Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 14 October 2020 at 4.00 pm

To be held as an online video conference

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, Abdul Khayum, Martin Phipps, Jackie Satur, Gail Smith and Garry Weatherall

Healthwatch Sheffield
Lucy Davies and Dr Trish Edney (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
14 OCTOBER 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 5 - 8)
Members to declare any interests they have in the business to be considered at the meeting

5. Minutes of Previous Meeting (Pages 9 - 18)
To approve the minutes of the meeting of the Committee held on 19th August, 2020

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

7. Care Homes for Older People and Adult Social Care Strategic Review (Pages 19 - 30)
Report of the Executive Director, People Services

8. Winter Planning for the City and Operational Delivery of Continuing Health Care over the Coming Months (Pages 31 - 36)
Joint report of the Interim Director of Adult Health and Social Care (Sheffield City Council) and the Chief Nurse (Sheffield Clinical Commissioning Group)

9. Continence Services Scrutiny Working Group (Pages 37 - 40)
Report of the Policy and Improvement Officer

10. Draft Work Programme 2020/21 (Pages 41 - 46)
Report of the Policy and Improvement Officer

11. Date of Next Meeting
The next meeting of the Committee will be held on Wednesday, 11th November, 2020, at 4.00 pm

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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 19 August 2020

(NOTE: This meeting was held as a remote meeting in accordance with the provisions of The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020.)

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

Non-Council Members (Healthwatch Sheffield):- Patricia Edney

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Lewis Dagnall (with Councillor Sioned Mair Richards attending as his nominated substitute), Councillor Jackie Satur and Lucy Davies, Healthwatch (with Patricia Edney attending as her nominated substitute).

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 Councillor Mike Drabble declared a personal interest in Item 7 on the agenda (item 6 of these minutes) – Covid 19 Pandemic and Mental Health – as a Counsellor for Mental Health; and Councillors Steve Ayris and Adam Hurst also declared an interest in that same item as members of the Sheffield Health and Social Care Foundation Trust - Council of Governors.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 22nd July, 2020, were approved as a correct record.

4.2 *Matters Arising*

4.2.1 In item 6.6(e) it was stated that a copy of the resolution would be shared with all Sheffield MPs and the Policy and Improvement Officer confirmed that this had been done.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 Jeremy Short, on behalf of Sheffield Save Our NHS, asked the following questions:-

1. COVID-19

It is widely accepted that the COVID 19 pandemic will significantly increase the demand on mental health services in the short and medium term. The Royal College of Psychiatrists has warned of a 'tsunami of referrals' to be expected. The most direct impact will be on frontline NHS and careworkers suffering from Post-Traumatic Stress Disorder (PTSD) as a result of weeks dealing with seriously ill and dying patients and clients. However, there are many other areas which will increase pressure on services, including:

- Worsening mental health amongst those with a pre-existing condition
- Impact of increased unemployment and financial insecurity
- Anxiety amongst children returning to school while infections are still being passed on
- Effects of loneliness due to prolonged lockdown especially amongst vulnerable people
- Impact on BAME communities from above-average vulnerability to the virus
- Women caught in abusive relationships
- Frontline workers in retail, transport etc. suffering abuse from customers – and pressures maintaining safe working.

We note that the Health and Social Care NHS Foundation Trust has produced a strategy to cope with the impact of the pandemic. However, given that the Trust's performance was found to be 'inadequate' by the Care Quality Commission in April this year, how confident is the Scrutiny Committee that the Trust is capable of delivering? In particular,

(a) What additional financial and other resources is the Trust putting in place to meet the expected crisis?

(b) Are there adequate supplies of PPE available for all mental health workers?

(c) Is rapid and regular testing available for workers and clients?

(d) Is there a commitment to resume face-to-face consultations when it is safe to do so?

2. CQC Report on Sheffield Health and Social Care Trust

(a) The Care Quality Commission (CQC) report on the Trust in April found the Trust to be inadequate overall and requiring special measures. To date we have seen no apology from the Trust leadership to either users or staff who have suffered because of mismanagement. Does the Scrutiny Committee think it appropriate to ask for such an apology?

(b) The CQC found 47 breaches of legal requirements across 8 regulations. How many of these have been rectified to date?

(c) In Involve, the Trust's magazine for members, it was stated that 'you can check on our progress at www.shsc.nhs.uk'. However, there has been no update since an initial post on 29th April outlining 5 general areas for action. Although

information is available buried in dense Board papers, why has the Trust posted no accessible update on its web-site for over 3 months during this critical period?

(d) From the August Board meeting papers, it appears progress is being made in some areas, although even in these there are problems with inadequate reporting systems. Specifically, what action has been taken to:

i. End mixed-sex accommodation to ensure safety

ii. Provide an adequate number of inpatient beds (particularly with regard to expected increase in demand)

iii. Ensure all staff are aware of whistle-blowing procedures and the Speak Up Guardian

iv. Ensure mandatory training will be carried out in the future

v. Ensure adequate experienced staff are in post rather than relying on agency staff

(e) Will the Council establish an independent inquiry, including trade unions and users, to investigate the running of the Trust?

3**. Finance and Management**

(a) Was the deterioration in the Trust's services directly linked to the aim of achieving £7.1 million in 'efficiency' savings targeted as part of the Mental Health Transformation Programme in 2018-19?

(b) Why was this found necessary when the Trust's own accounts show a total of £15 million surpluses over the last two financial years and that cash reserves rose by £10 million to £51m in the year to March 2020?

