Support with wider network engagement CD/Managerial support and development Sheffield CD Leadership programme Support set up and resource network PPG Support with a Network dashboard Access to accurate network level data Legal advice
West 5 Care	Walkley House Medical Centre Broomhill Surgery Manchester Road Surgery The Crookes Practice Selborne Road Medical Centre	37,246	Kate Carr	Tom Mcanea	To implement efficient and timely access to specialist mental health services within primary care. Specifically, direct 'face to face' assessment, joint assessment of patients with GPs, giving advice regarding therapeutics/prescribing, risk management of vulnerable patients. Supported by a Health trainer to explore social prescribing.			*		Zest Age UK	Health and Wellbeing Worker Network Mental Health Nurse ANP Independent Living Co-ordinator	Door 43	Managerial support, development and backfill Administrative support Resource to support attendance at meetings Asset mapping Network IT Interoperability IT, Training, Legal advice through PCS Data at the network level Funds to develop a network website Population health data at a network level IT Resource
Townships 1	Sothall and Beighton Health Centres Mosborough Health Centre Owlthorpe Medical Centre Crystal Peaks Medical Centre Birley Health Centre	43,231	Helen Lenthill	Tom Holdsworth	• Provide targeted support for frail elderly housebound patients reducing inappropriate admissions/emergency care. • Develop the Governance structures and experience of the Neighbourhood in terms of service delivery to leave the Neighbourhood ready to take on network contracts as they emerge as part of the NHS long term plan. • Building on successes of engaging with secondary care through the Neighbourhood MDT, we will further develop integrated working between primary and secondary care. • We will seek to develop the Beighton hub as a resource for our integrated working with our community partners and as a resource for expanded Neighbourhood teams as they emerge		*			Woodhouse District Forum		Woodhouse District Forum	Legal advice for employment liability Information sharing advice Resource to back development time Information sharing advice IT to support integrated working Support to establish network level PPG Network interoperability Data sharing support Network data
Townships 2	Stonecroft Medical Centre Charnock Health Primary Care Centre Jaunty Springs Health Centre Woodhouse Health Centre Richmond Medical Centre Hackenthorpe Medical Centre	34,487	Gordon Osbourne	Julie Hoskin						Woodhouse District Forum			
Seven Hills	Handsworth Medical Practice Clover Group Practice Darnall Health Centre (Mehrotra) The Medical Centre	31,227	Nicola Hrrison	Lucy Cormack		The project focuses on early identification of the top seven causes of early mortality in patients aged 25-39 years through health checks and intervention tailored to our community. It reduces the barriers of accessing support by training local volunteers to deliver tailored peer support and a helping hand to patients with identified needs within their community as well as using these community members to encourage engagement with existing intervention schemes. Volunteers will provide a trusted face and community language support where needed to help break down barriers.			*			Darnall Wellbeing	Support with Vision and Values Support for future wider network membership Support to ensure full network engagement Sheffield CD Development Managerial support and development PLI educational event to increase understanding Governance Support Support with the Network dashboard Access to Network level data Support to understand data sharing agreement Evaluation of the link worker role Setting up Network PPG
Heeley Plus	Sloan Medical Centre Gleadless Medical Centre The Mathews Practice Sharrow Lane Medical Centre Heeley Green Surgery Carrfield Medical Centre Totley Rise Medical Centre Abbey Lane Surgery Veritas Health Centre	49,649	Paul Roberts	Ollie Hart		Develop social prescribing and how we address the wider determinants of health in our PCN foot print.	*	*				Heeley Development Trust	Increased understanding/engagement across Network Capacity to engage in meetings Governance support and advice CD/Managerial development Administrative Support Gap support for PKW anchor Support with Network data analysis/ interpretation Support with PPG Network
Peak Edge	The Meadowhead Group Practice Avenue Medical Practice Baslow Road And Shoreham Street Surgeries Woodseats Medical Centre	42,343	Joanne Johnson, Elaine Rissbrook	David McAllistair	The proposed plan focuses on early identification of low level mental health conditions, supporting young people to self-identify and manage their condition and encouraging them to speak up leading to prevention of escalation of mental health issues. It is intended to support and develop a scheme with local schools (Meadowhead and King Ecgberts) whereby Sixth Form Students offer mentoring to younger students in Y7 – Y11 and also have access to a Wellbeing Café with a trained counsellor.					Chilli Pep Door 43 PCS King Egberts Meadowhead School	Mental Health Nurse	Reach	Facilitated support to establish vision and values Support to include wider network board members Managerial support with capacity and funding to ensure maximum engagement PLI time for wider network development Understand the impact of new roles Support with the network dashboard Support to understand the national data sharing agreement

N	Practices	Size	Manager Lead	Clinical Director	Transformation Phase One	Transformation Phase Two	Leading Sheffield	Time for Care	PCC	Current Partnership	Shared Network Staff	Link Worker	Identified Development Needs
City Centre with Students from SHU	Porter Brook Medical Centre Upperthorpe Medical Centre Harold Street Medical Centre Devonshire Green Medical Centre Clover City Practice	55,821	Deidre Malesa	Liz Alsop Nicki Bates (SHU)	The project aims to co-produce an integrated and enhanced model of health and wellbeing that connects with clients in a meaningful and holistic way and transforms the care provided to patients experiencing poor mental health and other health outcomes.		*			Zest SHSC		Zest	Core membership engagement Managerial support-governance Sheffield CD Development Vision and Objective setting Support to understand data sharing Access to network data Network wide educational events to increase understanding
SAPA5	Shiregreen Medical Centre Dunninc Road Surgery Buchanan Road Surgery Norwood Medical Centre Elm Lane Surgery The Health Care Surgery Barnsley Road Surgery	36,358	Sam Grundy	Magda Juszczyszyn Susie Lupton		To provide a person-centred, co-produced model of care across our network which enables effective working with services and organisations to improve the quality of care for the frail and elderly	*	*		SOAR		SOAR	Support to prepare for wider network membership Support to develop managerial leads Capacity for managers to carry out the role Support to release staff to attend training Sheffield CD training Network dashboard support Network level data Help with interoperability Resource for a programme of PPG network engagement Access to the relevant, expertise and support aligned to strengthening our governance
Network North	Foxhill Medical Centre Chapelgreen Practice Ecclesfield Group Practice Grenoside Surgery Mill Road Surgery	42,505	Michelle Payling	Nicola Moody	Extension of the provision of dedicated support to patients with Risk Score of 50-70 who are also at high risk of falls and severely frail. In addition we plan to commence a service of targeted discharge review for patients identified as at risk of admission/re-admission and the provision of a home visit service for patients who repeated request a GP home visit which does not require a GPs intervention.	Early Intervention Working for Children and Adolescents				Age UK	Administartor Independent Living Co-ordinator	SOAR	Sheffield CD leadership and development and support access to governance and legal advice Human resource training Support with interoperability Regular network sharing events Clinical director would like training on Population health management Improve links with STH Network PPG
Hillsborough	Tramways Medical Centre (O'Connell) Far Lane Medical Centre Tramways Medical Centre (Milner) Dykes Hall Medical Centre	36,135	Cath Williams Diane Dickinson	Emma Reynolds			*				HCA	Zest	Administrative support Legal support with the data sharing agreement Asset mapping Resource to attend meetings CD/Managerial Support/development Support to add additional membership to the network Network PLI to improve engagement Engagement with secondary care Access to legal and financial advice Access to network data
Upper Don Valley	Oughtibridge Surgery Deepcar Medical Centre Valley Medical Centre	20,756	Liz Sedgwick	Ruth Izard		Supporting Young people (13 – 25 year) in the Upper Don area to lead happy , healthy and fulfilling lives					HCA	Stocksbridge Leisure Centre	CD support and development IT Support Management training and development sessions
UoS Student Network	University Health Service Health Centre University	37,457	Ben Hallsworth	Naomie Whitt									Support in defining the managerial and administrative support Support to co-ordinate and facilitate external membership Support for the development of the CD via a Sheffield based programme PLI event for wider network development Support for network dashboards Access to the relevant, expertise and support aligned to strengthening our governance Expert resource, knowledge and support with network BI
Porter Valley	Nethergreen Surgery The Hollies Medical Centre Falkland House Porter Valley Rustlings Road Medical Centre Greystones Medical Centre Carterknowle And Dore Medical Practice	43,665	Daniel Sayliss	Humphrey Emery		Practical support to reduce isolation, promote independence and through encouragement achieve supported self-management to age well and live healthier for longer in partnership with Age UK	*	*		Dementia Action Alliance Age UK	GP Neighbourhood Coordinator	Door 43	Support to embed vision, values and governance arrangements Support to have an integrated IT system Legal and accounting advice at a citywide level CD Sheffield development Offer of development support for network managers taking in to account capacity and funding Support to develop MDT PLI event for wider network development to understand the impact of Administrative support Support with Network dashboard Support to understand the impact of data sharing agreement