(c) Should the Trust not have been spending this money to ensure that adequate staff and resources were in place instead of allowing services to continue to deteriorate so dramatically over the last two years?

5.2 The Chair thanked Jeremy Short for his questions and said that, with his agreement, they would be shared with the Health and Social Care Trust. She said that some of the questions would be answered during the meeting, but anything not answered would be put in writing and published in the public domain. With regard to scrutiny, that was the reason for holding this and subsequent meetings. With regard to the question asking that an apology be made, the Chair said that it was for the Trust to offer an apology, not within the remit of the Scrutiny Committee to ask for one. Relating to the question regarding an independent inquiry, there were regulatory arrangements regarding this, however if the Scrutiny Committee felt that appropriate improvement was not being made, then action could be taken in the first instance, but ultimately it was up to the CQC to take responsibility for that and appropriate further action would be taken.

6. COVID 19 PANDEMIC AND MENTAL HEALTH

6.1 The Committee received a report which provided an overview of the Covid 19 Pandemic and the impact it was having on the emotional and mental wellbeing of Sheffield citizens.

6.2 Present for this item were Jan Ditheridge (Chief Executive, Sheffield Health and Social Care NHS Foundation Trust), Mike Hunter (Medical Director, Sheffield Health and Social Care NHS Foundation Trust), Dr. Steve Thomas, GP (Clinical

Director, NHS Clinical Commissioning Group (CCG), Sam Martin (Head of Commissioning (Vulnerable People), Sheffield City Council); Heather Burns (NHS Sheffield Clinical Commissioning Group), John Doyle (Director of Strategy & Commissioning, People Services Portfolio, SCC); and Councillor George Lindars-Hammond (Cabinet Member for Health and Social Care).

6.3 Steve Thomas introduced the report and highlighted the key issues arising from it. He said that a substantial amount of work in the mental health sector had been done pre-covid, during and post-covid, as Covid-19 may be seen and portrayed as predominantly a respiratory virus, it can actually affect many organs and is a multisystem disease that can also be neuro-toxic. This can affect the brain directly and the consequences of Covid-19 clearly impact mental health and wellbeing. Mental health and mental non-wellbeing was also being severely affected by Covid. There was an increase in first episode mental illness, for example anxiety, mood swings, depression, the consequences of loneliness and isolation, brought about by intergenerational adversity, education, employment and housing. He said the risk of addictive behaviours has increased, including the use of alcohol and that there may be an impact on gambling with the use of online access having become more apparent and, as anticipated, there had been an increase in domestic violence. He said there had also been a significant impact on those who had faced bereavement. The Health and Wellbeing Board had requested a Rapid Impact Assessment (RIA) and this had been commissioned to help determine, and therefore plan for the anticipated increase in demand for mental health services. One of the things that had become apparent throughout the Covid pandemic, were social inequalities. There had been positive aspects of the lockdown in terms of mental health and wellbeing, by people spending more time reconnecting with families, nature, hobbies and activities and children feeling less stressed through not attending school. The Voluntary, Community and Faith (VCF) Sector had continued to provide emotional and practical support to those with mental health issues and offer independent mental health advocacy services and specialist mental health advisory services throughout the pandemic. The Sheffield Psychology Board was looking to address the immediate emotional and psychological needs of frontline workers and those working in care homes and care workers, keyworkers, as well as the general public. Over the past six weeks, over 200 people had been seen by the newly established Primary Care Mental Health offer that is currently being tested in four Clinical Network areas covering 200,000 of the Sheffield population and interventions made, with 40% of those interventions having been from the Black, Asian and Minority Ethnic (BAME) community. The anticipated increase in mental health problem presentation as a result of Covid-19 was likely to see up to a 40% increase in demand for support.

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

- Sheffield had seen an increase in domestic violence cases, however hard data regarding domestic violence was not clear and whether there had been an increase in cases during lockdown or whether numbers had been hidden due to people not attending A&E, GP surgeries or contacting the police. It had been anticipated at the start of lockdown that numbers would rise due to people spending more time together but the true picture was not known.

Nationally there had been a massive increase in calls, but locally it had not translated into a flood of requests for help.

- There had been an increase in the number of perpetrators who had been abusive towards their partners or ex-partners and had referred themselves to the Perpetrator Behaviour Programme aiming to change their behaviour and develop respectful, non-abusive relationships.

- There was an extended online counselling helpline available to children, aimed at providing stability during lockdown, although very few calls had so far been received but was starting to increase slowly. It was anticipated that towards the end of September, referrals from CAMHS would start to come through and teachers can see social pressures. Reference was made to the Door 43 Wellbeing Service, a service which offered support to 13-25 year olds on a range of emotional wellbeing issues, providing information, advice and guidance to young people experiencing issues such as low mood, stress and anxiety, loneliness, and who may have been particularly affected by the pandemic by the transition from primary to secondary school, transition to 6th Form, transition to university or the workplace and the lack of SATs, GCSE and A-Level examinations and results.

- It was anticipated in the school return, that a whole suite of services would be put in place by the end of September by working with clinicians, CAMHS, MAST and school representatives to prepare for the return to school, to offer support and training for schools to create a healthy environment for children as well as members of staff. Lots of measures were being put in place to help children get around school buildings safely, infection control and "bubbles".