Report to Scrutiny & Policy Development Committee 15-1-20

Report of: Sara Storey and Dawn Shaw

Subject: Locality Social Care & South East Neighbourhood Working Update

Author of Report: Dr Tim Gollins, Head of Localities, Adult Social Care: tim.gollins@sheffield.gov.uk, 01142930254 and Lorraine Wood, Head of Communities, Libraries, Learning, Skills & Communities: Lorraine.Wood@sheffield.gov.uk, 0114 2734508.

Summary:
Locality Social Care started to be introduced two years ago in October 2017. It was a major change to the structure of the Council's adult social care workforce, and to a long established ways of working. It also introduced major changes to the relationships between adult social care and its partners - both internal and external; and not least, to create a major positive change in the quality of the experience of adult social care for people who use services and their carers.

Neighbourhood Working in the South East of the city to connect practice / services, has been developed through a series of events and workshops with all partners across 'the system' providing services to Adults. The South East Neighbourhood Hub launched on 4th November 2019, providing 'hot desk' facilities and a space for services to come together to share good practice, collaborate and work together to support people who use their services .

Both the Locality and Neighbourhood working initiatives share a set of values and principles and both rely upon each other. This report aims to explain how these two initiatives have begun to bring a more collaborative and joined-up way of doing things, which creates the potential for system-wide efficiencies and improved outcomes for citizens, people who use services, and their carers.

Specifically, this update report:

1. Describes the various values, principles and elements that make up 'locality working' in Adult Social Care and 'neighbourhood working' in Communities
2. Describes key matters for further consideration and sets out some of the ways these are being addressed in both localities and the South East neighbourhood.

3. Acknowledges that the implementation of locality working arrangement and the South East Neighbourhood Hub are not fully established, either in systems and process terms, nor fully embedded in practice yet. Nevertheless, the report explains the difference that is already being made, and the difference getting locality and neighbourhood working right will make in the future for people and carers
4. Explains what key risks there are to these two areas of work, how these risks are being mitigated, and what elements may need further attention

The recommendations to Scrutiny Committee are:

1. To note that both locality working continues to be work in progress, but that advances are being made after a significant period of change and ongoing management of risks.
2. To recognise the potential future for locality working even amidst well discussed national issues of resource pressures across health and social care
3. To note that delivering system-wide benefits will require continued emphasis on the values and principles of locality working, and a commitment to change front-line practice from all system partners
4. To note that the South East Neighbourhood Hub was launched on 4th November and will be evaluated in March 2020.

The report is being presented to Scrutiny Committee to enable it to undertake its role in reviewing the implementation of an agreed policy direction.

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

The Scrutiny Committee is being asked to:
Consider the details provided and give views, comments and recommendations on the continued development of both locality and neighbourhood working.

Background Papers:

Appendix 1: Details of Conversations Count
Appendix 2: Adult Social Care Localities Map
Appendix 3: Changing the Conversation: Key Messages
Appendix 4: Feedback on Locality Working from the Whole Service Events
Appendix 5: Baseline File Audit Recommendations

Category of Report: OPEN (please specify)

Report of the Director of Adult Social Care
Locality Social Care & South East Neighbourhood Working Update

1. Introduction/Context

Locality Working:

1.1 Managing Employee Reductions (MER 305) was launched on 20th February 2017. May 2017 saw an Achieving Change programme agreed by the Council which introduced significant establishment changes to the Adult Social Care workforce. There was no reduction in staffing as part of this change. Use of agency staffing was reduced through a focus on permanent recruitment to ensure a more stable workforce.

1.2 The establishment structure was changed to enable a move to locality-based working for assessment and care management teams across Adults and Learning Disabilities services, with the creation of seven locality areas and four central teams: 0-25 Preparation for Adulthood, Future Options, First Contact, Hospital and Out of Hours.

1.3 The new structure for locality working Adult Social Care came into place on 4th September 2017.

1.4 Locality working was not a new concept, but it embodied a desire to link adult social care with developments in Housing, Community services, Children's' services, Primary Care, and Community Health services. It was therefore, part of a wider programme of improvements to the responsiveness and co-ordination of support to the public in Sheffield.

1.5 Some of the specific reasons for the development of locality working were:

1.5.1 The need for better co-ordination of care and support services for people where they live, drawing upon a clearer understanding of the assets and strengths of that area, and enabling social care staff to strengthen peoples resilience by supporting people to develop their relationship to their locality.

1.5.2 To make better use of resources, including:

- Better information and access to support greater independence
- Better processes to support greater productivity: less duplication, fewer hand-offs, greater focus on outcomes
- Better signposting and joint working, including a willingness to grasp an opportunity to develop a strong link to neighbourhoods, with the intention of supporting greater prevention activity

1.5.3 To align delivery of services with a new overarching vision and practice principles.

1.6 The vison and practice principles have been agreed and communicated to all adult social care staff and are being used to orientate our work with internal and external partners. The application of the vision and principles in localities is driving the decisions and the priorities we establish in moving locality working forwards:

1.6.1 The vision:

- Independence: Delivery of information and advice at the right time and in the right way, and helping people develop the skills and abilities they need
- Safe: Delivering Making Safeguarding Personal (MSP) , and strengthening the links between commissioning and contracts
- Well: Supporting 'wellbeing' – which means helping people to develop personal relationships, friendships, and their access and mobility around a community, enabling access to culture and leisure opportunities, and supporting people with their financial wellbeing

1.6.2 The practice principles:

- Involve: Actively listening to what people want and then agreeing what they need, consistently and fairly, whilst also being person centred
- Record: Making and recording professional decisions that are defendable because they follow the relevant legal frameworks
- Learn: Being self-reflective, learning from complaints (and complements) and focussing on evidence-based practice
- Collaborate: Being responsible for getting others involved (multi-agency), being a leader in a community or a network, that helps people achieve their goals
- Empower: Delivering timely information and advice, and professional support that helps people to develop the skills and abilities they need

1.7 Introducing locality working involved a number of diverse initiatives to support a change in culture and practice. These were;

1.7.1 A specific focus on culture, moving away from a mechanical process driven model of social care to one which valued person-centred practice and strengths-based approaches. This initiative was called 'Conversations Count' – a way of changing how Adult Social Care staff carry out their activities (details provided in appendix 1).

1.7.2 Investment in prevention. Investment in the first point of contact between people and adult social care. People who felt they needed some kind of help or information and advice used to have find out which department they had to go to. Only by going to the right department for their issues were they able to access the right help. First Contact was developed based on the principle of 'no wrong door', such that adult social care and other departments developed a single contact number and a single place for people to address their issues. People who need ongoing care and support are subsequently transferred across to locality teams. A diagram of the location of locality teams is in appendix 2.

1.7.3 Basing services in the localities they serve. One initiative created a first point of contact in the locality, - a GP service to be precise. This was

known as the ‘Darnall First Local Project’. More details about this in the main body of the report.

1.7.4 A focus on multi-agency working. Linking up of locality social care with neighbourhood working via the ‘South east Neighbourhood Hub project’. This also is explored in more detail in the main body of the report.

South East Neighbourhood working

1.7.5 South East Neighbourhood working is an important priority because of the need to do things differently to reduce health inequalities. It relies of shifting to a prevention focused health and care system but there are a number of problems stopping us from shifting the system e.g. multiple referrals asking for similar interventions; multiple front doors – but waiting lists mean service users stay in a revolving door and potentially hit ‘crisis’ before been seen by anyone – so then reactive response required; lack of Integrated Business Intelligence to inform ‘right’ intervention at ‘right’ time – leading to interventions not being sequential and treating symptoms rather than root causes creating re-referrals; Commissioning not joined up across services and partners.

2. Matters for consideration

Locality working

2.1 This section of the report focuses on some key issues and the difference both locality and neighbourhood working are making.

Culture change

2.2 Conversations Count: putting people at the centre involved developing six key messages (see appendix 3 for details). These conversations are being embedded through a variety of mechanisms, systems and processes to support staff to develop the new ways of working. One of the recent examples of this culture change work was the recent Vision and Principles whole service events run in October, (the outcome of which are in appendix 4).

2.3 The main approaches to continuing to develop the Conversations Count culture are:

2.3.1 Recording: Having implemented a new IT system at the same time as implementing the Conversations Count and the localities MER has been a very significant pressure on staff and resources. The result has been some confusion amongst staff about what information to record in which location and how exactly to do some of the recording. To ascertain the extent of the recording issues a Baseline File Audit was conducted in September 2019. The conclusions are identified in appendix 5.

2.3.2 The quality of recording has been addressed via ‘floor walkers’ and Liquid Logic Training but more emphasis is still required to get this core function correct. A direct action responding to the file audit has been the establishment of a Quality Assurance team

(created within current resources) shared across Localities, Business Support, and Finance, to directly support the improvement of recording practices.

2.3.3 Thematic improvement: A series of workshops have been created for delivery in the New Year 2020 to support staff with a number of different aspects of their work and the recording of that work including:

- Finance conversations with people and carers
- Carers referrals and advocacy
- Safeguarding and the use of case notes
- Professional decisions taking
- Improved understanding in localities of brokerage and social care commissioning and contracting

2.3.4 Preparation for Adulthood: Work with our colleagues in Children's service, SEND and Special Schools has begun to develop our approach to Transitions, emphasising the development of independence and wellbeing between the ages of 14-18 and for some young people to the age of 25 if in full-time education. The aim of which is to support transition of the family as well as the young person to life as an adult with as few restrictions as possible; also with the greatest continuity and avoidance of a 'cliff edge' on entry to adult social care, whilst promoting the greatest quality of life.

2.3.5 Time: One of the persistent and most challenging issues facing locality working is the pressure on social care workers in the field to have the time with people who use services and carers to make their conversations count. A project led by the Practice Development team has analysed a raft of information from across all 7 localities, and a plan to address the findings is in place. The South East Neighbourhood Hub model also brings with it opportunities to save time and use resources in more efficient ways. This initiative represents the potential for a substantial step forward in how locality social care staff will undertake their roles.

Interfaces

2.4 First Point currently provides high quality, quick responses, and tailored information and advice, from one place. If people or their families need to talk with more, perhaps needing some crisis intervention work, First Contact and the associated prevention and early intervention teams will do that work. Everyone presenting at First Point gets a positive response to help them 'get back on their feet'. Broadly however, there are three groups of people that make up the main focus for the First Contact teams:

a) People need support in the community and are not already known to locality teams
b) People who are being discharged from hospital
c) People who have immediate Safeguarding needs

2.5 Once the prevention and early intervention work has been done hopefully individuals have regained their independence and they are

back in control of their wellbeing. However, sometimes people need ongoing care and support. In this case the prevention and early intervention teams will, once they have ensured the person is safe, check which part of Sheffield they live in, and transfer them to their locality team.

2.6 The interfaces between first contact prevention and early intervention teams and localities staff continue to need work, to improve the experience of people who use services and carers. Specifically to reduce the 'hand-offs' and the repetition people have to deliver the same set of experiences. This is particularly in relation to joining up Safeguarding not only between first contact teams and localities, but also between Contracts, Providers and other key partners. This work is underway with specific training developed and now being delivered alongside the Safeguarding Board.

First Local - Darnall

2.1 One of the important ways in which the current First Contact arrangements might develop in future is to build on the learning from an informative pilot site called 'First Local' in Darnall. This innovation site has joined up locality social work and the prevention and early intervention teams in a shared locality setting. The project planning began in early March 2018, and the team started officially on July 2018. The details are as follows:

Aims and vision

2.2 First Local is an innovation site set up during the second phase of the Conversations Count trial process, supported by Business Strategy colleagues. The project involves a multi-skilled team made up of staff from First Contact, Equipment and Adaptations and Locality 6 Team 2 co-locating at the Darnall Primary Care Centre.

2.3 The project is designed to offer a new way for people who could benefit from very early intervention and prevention to engage with Adult Social Care. The team can provide information and advice as well as demonstrate equipment and telecare devices, and visit people in their homes. The aim is to take prevention to the heart of an area of Sheffield that sees a high proportion of GP referrals to Adult Social Care, changing people's perceptions in the process and engaging with people who might otherwise not become known to the Council until they are in a crisis.

2.4 The team initially ran a full-time drop-in service during the surgery's opening hours for anyone to approach them to have a chat about promoting their independence, increasing their level of social inclusion and improving their opportunities in life.

2.5 GPs from Darnall Primary Care Centre itself alongside a number of other GP surgeries in the area are able to direct people to the drop-in as an alternative way of asking Adult Social Care to help.

2.6 The project aims to resolve issues as early as possible, engaging with local communities in the process and collaborating intensively with local voluntary and community organisations as well as with NHS colleagues.

Progress

2.7 The team has collected a great deal of learning about complex partnership working as well as practical and logistical considerations that will help feed in to any future local access points in the city. A lot of time has been spent on building strong relationships with Health staff across surgeries and the CCG, and these will also prove valuable for the future.

2.8 Over the first couple of weeks roughly 2/3 of the 60 people who attended the drop-in had not previously approached Adult Social Care. Most people enquired about issues relating to access and mobility issues (either their own or a relative's), and most people had come because they had either seen a poster or flyer in a GP surgery, or because a GP had suggested they attend directly.

2.9 In terms of the difference the project is having on people's lives, the vast majority of people who spoke to a member of the team would otherwise have done nothing to improve their situation – meaning that their circumstances or those of a loved one may have otherwise deteriorated, unnoticed, until they reached a crisis point.

2.10 Most staff have also reported that they are highly satisfied with this new way of working, as they can see for themselves how they are able to relieve anxiety, respond quickly, spend quality time with people, reassure people that someone is listening to them, and see people go away happier in the knowledge that they don't have to face issues alone.

Case study

One of the innovators at First Local was approached by a person who explained that she had received a letter from her Housing Association demanding that work be done to her bathroom to remedy an issue with the floor. The person in question was distressed and did not know how to deal with the demand.

By listening to the person, the innovator learned that the person was suffering from a brain tumour and that she was climbing in and out of the bath with assistance from her daughter, who was then pouring water over her using a jug. The innovator arranged to visit the person in her home there and then. At the same time, she contacted the Housing Association to explain about the person's medical and personal circumstances – for instance, how her illness was affecting her vision and causing distress – as well as requesting a shower head that could attach to the person's bath taps as an immediate, interim solution.

As a result, a full assessment of the person's home can take place to see how her home might be adapted quickly, and the Housing Association has said that it will stop contacting the person with its demands until the innovator has been able to finish working intensively with the person herself. They have also said that they will look into long-term solutions themselves, such as changing the flooring in the bathroom.

- ➔ The innovator felt as though she has made a real difference in the person's life by preventing her having to continue living under considerable stress
- ➔ Ultimately, the Housing Association would have contacted the Council to get involved and would not have dealt with the person with as much empathy
- ➔ Only now can the person concentrate on her progress and her treatment. If she had not visited First Local, she would still have to contend with significant anxiety that would have added an extra pressure to an already vulnerable person

Summary and next steps

2.11 First Contact and First Contact Prevention have proved successful at bringing a strong, multifaceted preventative approach to people accessing adult social care. Together in a single office, social workers and care managers sit alongside occupational therapists, community support workers, prevention officers, travel trainers and sensory impairment officers – all to the benefit of people who want a streamlined, efficient and effective service based on an in-depth understanding of what a good life looks like to them.