- The City Council had engaged in the Government's "Everybody In" initiative and worked with a range of partners to accommodate all rough sleepers in either supported or hotel accommodation at the beginning of lockdown and this had proved very successful in getting the homeless off the streets. Successes had been seen and a number of rough sleepers were ready to move into assisted accommodation, but not every rough sleeper wished to make that transition and some have drifted back into hanging around city centres. The Government, through Public Health England, were providing resources to maintain the work that had been initiated, as it was not possible to leave rough sleepers in the accommodation that had been provided throughout lockdown. There are resources to sustain that work to offer a number of options to help maintain the support they have received and continue with that support.

- The Homeless Assessment and Support Teams had worked throughout the crisis and there hadn't been a complete stand down of face-to-face care in services. The decision to offer face-to-face service had been based on assessments of the whole situation carried out by doctors wearing full Personal Protective Equipment (PPE) and making sure they got the assessments they needed. The Early Interventions Psychosis Service, consisting of staff from a variety of disciplines, including nursing, social

work, occupational therapy, and psychology, had held fewer face-to-face consultations, and contact had been made by telephone, although it would be disingenuous to suggest that not seeing people face to face there wouldn't be a downside to that as seeing people was fundamental to what they do.

- Covid was an amplifier and magnifier of health and social inequalities. The NHS Implementation Plan refers to everything that we are trying to put in place to measure and modify to take into account the effects of Covid on the most disadvantaged groups and also including BAME, in all services and mainstream mental health services. In relation to the point raised about substance misuse, the evidence was not clear on this, although the use of alcohol has shown an increase. Services were keen to carry on conversations to make sure we have the most resilient plans possible.

- The physical health of approximately 30% of those affected by Covid are thought to have long term health conditions but it was not known at present what the medium or long term health consequences were likely to be.

- Some of the frontline workers who had cared for and gave support to those affected by Covid, were now requiring support themselves.

- It was predicted that there would be a big demand for mental health support services across all ages and as yet, we have not seen the full mental health impact caused by the virus.

- One of the things resulting from the pandemic was the digital revolution platform. St. Luke's Hospice had championed an educational methodology called ECHO, allowing care homes to participate in a wide variety of training, for example on the use of PPE, dealing with social distancing and how to reintegrate visits from family and friends into care homes.

- Greg Fell, the Director of Public Health in Sheffield has set out clear guidance around visits to care homes. The guidance sets out the only practical way of doing things and there may be times when there were clashes, but there was no easy resolution to this issue.

- Access to mental health services were currently at different levels, and prevention and promotion of wellness was of great importance. The methodology may have changed, with increased use of video and telephone conference. The Primary Care Mental Health Framework operates across 21 GP practices. 200 people who have been seen would traditionally not have accessed mental health services, due to being too complex for IAPT and not complex enough for secondary mental health services.

- There was a need to develop services to be able to see more people, and as we become confident in delivery of care we need to meet the challenge. There was an opportunity to do something different and get on top of prevention through focussing efforts and resources into primary prevention so there wasn't as much need for secondary care.

- The key was to stop looking at pre-covid and focus more on post-covid and carry out a review across all services.

- At present, initial assessments being carried out by GPs was via telephone or video conferencing, GPs then deciding whether someone needed to be seen face-to-face the same day, by proper use of PPE, then deciding what steps should be taken. A number of people have been proactive in their choice, preferring telephone or video conferencing, reducing the need to travel or sit in a busy waiting room.

- The caseloads of workers in every Service have been risk assessed to ensure they aren't taking on too much.

- For those with physical disabilities, there hasn't been a large impact. Phase 3 will request GPs to review at least two thirds of patients with learning disabilities.

- There is a difference in national funding regimes for mental and physical health - every time someone attends hospital presenting with physical health issues, the hospital gets paid. Mental health services aren't funded in this way, which has resource implications.

- Mental illness and mental health problems account for nearly 25% of all the mortality and illness that the NHS deals with, yet only receives approximately 12% of the budgetary resources. This will only worsen as we continue to live with Covid-19.

6.5 RESOLVED: That the Committee:-

(a) thanks Jan Ditheridge, Mike Hunter, Steve Thomas, Sam Martin, Heather Burns, John Doyle and Councillor George Lindars-Hammond for their contribution to the meeting;

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

(c) is keen to see that the good practice and learning developed in mental health services through Covid19 is captured and built upon;

(d) recognises that there is commitment in Sheffield to overcoming barriers to accessing mental health services, and will be looking for evidence that access to services is improving;

(e) notes national issues around parity of esteem and insufficient funding for mental health; and expresses concern that it will be difficult for local areas to meet the anticipated increase in demand for mental health services due to Covid19, unless national government puts appropriate financial arrangements in place;

(f) notes that digital solutions have been an important part of accessing services during Covid19, and as such, the City needs to address issues of digital exclusion;

(g) supports efforts to improve how the mental health needs of Sheffield people are met, and recognises the importance of doing so; and

(h) recognises that work is ongoing to analyse the impact of Covid19 on mental health in Sheffield, for example through the Rapid Impact Assessment, and looks forward to seeing an action plan to address the issues identified as a result of this assessment.

7. CARE QUALITY COMMISSION IMPROVEMENT PLAN - PROGRESS REPORT

7.1 The Committee received a report detailing the progress that had been made in relation to the delivery of the Sheffield Health and Social Care NHS Foundation Trust Improvement Plan, following the Care Quality Commission inspection of the Trust in January, 2020 when the Trust received an overall rating of “inadequate”.