2.12 First Local adds another dimension to this model by creating a local access point focused on enhancing prevention out in the community, and enhancing the 'no wrong door' approach. We are seeking to bring information and advice to the places where people go, rather than try to push people into using existing access channels. We are also seeking out people who may not always seek early help through what they see as 'formal' channels.

2.13 In order to manage additional local access points, building on the learning and success already being achieved through First Local, input from Locality teams alongside the involvement of occupational therapists/occupational therapy assistants and further community based preventative support (e.g. CSW's) would be key in progressing the model and continuing the shift from case management to prevention.

<u>Specialist vs generic working</u>

2.13.1 One of the key challenges to developing locality working has been the necessity to spread specialist teams across the 7 localities rather than have them working closely together located in one building. This has been applied to three specific areas, Continuing Health Care (CHC), learning disability, and connected to this, autism. Expertise in these specific areas has been spread quite thinly and a training programme has begun to develop the specialist experience and knowledge across generic social care workers in all localities.

2.13.2 It should be noted that whilst some specialist teams have been shared across locality sites, other social care functions have remained specialist. For example, mental health social workers who have maintained their seconded arrangements to Sheffield

Health and Social Care Trust (SHSCT), and we continue to work closely with the carers centre and advocacy providers for their specialist support.

2.13.3 The continued specialist teams present challenges for a locality model of working, evidenced by the persistent difficulties report by locality staff in finding community-based mental health workers able to contribute to the support arrangements for people with long-term mental health problems where they live. One of the main reasons for this is the lack of quality communication and information sharing between organisations working with complex individuals, and a similar lack of efficient mechanisms for al organisations to engage better with each other.

2.13.4 The principle way in which this issue is being addressed is by actively supporting and participating in the development of the SE Neighbourhood Hub.

Neighbourhood working

The South East Neighbourhood Hub

2.13.5 The neighbourhood hub provides a direct contact point for professionals who support individuals requiring early help services. The hub enables practitioners to work together effectively to join up their support for individuals so the 'right intervention' takes place.

2.13.6 The Hub is currently developing the Team Around the Person concept through co-production with frontline workers across the 'system', service users and the Townships Primary Care Networks. It is also testing the process through holding and facilitating TAPs with relevant professionals.

The Team Around the Person (TAP)

2.13.7 A Team Around a Person (TAP) is a group of practitioners working with a particular individual and their family.

2.13.8 A TAP is a meeting between some or all of these practitioners and the individual (where appropriate) and / or their careers.

2.13.9 The purpose of a TAP meeting is for practitioners and individuals to share information and to create a solution focussed action plan that best suits the needs of the individual and family.

2.13.10 The TAP model is based on the idea that flexibility is essential if services working with individuals are able to meet the diverse needs of each and every individual. The TAP model places the emphasis firmly on the needs and strengths of the individual rather than organisations or service providers.

Key principles of the TAP

2.13.11 To ensure that individuals are placed at the centre throughout their involvement with TAP

2.13.12 To ensure that individuals are able to identify the significant individuals in their life

2.13.13 To use a strengths based, restorative approach to communicating with and engaging with individuals/families, listening to their story and supporting solutions

2.13.14 To coordinate the provision of multi-agency support that is accessible and meets the needs of individual/ families

2.13.15 To use evidence based approaches and evaluation measures in order to ensure the best possible outcomes for individuals and families

2.13.16 To support individuals to implement and review their action plans to ensure that they are relevant and tailored to their individual needs.

3 What does this mean for the people of Sheffield?

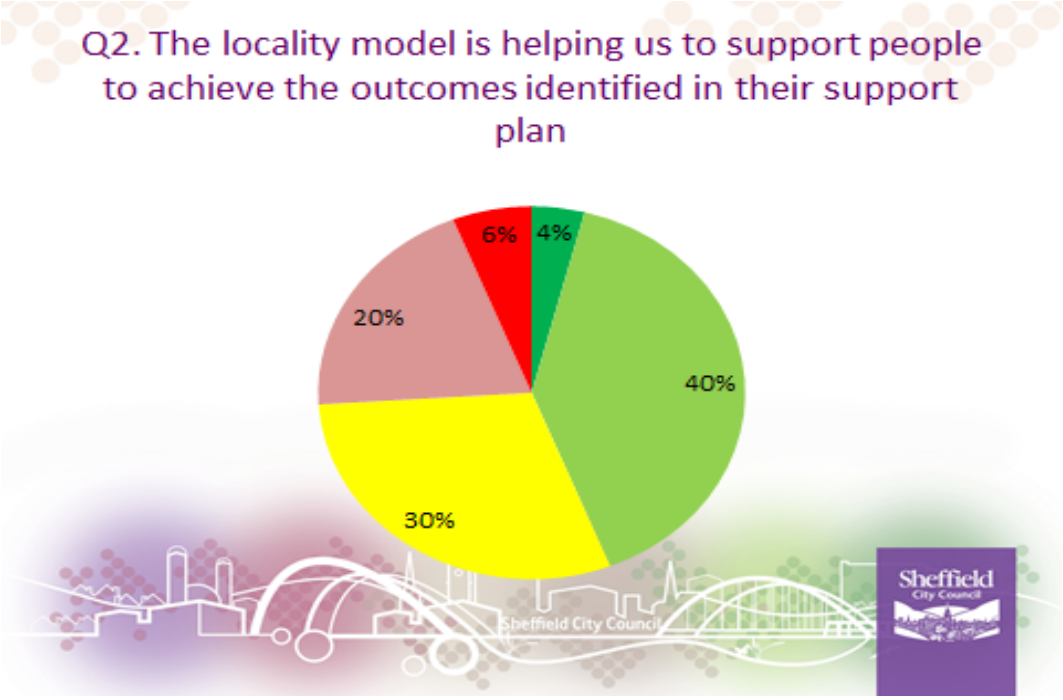
Locality Working

3.1 The impact of the move to locality working in Adult Social Care (ASC) on people who use services and carers is very difficult to measure. There are a range of outcome measures used in ASC to identify progress but they are notoriously affected by a wide range of issues, which have nothing to do with the move to locality working. For example, the external provider market failing to deliver sufficient potential placements might skew the use of a particular service response. Another example would be increasing demand for a particular service outcome, perhaps because of an increase in hospital discharges during winter pressures might increase residential care placements when locality working might be successfully reducing tem.

3.2 The nationally recognised increasing demand for health and social care provision, alongside the success in delaying needs may also generate a greater demand ‘later’ as people return to the adult social care with greater acuity. There are many further variables which mean attributing a positive or negative change in the ASCOF figures to the introduction of locality working would be incorrect.

3.3 Nevertheless, a set of key performance Indicators are being constructed which will track the effectiveness of locality working as best we can over the financial year 2020-21. These will consider indicators in localities of things like the number of hospital admissions avoided, the reduction of residential care placements and the amount of time people remain at home with a care package, the number of carers assessments and advocacy used, and the satisfaction of people who use services and their carers.

3.4 Despite the difficulties of attributing outcome measures to the performance of locality working there are a number of ways in which its success can be judged from an adult social care perspective. One way is to consider the effect of the change to locality working on staff. The following graphic perhaps shows the best evidence of the impact locality working is beginning to have, where Greens are 'strongly agree' and 'agree', yellow is 'neither agree nor disagree', and reds are 'disagree or strongly disagree'. It suggests that broadly 44% are confident that locality working is proving effective for the people we work whilst 30% are unsure. If over the next year these staff members can be convinced of its value over 70% of staff will feel the model is effective in gaining belter outcomes for people.



South East Neighbourhood working

3.5 A summary of 7 TAP 'learning' cases, dealt with in the Neighbourhood Hub at Shortbrook:

- All 7 of the cases are currently involved or had involvement from Adult Social Care
- 6 out of 7 Cases have had involvement from Housing officers
- 6 out of the 7 cases have Home Care packages in place
- 5 out of 7 cases are due to deterioration in hygiene/ cleanliness/hoarding of the home.
- All cases have required involvement from all services around the table

3.6 Currently the following services involved in TAPs are:

- Adult Social Care

- Community Support Workers
- Housing Officers
- Care Managers
- Woodhouse Forum (People Keeping Well)
- District Nursing
- Occupational Therapy

Risks

3.7 Many of the detailed risks associated with both locality working have been described already, along with mitigating activity. In this section the main high-level risks are presented and mitigations are explained.

3.8 All of these risk areas will need close attention to ensure both locality working emerge to be the successful model for both Communities and Adult Social Care that it promises to be. See the table below for further details:

Risk	Mitigations
Ambiguity about practice standards	In localities a series of workshops are scheduled to start in the next quarter to run throughout the year, focussing on thematic elements and the standards that need to be met. A quality assurance team will be created to support staff and correct inaccurate practice. New ways of working in the South East Neighbourhood Hub are being tested and practice standards are being developed and shared for comment.
Ambiguity about internal and external interfaces	Partnership workshops are being delivered across the locality teams to support improved working arrangements, improving communication and relationship building.
Unsuccessfully changing the culture	Culture change is being supported by active leadership, whole service events to explain and communicate vision and practice principles, supported by the thematic workshops and continued investment in the front-line workforce.
Time constraints mean new working arrangements are not effective	Time will be used more efficiently and effectively as a result of: new IT systems, mobile working arrangements, and new IT hardware, clearer processes and decision taking at the lowest possible level in the organisation.
Training is unsuccessful in skilling-up staff in specialist aspects of	The effectiveness of the thematic workshops and the quality assurance team, as well as regular training opportunities will be monitored and any necessary changes will be made if they prove ineffective.

social care and neighbourhood hubs	Supervisions and personal development reviews will also be used to support the skilling-up process
Projects to support multi-agency working do not deliver needed innovations	Project support to monitor important pilots like First Local and the South East Neighbourhood Hub is in place and will react to any issues that arise. A governance structure is in place to enable changes to be made quickly where they are needed.
Performance measures are not robust enough to evidence progress	A performance framework that can be applied to locality working is in development. A governance structure is in place to properly report on performance and instigate corrective actions.

4. Recommendations

4.1 The recommendations to Scrutiny Committee are:

1. To note that locality working continues to be work in progress, but that significant advances are being made after a significant period of change and the ongoing management of risks.

2. To recognise that the potential future for locality working, even amidst well discussed national issues of resource pressures across health and social care

3. To note that delivering system-wide benefits will require continued emphasis on the values and principles of both locality working, and a commitment to change front-line practice from all system partners.

4. To note that the South East Neighbourhood Hub was launched on 4th November and will be evaluated in March 2020.

Conversations Count: changing the conversation in Adult Social Care

We're changing the way we approach adult social care in Sheffield. This paper explains why, and how.

Our new approach is all about the conversations we have with people. It's about listening to people, and talking with people, to really understand who they are, what matters to them, what a good life looks like to them and to their family, and how we and other people can work with them to achieve this. Instead of focusing on what people struggle with, defining them by their needs and assessing them for services, we will look at people's identity, their strengths, what they want to achieve, and what they, their family and community can, or could, do with the right motivation and support.

It's also about liberating workers from the endless forms, referrals and bureaucracy of our current system, and enabling them to explore a new, more exciting and more rewarding way of working – with a new IT system to support them. It's about increasing morale in teams, working together and trusting the professional and personal judgement of staff.

Finally, it's about more equitable use of scarce resources.

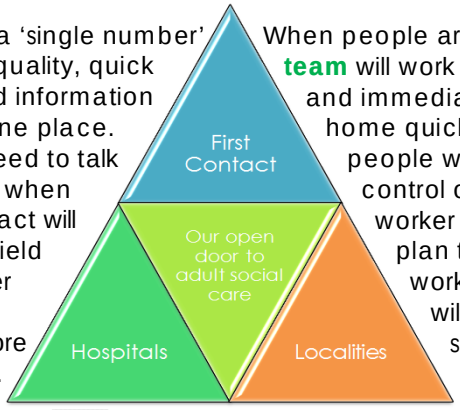
Our new way of working is called 'Conversations Count', and it's based on the Partners for Change 3 conversations approach. We're working with Partners for Change to change the conversations we have – not just with the people and families and communities we're working with, but also with each other and our partners in Sheffield – to build relationships and work together to support people to build better lives.

Conversations Count represents a significant cultural and behavioural change for us all. However, it is completely aligned with our core values, and the reasons we all work in adult social care.

Opening our doors

Our new approach will mean people and families will be able to contact us in three main ways. We will have open doors, not closed gates. There will be no wrong door. We will trust and rely on the professional and personal skills and judgement of our staff to focus on what really matters to people.

First Contact will operate a 'single number' point of contact for high quality, quick responses, and for tailored information and advice, given from one place. If people or their families need to talk with us more (and always when they are in crisis), First Contact will check which part of Sheffield they live in, and will transfer them immediately to the relevant locality team, before they start to tell their story.



When people are admitted to hospital, a worker in the **Hospital team** will work with them to understand what matters to them, and immediately begin planning with them how to get them home quickly and safely. The same worker will stick with people when they leave hospital, until they have regained control of their life. If people need on-going support, the worker will talk with them and their family, and agree a plan to put this support in place. If people we're working with in the community go in to hospital, we will keep working with them during their hospital stay, and on discharge, as outlined above.

Locality teams will know their local neighbourhoods and communities and everything that happens there. People and families new or known to us will be able to contact their Locality team directly, rather than going through First Contact. They will be able to do this either by phone/email or in person at **First Local** centres in their community. Locality teams will be adequately resourced to be fully involved in their neighbourhood, to play an active role in the lives of all those living locally, to respond immediately where necessary (and always when people are in crisis), and to have detailed knowledge of local opportunities and support, not just formal care services. The primary purpose of Locality teams will be to actively connect people to those local resources, and to be immediately available for intensive short term involvement when people experience crises. Locality teams will work closely with colleagues in primary and community health to ensure a coordinated experience for local people, using the three conversations approach as their working practice. The worker who has the first conversation with people and families will stick with them, bringing in additional people and skills where required. There will be no hand-offs or referrals. Where people have existing support in place, they will know who to contact in their relevant Locality team, and how to contact them.

Working together and sharing decisions

We will work closely within our teams, and will have open and honest conversations where we will question and challenge each other, and reach agreements together. We won't expect senior managers to make decisions about people they've never met. Senior managers will support the professional and personal skills and judgement of front-line staff and managers, who will only ask for support with decision-making where collective agreement can't be reached in the team.

Reducing bureaucracy and process

We will take seriously the Care Act requirement to work appropriately and proportionately. The number, type and length of conversations we have with people will be appropriate and proportionate to what they would like to achieve and to the severity and extent of their needs. We won't obsess about process, but we will be guided by our principles. We will focus on people's lives. We will spend significantly more time with people, and significantly less time in front of a computer.

Using scarce resources effectively

We will connect people to local, effective community resources to help them get on with their lives. We will challenge assumptions that services are solutions, and will reduce dependency on formal care services. We will reduce the number of people who return to us repeatedly because what we've put in place isn't working, we haven't listened or we haven't done what is most effective. This wastes money and time. We will intervene early, when people are less likely to be in crisis, and when they are in crisis we will work quickly and effectively with people rather than leaving them waiting and letting the crisis build. We won't tolerate waiting lists – they are bad for the people we're working with, bad for us, and bad for our budget. We will gather compelling evidence that this way of working is the most effective way of using resources, and delivers the greatest return on our investment for our people, our communities and our organisation.

Continually reflecting and learning

We will support each other in our teams through peer support and reflective practice. We will focus on finding solutions rather than identifying problems. If something isn't working, we will change it.

Redefining our principles

Our Conversations Count principles are fundamental to our approach. If we're not working in a way that promotes our principles, we will need to change the way we're working.

These are our principles.