7.2 Present for this item were Jan Ditheridge (Chief Executive) and Mike Hunter (Medical Director) (Sheffield Health and Social Care NHS Foundation Trust) and Alun Windle (Acting Chief Nurse, Sheffield NHS Clinical Commissioning Group).

7.3 Jan Ditheridge referred to the questions asked by Jeremy Short and stated that the Trust was truly sorry for the inadequate rating it had received and had written to its members and all members of staff with an apology for what had happened. She said that an apology had also been made at a public Board Meeting and at a number of other arenas. Jan Ditheridge thanked Mr. Short for pointing out that the link, included in the Trust’s magazine, did not work and said that this would be put right. There were two action plans, one around core services and the other around “well led”. The Trust had been given tasks and have a number of actions to complete. Oversight arrangements have been different because of Covid and lockdown, although meetings were held on a regular basis to scrutinise progress against the actions in the action plan.

7.4 Mike Hunter stated that the Trust’s core services had been inspected by the Care Quality Commission (CQC) in January, 2020 and immediately following this inspection, a Section 31 Notice, stating that 16 and 17 year olds should not be admitted to shared accommodation in the Psychiatric Decisions Unit, was served and the Trust took immediate action and complied with the Notice within 24 hours. In February, 2020, the Trust received a Section 29A Warning Notice, which identified four areas which required significant improvement. The CQC found issues with staffing, mandatory training, safeguarding, the management of physical health, environmental safety and incident reporting. The two main areas where there were problems were in Acute Wards and Crisis Services, in that they were inadequate in terms of safety and not well led. Since then, management on a day-to-day and weekly basis had seen significant progress being made, and the CQC have engagement calls on a fortnightly basis to monitor progress. It had been challenging to adhere to safe staffing numbers on acute wards, and flexibility of working practices was required. The Trust put in place an Improvement Plan, and

a “Getting Back to Good Board” meets monthly to oversee and drive delivery of the actions required, which the Trust thinks will take 12 months to implement. All of the urgent actions in the notice have been completed, and the Trust were about one third of the way towards implementing all the actions required.

7.5 Members asked a number of questions, to which responses were provided as follows:-

- Staff morale had been hit hard, but the issues have been addressed, although staff felt that they were still in the thick of it. There still remained a number of staff vacancies. The Covid 19 pandemic had lifted staff spirits as they worked as a team, were more flexible and volunteered and felt well supported by the team response. They had proved to themselves that where there were infections they managed to contain the virus very well.

- The Trust still rely very heavily on bank staff and agency nurses, who were very much part of the team. Bank nurses work regularly, in the same areas, and go through the same training as regular staff.

- There were 22 newly qualified nurses due to start at the end of August, 2020, which was a welcomed development. They are newly qualified and enthusiastic.

- Improving Access to Psychological Therapies (IAPT) services continued to grow and change. The Trust has now appointed more care co-ordinators in its Community Mental Health Teams in order to reduce caseloads and allow for more therapeutic time with patients.

- Governance arrangements have been refreshed and data was available to understand where the risks are. The Trust has undertaken a lot of work to build a performance framework and this had been complemented by Board visits and visibility out in the field.

- Memory Services perform well in Sheffield and responded well to change. The services that had slipped were the acute wards and indicators show that the Trust is heading in the right direction and improvements were being made.

- There was a distinction between management and practice supervision. The CQC want to see improvements in practice supervision (reflective practice), getting practitioner leaders to engage with staff more readily. The Trust have not changed the leaders and managers through the organisation but what has emerged is that there are many layers of management and this was a root cause that has tripped them up. Leadership programmes were in place but there was room for more. The results being seen are in terms of compliance with supervision and appraisals.

- The usual response to an inadequate rating, was that there was an NHS Improvement Management Team established to oversee improvement. Feedback received shows that there had been rapid improvement in some

areas. The Regional Executive Management Team will continue oversight of the Trust.

7.6 RESOLVED: That the Committee:-

(a) thanks Jan Ditheridge, Mike Hunter and Alun Windle for their contribution to the meeting;

(b) notes the contents of the report;

(c) is satisfied with the information provided by the Sheffield Health and Social Care Trust on the CQC Improvement Plan; and

(d) requests a further report to the Committee in six months on progress, with a focus on how the changes being implemented as a result of the Improvement Plan will improve outcomes and make a difference to Sheffield people.

8. WORK PROGRAMME

8.1 The Committee received a report of the Policy and Improvement Officer on the Work Programme for the Committee.

8.2 RESOLVED: That the Committee:-

(a) approves the contents of the Work Programme; and

(b) requests that the local impact of changes to Public Health England be added to the work programme long list.

9. DATE OF NEXT MEETING

9.1 It was noted that the next meeting of the Committee will be held on Wednesday, 14th October, 2020 at 4.00 p.m.

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

Report of: **John Macilwraith**

Subject: Care Homes for Older People and Adult Social Care Strategic Review

Author of Report: Joe Horobin and Nicola Shearstone - Heads of Commissioning
Tel: 0114 2735891

Summary:

This report describes the work being carried out now and over the next few months around the residential and nursing home sector in the city and how this sits within the context of a broader review. The report is divided into three sections.