1. We have conversations with people about their identity, their lives and what matters to them

We listen hard, and have conversations with people based on what they want to say to us, not what we want to ask them. We're interested in how people see themselves, what's important to them and what they'd like to achieve. We don't make assumptions, or prejudge what people's main priorities or concerns will be, or the solutions that will work for them. In our conversations we explore what people enjoy, what they're good at, where their strengths lie, and we talk about how some extra support from their family and friends and their communities could help them live as independently as possible for as long as possible. We have conversations in places where people feel safe, and we allow enough time for relationships and trust to be established.

2. We recognise that everyone is an individual, and we treat people as individuals

We know that people are the experts in their own lives, not us. We take full account of their views, wishes, feelings and beliefs. We don't define or categorise people by their needs, or by their age, disability or health condition. We work with people and their families to support them to live the best life possible, rather than simply operating a pre-defined, 'one-size fits all' assessment for services. The number, type and length of conversations we have with people are appropriate and proportionate to what they would like to achieve and to the severity and extent of their needs.

3. We keep people safe

We make sure that people are, and remain, protected from abuse or neglect. If we're concerned about people's safety, we work intensively with them to make sure they are fully involved and have choice and control over what happens next. We continue to work closely with them until we're satisfied that they have regained some stability and control in their life, they feel safe, and they have the right support in place to get on better with their lives.

4. We don't expect people to have to tell their story more than once
We never start conversations then pass people on, expecting them to tell their story again and again to different people who are only interested in one small element of their lives. This is particularly important where people are in crisis and need something to change urgently. Where people need more support than we can offer, we bring others in to help. People know how to contact us, and can contact us in a way that works for them.

5. We use language that demonstrates our respect and that is easy to understand
We communicate and provide information in a way that is easy for people and their families to understand, and that shows we respect them. We don't use jargon or acronyms. We identify, record, flag, share and meet people's accessible information and communication needs. We check to make sure that people understand, and can retain and use the information we give them, and can communicate their views, wishes or feelings. If people find this difficult, and they have no one else to help them, we arrange for an independent advocate to support them.

6. We know people's neighbourhoods and communities, and have an active role in them
We consider people in the context of their families and support networks, and take into account the impact of the person's situation on those who support them. We recognise that everyone is part of a community, or several communities, due for example to where they live, their interests, or their circumstances. Their community may have a physical base, or could be virtual. We see people, families and communities as equals. We listen to them. We recognise that people and their families know best about what will work for their lives, and communities know best about what will work in their area. We invest in small projects and initiatives to help them to thrive. We co-design solutions to meet identified gaps.

7. We don't plan long-term support unless there really is no other option
We don't assess people for services. We explore with people all the opportunities and support available within their own networks and communities. If we feel we've exhausted all the options, we check this out with our colleagues before considering more formal, long-term options. We never plan long-term support in a crisis. If people are in crisis, we help them to identify what needs to change urgently for them to regain some stability and control in their life, and work with them intensively to make this happen. We stay around and in contact to make sure the short-term plan is working. Once the crisis is over, we make collaborative decisions about what to do next.

8. We support people to make their own decisions
We always assume that people have the capacity to make a decision, and we explore all possible ways to help them to make their own decision. We understand that people have the right to make what we or others might regard as unwise or unusual decisions. If, following a capacity assessment, we don't feel that people have the capacity to make a specific decision, any action we take, or any decision we make for them or on their behalf, is made in their best interests, with the least restrictive impact upon their basic rights and freedoms.

9. We record conversations, not tick boxes
Liquid Logic supports rather than dictates our Conversations Count approach. We make real-time records of conversations. There is space to write, not boxes to tick. Our records capture, proportionately, who said what and why, and give a sense of people as individuals – their identity, their lives and what matters to them. Our records make sense to the people they're about, and we give people copies in a format that works for them. We make sure that people understand what is going to happen next.

10. We don't review support - we take stock with people about their lives
We want to know whether people's lives are working or not, and what might need to change to make their lives work better. We don't complete tick box reviews after a set number of weeks. We contact people and families after our conversations have finished to check how things are, and take stock at least once a year. If everything is working we record that and leave people alone. If not, we have more conversations to support people to get on better with their lives.

Changing people's lives

Our new approach will change people's lives.

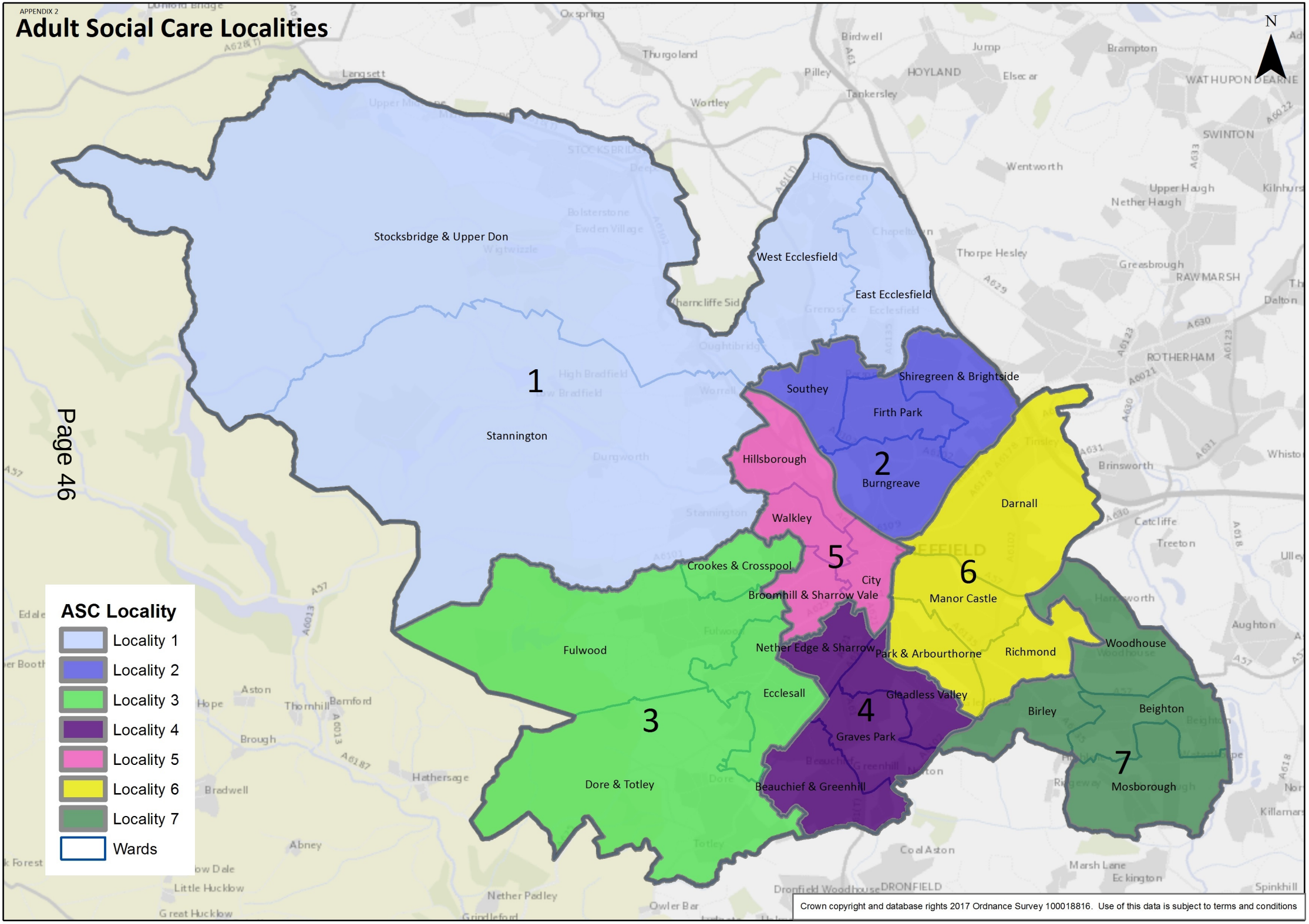
People and families in communities in Sheffield will be more independent, and safer. They'll feel more in control. They'll feel we know them, and feel that we care about the same things they care about.