Part I – This sets out our approach to reviewing the older people's care home market in the context of immediate Covid19 pressures and the annual cost of care and fee rate exercise.
Part II– A description of how this sits in the context of a wide ranging strategic review of the Adult Social Care including the care home sector in the city
Part III – Describes briefly the effect of the pandemic on care homes in the city and explains the Council's response and proposals for future engagement with the sector

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	

The Scrutiny Committee is being asked to:

- Note the contents of this report and provide views, comments and recommendations.
- Support and contribute to the adult social care review consultation using the links provided on page 8 of this report.

Background Papers: None
Category of Report: OPEN

Introduction/Context

This report is divided into three sections which outline the Council's actions and plans in relation to care homes for older people in the city

1.1 Care Home Market Review and Cost of Care
1.2 Strategic Review of Adult Social Care
1.3 Covid-19 and its effect on Care Homes

We are working in very challenging times and we are still unsure about when, if ever, we will return to pre-Covid-19 conditions and "normal" ways of working. A huge amount of time and energy is being spent across the city and within the Council dealing with the immediate issues that we face, not least the safe and effective operation of the care home sector including the stability and viability of individual homes.

We cannot, however, allow ourselves to lose sight of the longer term planning that is needed across the city. Throughout the pandemic, we have been learning a lot about care homes and working closer than ever with the sector. This should put us in a good position to study and analyse the strengths and gaps in the city and establish a clearer view of the current market and how we support it to respond to the current challenges and become fit for the future ambitions for the city.

PART I – Care Home Market Review and Cost of Care

This section outlines the approach of commissioners over the next few months to reviewing the current care home market and fee rates in the context of the Covid19 pandemic and our best understanding of future demand for care. This work is part of our commitment to reviewing the market as set out in the Cabinet Report from March 2020: *"Maintaining a Stable Adult Social Care Market".* Timescales for this review of the market have been shifted back because of the impact of the pandemic on the market and on the Council but the work is now progressing with input from providers via the Sheffield Care Association and the Care Home Owner Forum. Commissioners are also working with some third party experts in the care home market to look at how they can also add value to the review.

Commissioning Principles: Quality, Diverse, and Sustainable Adult Social Care Market.

The Care Act enshrines the duty of the local authority to ensure that there is a high quality, diverse and sustainable care home market, sufficient to provide choice to meet people's needs and promote and support their wellbeing.
According to the Act, the scope of care home provision should be diverse and reflect the needs of the population. The intention is that the review of the market and cost of care for older people's care homes will sit within the wider context of ASC Strategic Review (see Part II) and be aligned with the Council's business planning process.

Practice Principles: Independent, Safe and Well

The work of operational commissioning is in the context of the current social care practice values and principles. These values will be incorporated and reviewed as part of the wider Adult Social Care Strategic Review.

- People feel safe and supported to achieve their full potential
- People are at the centre of our practice

- We intervene at the earliest opportunity
- Our workforce is skilled and supported to do the work that they need to do
- People benefit from high performing, high quality support.

The work of operational commissioning is to ensure that these principles are demonstrated in care homes and that care and support provision in Sheffield (including for self-funders) supports people as far as possible to be independent, safe and well.

Challenges Facing the Market

Last year's fee review (culminating in the Cabinet Report March 2020) highlighted particular challenges facing the care home market and the need for a more in depth review of the market that would include terms and conditions of staff and longer term investment needs of aging care homes. Issues such as fixed cost inflation and collection of service users' contributions were also high on the agenda for providers.

Since then of course, the Covid19 pandemic has impacted significantly on all sectors and raised the profile of the challenges facing local authorities and care home providers. Vacancies are at an all time high and this challenges the assumptions used in financial modelling done by providers and the Council during the fee setting process.

This is an evolving picture with increasing concerns about the likelihood of a second wave as infection rates rise and the intersection with winter pressures, longer term impact of reduced or adapted services on people living at home and their carers and changes in elective surgery and hospital activity in the city.

Commissioning Priorities

Given the complexity of the pressures and challenges facing the care home market in the months since the Fees Cabinet Report in March 202 and commissioners' need to ensure quality of care in the face of huge financial pressures on the Council, the following areas will be the focus of the care home market review over the next 4 months:

i. Dynamic evaluation of likely short, medium and longer term care home market demand and supply to inform funding through fee rates and the targeting of support to the sector to ensure it is fit for future demand.
ii. Market analysis and proactive market management and shaping.
iii. Support for any market exits/contraction that minimises negative impact for vulnerable residents, optimises any suitable opportunities for insourcing of residential care and avoids cumulative significant impact of multiple rapid closures.
iv. Review of fees in the context of market analysis and Covid-19 driven changes, including options-modelling and an outline proposal of likely fee ranges to inform senior and political decision making on policy options relating to the care market.
v. Further detailed analysis and consultation with the provider market will be required before fee rates are recommended to Cabinet for approval for 2021/22 by December 2020.
vi. Continued administration of existing Covid-19 support measures including administration of the recently extended Infection Control Fund, additional costs if deemed necessary and occupancy payments as these continue to taper. Also a monitored inbox for care providers, regular updates and briefings, access to emergency staffing support, regular provider forums and the care home helpline.
vii. Ongoing contract and performance management, brokerage and quality and risk monitoring and management (core business).

The following two sections set out the approach and timeline for the first two of these priorities:

Market Analysis and Proactive Market Management:

Older people's care homes (residential and nursing) are the highest area of risk currently in terms of the conditions in the market. A fortnightly dashboard is produced, with input from a range of sources and data, which presents an assessment of the potential risks to viability facing each home in the city. This has highlighted specific care homes that appear to be facing particular challenges across a range of criteria including vacancies, size of home, business model, ownership etc.

The Adult Social Care Strategic Review will address the potential for wider scale transformation across the Adult Social Care system however there is also an immediate need to ensure that the current market is managed and that opportunities for positive change and market shaping are not overlooked in the short term to medium term as described in the Cabinet Report of March 2020. The following approach for care homes is therefore as set out below:

Care Home Market and Risk Management

Care Home Market Review	**Care Home Review and Risk Management**
• Care Home Dashboard • Reviews of Supply and Demand • Work with Public Health and CCG • Consultation with providers/owners • External resource and expertise • Assessment of likely volume and shape of demand • Fee review to inform 21/22 rates	• Ongoing Covid19 support via monitored inbox and helpline • Weekly Sit Reps • Quality and risk monitoring with CCG • Regular care home manager meetings jointly with the CCG
Focused Development Support for highest risk providers	**Development of SCC and CCG Care Home Exit Response**
• Fortnightly Meetings with Provider/Owner to track recovery and development plans • Commissioning of independent advice for homes • Joint assessment of risk with Providers/Owners and mitigation options • Support for market exit, transfer or insourcing	• Development of current re-provision process to respond at scale • Impact assessment process • Alternative intervention options e.g. in-sourcing, take over, change of provision

PART II - Adult Social Care Strategic Review

Background

The Adult Social Care Strategic Review was established in June 2020 to look at all aspects of adult social care including the support which is both delivered and commissioned and the systems processes and ways of working which affect and define social care.

There were many reasons for deciding the review was needed and deciding whether it was the right time to do it. The pandemic has meant rapidly responding to many emerging and unknown issues but it has also offered an opportunity to really look at the way we work, review, challenge and take stock and decide if some things are still the right thing to do and sustainable in the longer term.

More specifically however people have told us:-

- The quality of support and their experience and outcomes can vary
- They want more personalised support which helps them live the life they want to live
- The want to be co-creators of the type and design of support
- Providers want to be part of this long term vision and help to shape the sector.

We also know that

- Too many people are still admitted to care homes who could be cared for in the community if the right support was in place.
- The acuity of people in social care is increasing and we need to be able to respond to this
- The care market has been disrupted and we need to stabilise this by setting out our strategic direction
- Our current commissioning strategy is not strategic, creative or bold enough to deliver new solutions for the future

The Covid-19 situation has also brought some opportunities

- Increased innovation, with providers developing different ways of working to meet peoples needs
- Some people reporting they have felt liberated by these new ways of working and so we want to look at how we can continue this
- The market has been disrupted so we need to set out what our ambitions are for the future so the market can engage, respond and we can create some sustainability
- We already have a challenge to reduce the number of people going into care homes who don't need them

We need to make the move towards prevention and recent events have highlighted the need to do this swiftly but with consideration.

The overall ambition is to have a city for all ages with equitable access to the right support to help people live the kind of life they want to live. It means being bold and ambitious and sometimes doing very different things (and learning from this) but it may also mean

continuing some of the things that have always been done because it's the right thing to do, they work and people value them.

The strategic intention is to support a shift into prevention and well-being. This means moving away from a crisis intervention model and instead increasing the focus on access to universal services, early help and preventative support.

There are also some opportunities and barriers, we know that recovering from the Covid-19 situation will mean we need to help people affected to regain the confidence to make decisions about their lives and to lead their own recovery but this time has also presented an opportunity to look at things very differently and people have already embraced this.

These proposals have been shared with health colleagues and they are both supportive and committed to assisting with and supporting the review, strategy and its delivery.

Where we are now – The Adult Social Care Strategy

We are not starting from a zero base. The city already has a wealth of strategies; there is legislation (e.g. the Care Act) and national and international good practice guidance which can be drawn upon to help design the strategy.

From our previous consultations we know people are really interested in what we deliver as a result, the "so what" and therefore the intention is that the strategy will be simple and concise acting as a frame work for the delivery and that the delivery of any change will be co-produced and co-designed.

The format of the strategy will be as follows.

a) Vision

We currently have a vision that was co-produced with partners and has been well received. However, the Social Care Institute for Excellence (SCIE) recently released a vision statement for adult social care, this was co-produced with individuals and extensively consulted on, and therefore it is proposed that this becomes the new vision statement which Sheffield should adopt and consult locally on.

"We all want to live in the place we call home, with the people and things that we love, in communities where we look out for one another doing the things that matter to us"

b) Key principles

Within the current city strategies[1] there are statements about what will be achieved for the people of Sheffield. These have already been consulted on. Many are areas which adult social care could drive and develop and therefore we have developed a set of principles and commitments based on these where we believe Adult Social Care can make a real

[1] Based on
Joint Health and Wellbeing Strategy 2019 – 2024
Shaping Sheffield Place Based Plan 2019 – 2024
ACP Ageing Well Board priorities 19/20
South Yorkshire and Bassetlaw – Sustainability and Transformation Plan
Strategy for Adult Social Care 2019/20
Adult Social Care change report to Scrutiny March 2019

difference. We intend, as part of the consultation, to ask if we have missed anything really important.