Staff working in Adult Social Care will feel liberated and trusted, and that their professional judgement and their gut instincts matter. They'll feel happier. They'll feel like they're working in a way that is true to who they are, and true to what they believe.

Services will become less important. People's lives will become what matters. This will become our focus.

APPENDIX 2

Adult Social Care Localities



Changing the conversation: six key messages

1. How people initially contact us, and how we then work with them (access and case management)

Vision

We have open doors, not closed gates. There is no wrong door. We trust and rely on the professional and personal skills and judgement of our staff to focus on what really matters to people, and to be useful. When we start a conversation, we either immediately determine that the person needs to speak to someone else and we connect them quickly, or we stay with them, so they don't have to tell their story more than once.

We don't manage 'cases'. We listen to people, and talk with them, to really understand who they are, what matters to them, what a good life looks like to them and to their family, and how we and other people can work with them to achieve this. People matter to us, and we continue to check back in to make sure their lives are working for them.

Action

First Contact will focus on resolving some issues immediately (i.e. through a Conversation 1a) and passing all other work straight to the relevant locality team. We will learn about when we can work with people best from one central point and when they need to be connected immediately to a locality team.

Any urgent or crisis work will always be passed straight through to locality teams.

We won't arrange a package of care in a crisis and the pass to someone else.

We will continue to explore innovative, local and flexible ways of interacting with people e.g. First Local

2. Safeguarding

Vision

We make sure that people are, and remain, protected from abuse or neglect. If we're concerned about people's safety, or think that they are experiencing, or at risk of, abuse or neglect, we work intensively with them to make sure they are fully involved in any decisions and have choice and control over what happens next. We don't rely on forms and processes to keep people safe. We rely on our principles of no hand-offs, and of sticking with people in crises, and we continue to work closely with them until we're satisfied that they have regained some stability and control in their life, they feel safe, and they have the right support in place to get on better with their lives.

Action

Everybody needs to be safe – and we will ensure this through using Conversations Counts practice in teams to support people in a way that keeps them safe. We won't refer them to another team or 'pathway'. We will use excellent safeguarding skills based on Making Safeguarding Personal – and count and measure our performance in relation to keeping people safe. We will use Conversation 2 mode and mentality when people are at risk to put together high quality immediate plans to keep them safe, and stick with them to make sure the plans work.

3. Prevention and reablement

Vision

Prevention is not just the responsibility of a dedicated team. We are all responsible for prevention – collectively (and in collaboration with our partners) in developing wide-scale whole-population initiatives aimed at promoting health and wellbeing, and individually in each and every conversation we have with the people we're working with.

Likewise reablement is not a just a service we throw at people by default, but a way that we work with people to identify and put in place helpful solutions to support them to regain, or learn new, skills and abilities to better get on with their life in a way that works best for them.

Action

We will coach and mentor our staff to work in a 'prevention and reablement' mindset in all the work that we do, through reflective practice sessions and leadership**.**

4. Continuing Healthcare (CHC)

Vision
We always retain a focus on the person and avoid lengthy wrangling about funding and cold hand offs. We keep people informed, we explain and we're honest. We have collaborative discussions with our NHS partners rather than rely on bureaucratic processes shaped by forms and timescales.

Action
We will seek to agree with NHS colleagues how best to resolve funding issues in relation to CHC that don't involve lengthy delay for people while professionals dispute who is responsible.

5. Decision making

Vision
We support people to make their own decisions, and never exclude people from decisions about their care and support. We always assume that people have the capacity to make a decision, and we explore all possible ways to help them to make their own decision.

We work closely within our teams, and have open and honest conversations where we question and challenge each other, and reach agreements together. We don't expect senior managers to make decisions about people they've never met. Senior managers support the professional and personal skills and judgement of front-line staff and managers, who only ask for support with decision-making where collective agreement can't be reached in the team.

Action
We will develop sound, transparent and accountable mechanisms for maximum devolution of decision making to frontline staff and teams, whilst ensuring budget holding managers have full visibility of spending decisions and can intervene where necessary.

We will introduce a culture of peer reflection/support where teams work closely together in (locality based) worksites rather than in isolation from home, and feel confident and supported to make decisions collaboratively and challenge constructively where appropriate.

6. Brokerage

Vision
We know people's neighbourhoods and communities, and have an active role in them. We know about the informal, small scale opportunities and local sources of support and we connect people to them. We recognise that people and their families know best about what will work for their lives, and communities know best about what will work in their area. We invest in small projects and initiatives to help them to thrive. We co-design solutions to meet identified gaps. We work collaboratively to make the best use of all the available resources.

Action
We will always attempt to help people, in the first instance, through connecting them to local resources and systems of support in their communities. When we need to help people access formal care we will do this efficiently and collaboratively.

We will collect, maintain and share useful and comprehensive information on community resources and support.

Feedback on Locality working from the Whole Service Events October 2019

Team	Comment	Principle	category
Localities	Customer Engagement- Better collaboration between front line staff i.e. Business Support & operational staff with O Staff taking/responding to client calls rather than say "take message" resulting in customer frustration not being able to talk to the right person Business Support - Localities	Collaborate	Improvement
Localities	Improve quality of case agency to enable empowerment	Empower	Improvement
Localities	Work in specialist teams to promote confidence in workers & enable them to Empower customers		Structure
Localities	Record. Reduce mistakes once learnt pathways for Liquid Logic	Record	Improvement
Localities	Improve IT e.g. give staff the ability to send secure/encrypted email so that everything doesn't have to go through business support. Keep an electronically updated list of providers rather than emailing lists that go out of date etc.		Systems
Localities	Conversation model better way of 'Assessing'	Involve	Comment
Localities	Some Specialised Teams need to be developed to improve the customer journey & increase confidence & reduce waiting times.		Structure
Localities	Ability to truly hear customer experience 'hubs'	Involve	Comment
Localities	Caseload management: sharing resources effectively across localities.	Collaborate	Improvement
Localities	Network/identify local services	Collaborate	Improvement
Localities	Support level 1 staff to progress to level 2 faster (with protected time to do the portfolio etc)-so that staff feel valued. Most of them are already doing the work!		Staff
Localities	Go back to Specialist Teams		Structure
Localities	It means we can get back to social work and its principles		Comment
Localities	Hubs in localities sound like a good plan-esp if it is multidisciplinary LA/CCg + 3rd sector	Collaborate	Structure
Localities	Time to reflect on practise as a team	Learn	Improvement
Localities	I record my conversation and learning from all I come into contact with	Record	Comment
Localities	Improve communication especially with CCG to stop delays + aid us to collaborate	Collaborate	Improvement

Localities	Providers having bank staff on 0 hours contracts (NOT ALL) the ones that are happy for short term work when they are available-This so people in hospital can come out with the same provider.		Improvement
Localities	Listen to others to see how they'd do it (improve practise)	Learn	Improvement
Localities	Training opportunities to enable staff to be more confident with different customer groups	Learn	Training
Localities	Additional resources or better resource management so we align resources to where they are most needed		Resources
Localities	Recruitment & Retention Strategy- needs developing as struggling to retain talent & increase suitable candidates to vacancies.		Resources
Localities	Increase staffing so we have time for prevention/empowerment not just crisis management.		Resources
Localities	Bed vacancy in Care Homes recorded centrally with information about top up fees	Record	Improvement
Localities	Collaboration is being affected by separation of professionals e.g. Love street –OTS, Physios will be based at different sites, need to maintain the current status quo.	Collaborate	Structure
Localities	Involve people in conversations-collaborate with them + other people both professionals + charity empowering the person to live the life they need		Comment
Localities	More coproduction-Peaks are developing a local forum	Involve	Improvement
Localities	Need consistent support from SLT		Management
Localities	Bullet points on case notes	Record	Improvement
Localities	Use of abbreviations sometimes makes understanding difficult	Record	Improvement
Localities	Create team to collect debt-SW/CM should not have to be debt collectors – ruins relationship when they have to talk about money owed too much…. Does not support conversations count?		Structure
Localities	Poor Quality IT-Liquid Logic has created more problems than it has solved, it is illogical & has got in the way of the innovations & reduction in bureaucracy promoted by Conversations		Systems
Localities	-Pooled budget for JPOC's or agreed e.g.so-so split like for S117 –would then more time ensuring people's needs are met and less arguing about budgets!		Finance