The Principles we are proposing are:-

- Increase our focus on ***prevention*** - helping people to help themselves and providing support when they need it to maintain or regain skills – a strengths based approach
- Ensure people can ***stay at home*** for as long as they are able – Care and support shaped around the person, personalised and responsive
- Commissioning for ***Outcomes and Quality*** – ensuring everyone has a consistent experience and standard of care
- Improve Mental Health and Wellbeing – promoting positive ***mental health and wellbeing*** and recognising the importance of meaningful social contact
- Sustainable health and care – working together to use the money we have as effectively as possible and valuing the ***social care workforce*** and the pivotal role they play in helping deliver our vision

c) Commitments

The 10 commitments are again drawn from previous strategies and consultations and show the key areas we will focus on, we anticipate delivery of the strategy will sit under these key commitments

1. We will support people to remain as independent as possible without the need for care and support.
2. We will offer regular meaningful support so people can continue to live in their own home for as long as possible
3. We will provide temporary assistance to help people regain some stability and control in their life following a period of ill health or crisis
4. We will provide care and care with accommodation when this is really needed and in a safe and supportive environment that can be called home
5. We will understand what matters to each of the people we work with and enable them to live a meaningful life
6. We will recognise and value the social care workforce and the contribution they make to our city
7. We will help support and maintain a sustainable care market
8. We will ensure the services we buy are of a high quality and as a result improve people's experience of care
9. We will work to improve people's mental wellbeing as well as physical wellbeing
10. We will monitor the strategy and the implementation plan supporting it.

d) Key outcome measures

We are starting to develop the key outcomes and indicators to help measure success, this will mean ensuring they are measurable and we have a baseline to measure against; we are also asking people as part of the consultation, to say what they think a good measure would be.

What next for the Adult Social Care strategy?

The vision, principles and commitments will form stage one of the consultation. We will be asking people to confirm that this is what they have already told us and check that there are no gaps.

Alongside this we will use the consultation to identify people who are interested in working with us on the delivery so that we can engage people from the start.

The consultation will run between 28th Sept and 29th Nov 2020 and will be available via Citizenspace and other accessible formats where needed, including an audio file and braille

The link to the consultation information is here:-

- public information leaflet,
- or easy read leaflet,
- or on listen or download an audio reading.
- Or visit the Council's Citizen Space consultation page

The plan is to develop the strategy and gain sign off at Cabinet in April 2021

Next Steps – the delivery

Alongside the development of the strategy, we are looking at ***how*** the strategy could be delivered.

Whilst the strategy itself will be "all age", the delivery will initially focus on the older frailer population.

Commitments 1-4 (above) are linked to the commissioning of care and support but it is expected these will be considered on a much broader and larger scale than has previously been the case. The proposal is to look creatively at new models of support rather than only focussing on the current contracts, so for example rather than looking at home care there will be a commissioning plan looking at care at home and everything a person needs to live safe and well at home.

Other themed areas for the delivery of commissioning plans (subject to consultation) include;-

- universal services – what is and should be available and accessible to all
- resilient communities – how can we encourage, build and support these
- targeted help – what are the interventions and support we can target to keep people independent and well
- crisis and re-ablement – how do we plan and avert crisis and when it does occur how can we respond effectively
- care at home – what do people really need to live safe and well at home
- care with accommodation – when people can no longer stay at home what should be available to support them and what should this look like – current care home provision will be an integral but not exclusive part of this development. This will build on the review of care homes that is described in Part 1 and will be ongoing during the autumn and winter of 2020/21.

Commitments 5-10 are linked to cross cutting areas of work and include all the change processes, systems, training and culture changes that maybe needed.

The timescales for this work are currently being developed.

Governance arrangements are proposed through a programme management approach; this will include external partners in the governance arrangements although the decision making will be via the Adults Improvement Board.

Work is also continuing to look at how the strategy and its delivery links into the budget planning process to aid any changes and shift in investment.

What does this mean for the people of Sheffield?

For the Adult Social Care Strategic Review the likely outcomes for people are:-

- Sheffield is a friendly and inclusive city that enables self-help, supports carers and has a positive impact on people's well-being;
- More people will feel able to access the means to live in their own home with confidence;
- More people are able to regain their independence following a crisis, returning to their own home and the life they want to live;
- More people who need long term support say they are able to access it and people feel safe and supported in their home environment;
- Carers and individuals receiving care and support are actively engaged in how their support improves their quality of life, they are listened to and have a positive experience of the service;
- Staff feel valued, value the impact they have on people's lives and have a defined career pathway;
- Providers will know what services people want and can adapt their business to meet those needs;
- Individuals receive a consistently positive experience of care and support; they feel listened to and in control;
- More people feel their community has a positive impact on their mental health and mental health becomes part of everything we do.

PART III – Covid-19 – Impact on care homes and SCC response

The Covid-19 pandemic has taken a heavy toll on older people's care homes in Sheffield. 349 care home residents have lost their lives to the disease since the pandemic began (almost 1 in 10 of all residents). 44 of the 75 homes for older people have experienced at least one death and the worst affected home lost 27 of its residents.

Alongside the human cost has been the financial effect of the pandemic. The reduction in occupancy caused by the deaths of residents has been exacerbated by a much reduced rate of admissions into care. Despite some recovery, the admission rate of older people is still only half pre-Covid-19 levels. Average occupancy in care homes which is normally around 90-95% fell to 80% at one point and has only recovered to 83% at the time of writing. The worst affected care homes are running with 50% of their beds empty.