Localities	"Holistic" Collaborative, innovation from all Service, localities areas. Team Players, respect each other's roles not them and us	Collaborate	Comment
Localities	Senior managers should ensure systems are tested to ensure that thye are effective prior to launching a system live! Yes we are talking L.L. + control		Systems
Localities	What needs to change – More staff		Resources
Localities	Events to start in a timely manner 100 staff x 30mins = 50 hours cost to council to sit and chat!		Complaint
Localities	More support on site with L.L. issues having to send emails slows the learning process down and momentum is lost		Systems
Localities	Better collaborative working	Collaborate	Comment
Localities	Start these events on time !!		Complaint
Localities	More staff- chasse (?) the depts to allow service to those who don't shout as loud		Resources
Localities	More collaborative working between-localities-SCAS-commissioning-Providers-PKW-CSW	Collaborate	Comment
Localities	Liquid Logic development & better training & support	Learn	Systems
Localities	Fair distribution of resources –Childrens Services have far more than Adults services		Resources
Localities	Resources linked to Demographics		Resources
Localities	Change management-more consultation prior to change		Change
Localities	Feel more valued by our SCAS departments –work in collaborations	Collaborate	
Localities	I need to clone myself as there isn't enough time to do my job by 1 person		Resources
Localities	Better open market, equity of service for LD + adults, stop being dictated by control		Commissioning
Localities	Better equipment for staff-you talked about staff respecting SU's-something needs to happen in Sheffield –there is little respect for SW's		Complaint
Localities	360 degree feedback –Career development framework-Talent Management Programme –Training need analysis-leading to bespoke learning opps		Development
Localities	Home support-it needs flexible consistent service, quality above quality		Services
Localities	Localities-G drives from localities services to shared access so we repeat-consistent messages from all managers-consistent + clear messages about recording	Record	Improvement
Localities	Clearer processes in a timely Manner		Improvement
Localities	More interaction between team managers		Management

	across services		
Localities	We need to collaborate more with C.C.G	Collaborate	Comment
Localities	Improved home care providers		Services
Localities	Drop down in localities sorted – seems as we mobile work		Systems
Localities	Need to recognise that empowerment, involving Sus etc… takes time to achieve. The pressure from current workload makes This challenging. Team managers need to facilitate This rather than a token gesture!	Empower	Resources
Localities	Some new blood in middle mgt to support new directives.		Management
Localities	Locality working has not achieved what it expected to –still don't know enough about local resources! Too many wider service targets to meet.		Structure
Localities	Investment in more staff. Resources.		Resources
Localities	Quicker payments.		Finance
Localities	Quality of homecare. Bring back Care4You as main provider.		Services
Localities	To have link people in each area so we can know who to go to for information and improve communication across the service	Collaborate	Improvement
Localities	There are far too many managers (service + team) who do not have social work qualifications		Management
Localities	Back to specialism. People's skills and service is diluted. Staff lacking confidence in specific areas.		Structure
Localities	Professionally qualified managers .		Management
Localities	We need to collaborate more with C.C.G.	Collaborate	Comment
Localities	Balance the specialisms in locality teams – part of a robust workforce development place		Structure
Localities	Outcome based commissioning. Our providers need to commit to this & assessors would then write outcome focused plans	Empower	Services
Localities	Localities-Needs to change. Create space & time to have better conversations		Resources
Localities	Notice boards to reflect to all staff & service users it works at Brushes		Improvement
Localities	Whole locality team meetings rather than individual team meetings	Collaborate	Structure
Localities	We are currently starting to collaborate in locality 7 hub. Denise MDT's in Beech Hill- To share responsibility- Inter-professional practise	Collaborate	Improvement
Localities	Specialisms work better in some areas. Bring these back for e.g. supported living & CHC. Better for the person.		Structure

Localities	More Autism training	Learn	Training
	feedback from Incident form	Learn	Improvement
	Workshops on site.	Learn	Improvement
Localities	Clearer processes between First contact & localities-Roles & responsibilities are too changeable.	Collaborate	Improvement
Localities	Believe there is still a need for specialist teams. Skills have been diminished and staff lack experience.		Structure
Localities	Care Home Team Req'd.		Structure
	Better locality Bases. Be based in our locality.		Structure
	We need to hear about the good stories	Learn	Communicatio n
	* BRING BACK SPECIALISM TEAMS*		Structure
Localities	Managers to ensure recording really reflects the principles-stand firm & return work which doesn't reflect principles.	Record	Management
Localities	Change: Hospital teams changing regularly. Diagram required of all teams and how and where new teams fit wrap around the person –Tops Team	Collaborate	Structure
Localities	More consistency regarding processes		Systems
Localities	More interaction between team managers (All offer different advice)		Management
Localities	More interaction between team managers across services too.		Management
Localities	Executor services needs to change as cases coming up for COP application when clients and providers requesting funds and being denied. This does not promote independence well-being and is not strength based empowerment approach.	Empower	Improvement
Localities	More time as a team to share & reflect & learn.	Learn	Resources
Localities	Poor management support at present. Managers appear unaware of current stressors within the office and one staff member was supported by a manager outside of locality who was visiting. Bring back Senior Practitioners to support workers		Management
Localities	MDT barrier. Health vs social care. Consultant / MDT barriers respect and being kind.	Collaborate	Comment
Localities	IT equipment		Resources
Localities	Front door into localities	Collaborate	Structure
Localities	OT in each locality	Collaborate	Structure
Localities	Access to insight		Systems

Baseline File Audit Recommendations

September 2019

1. Records must demonstrate how staff have applied practice principles, by:

- Evidencing how staff have supported the person to be involved in conversations and to make decisions about their lives.
- Reflecting on what matters to the person and what has been agreed will help them to live the life they choose (including: what they'll do themselves; what family, friends and others in their support network will do to help; how technology can open up opportunities; what formal support, if any, is included, and how support will be funded).
- Evidencing a collaborative approach to decision-making, clearly demonstrating who has been involved in supporting the person to make decisions about their lives and why the decisions were made.
- Being accurate and up-to-date.
- Creating more transparency in our recordings, to help empower people and support better outcomes for people who already use our services.

2. Work to embed the practice principles must include discussion about what good records look like as well as what good conversations look like. To support this, the Practice Development Team will work with teams to update the recording principles and develop additional recording guidance and exemplars so we have a shared understanding of what good looks like and why it matters.

3. As well as embedding the principles we also need to ensure there is a shared understanding across the service about our legislative requirements, with an emphasis on wellbeing and about eligibility being much more about the person's individual life and goals, not just a lack of knowledge about the legislation.

4. To assure ourselves that the principles are being understood and are being applied consistently into everyday practice, we need to implement a monthly file audit across the service. Auditing records within supervision will enable us to reflect, learn and understand how we could do things different, and how we can improve. It will promote excellent practice where it exists and look at actions for improvement in service delivery

Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Wednesday 15th January 2020

Report of: **Policy and Improvement Officer**

Subject: **Work Programme 2019/20**

Author of Report: Emily Standbrook-Shaw, Policy and Improvement Officer
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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 26th February 2020 4pm		
Mental Health Strategy	To consider and comment on the draft Mental Health Strategy in advance of it being presented to Cabinet.	Sheffield City Council NHS Sheffield Clinical Commissioning Group
Sheffield Adult Safeguarding Partnership	To consider the review of the strategic plan, and seek assurance that appropriate safeguarding arrangements are in place and performing effectively.	Simon Richards, SCC David Ashcroft, Independent Chair of Safeguarding Board.

Continuing Health Care	Follow ups from November meeting – seeking assurance that progress is being made on person-centred approach to CHC (assessment and beyond) and gain further understanding on the appeals process – particularly around its independence.	Sara Storey, SCC Alun Windle, Paul Higginbottom NHS Sheffield Clinical Commissioning Group
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*