The Council has a legal duty under the Care Act to:

"promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market has a variety of providers to choose from…[and] a variety of high quality services to choose from. "The Local Authority must …have regard to…the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not)"

It has therefore been a priority to ensure that the care home market has remained as stable as possible throughout the pandemic. SCC does not have the ultimate say on whether a care home continues to operate, but the uncertainty created by the high level of vacancies led to concerns that one or more homes may decide to close at short notice. Unmanaged or multiple closures would pose risks to those residents needing to move to a new care home in terms of the impact on their wellbeing, location near to family and friends, familiarity of carers and environment but also potentially in exposure to or transmission of Covid-19 as a result of moving homes. There would also be significant impact on Council resources to support short notice closures which require intensive support from social workers, commissioners and advocacy services.

To this end, the Council implemented a range of measures shortly after the pandemic started to support the care home market:

- Infection Control Fund (ICF) – central government asked local authorities to administer a fund to support care providers with infection control measures. 75% of this was ring fenced to care homes which in Sheffield amounted to £4.25m.
- Personal Protective Equipment – there was a national shortage of PPE at the start of the pandemic. The Council implemented a system for provision of free equipment to providers who were struggling sourcing their own. This is still operating.
- Staffing support – in cases where care homes could not provide enough staff to cover essential duties due to illness or self isolation, SCC staff provided cover.

Additional financial support to care homes took three forms:

- A 5% increase to care home fees (March to end of June)
- Payment for SCC funded vacancies arising since the start of the pandemic. This has now tapered to 80% (will be 60% by October Scrutiny) and is anticipated to reduce further in coming months subject to ongoing review. A contingency fund

has been set aside to deal with particularly serious financial issues. This is still operating.

- Payment for additional expenses caused by the pandemic and not covered by the ICF fund. This was only paid to care homes who specifically applied and who could demonstrate they had incurred the additional costs. This is still operating.

In total, the Council has spent over £10m on these financial measures so far, of which £4.2m came from central government for the ICF payments.

Monitoring Market Conditions

In order to ensure as far as possible that early warning signs of potential provider failure are spotted and that support can be put in place to protect vulnerable residents, the Council has been monitoring the market in a number of ways.

Using data from a variety of courses, each home has been assigned a RAG rating based on factors such as the number of vacancies, the specialism of the home, the location of the home and its size and ownership. This is updated weekly and those with a high risk rating have been monitored more regularly and offered individual discussions with senior Council officers to ensure that all possible support is being accessed by the home.

In addition all homes have been advised that if they are concerned about viability, they should make contact with Council officers to alert them to the situation and to work together where possible to develop recovery plans or achieve safe and managed withdrawals from the market.

Commissioning staff have been talking regularly to owners and finance managers. These conversations have been about viability and how the Council's plans for tapering vacancy support for example might impact on the care home operators and ultimately on the continuity of care for vulnerable residents.

What are the Providers saying?

Most providers we have spoken to have been satisfied with the Council's support for the sector and say that the support has been helpful. Furthermore, most acknowledge that these can only be temporary measures.

Some providers, when asked about financial stability, have expressed concern about the losses being incurred. At the time of writing, we are working closely with those homes to understand their position and how we can support them. Care homes are however independent providers and we acknowledge that not all operators may openly share commercial concerns about their viability. We continue to encourage providers to talk to us about how they are coping and any plans they have to remodel or make changes to their provision that would affect residents or the volume of care available.

Future Support and Viability

The Infection Control Fund funding from central government was expected to end in September however the announcement last week of further funds suggests that this will be extended. The details are yet to be confirmed. The Council's local scheme to pay some additional expenses not covered by IPC was extended to September and will be reviewed ongoing.

Even though the vacancy rates are starting to improve very slowly, there are still 29 care homes with vacancy levels above 20%. This number has come down from 35 at the height of the pandemic.

Although the effect of the pandemic appears to have eased at the time of writing, it is likely that any further rise in cases will have some impact on care homes again although death rates may be lower because many frail and vulnerable residents have sadly died during the first wave.

The Covid-19 pandemic has so far caused the earlier than expected deaths of nearly 350 residents and increased vacancies as described above. This has resulted in a current over supply of care home beds. The health and social care system has redoubled its focus on 'home first' principles for people leaving hospital or whose needs have increased in the community. However, further work is required to fully understand how COVID-19 has effected the medium and long term demand. This will be considered as part of the review outlined elsewhere in this paper.

Public opinion and trust in the care home sector is likely to have an impact as well as furlough schemes (now ending) which may have enabled families to care for loved ones for longer at home and avoid a care home admission. However from a longer term demographic analysis of likely demand there is nothing to suggest that the underlying population level demand for residential and nursing care will have reduced permanently – we still have an aging population and the impact for survivors of Covid-19 longer term may yet drive a different demand for nursing and residential homes. In the short term however there is a significant drop in demand.

We may reasonably expect occupancy to gradually increase back to pre-Covid-19 levels based on long term demographic projections, but the current trajectory suggests an incremental pace and the impact of any further increase in cases is unknown. It follows therefore that while the city may expect some exits from the market and some remodelling of provision and 'right sizing' of homes, it would not be advisable to drive a mass or unmanaged contraction of the market in the city.

The emphasis in commissioning of, and support for, care homes is on balancing the risks for the existing vulnerable residents of care homes with the challenges facing the market at a macro level and individual providers and their employees. The responsibility of the local authority is to ensure there is a sustainable, quality and diverse market that meets the needs of people in the city now and in the future. The care home market review this autumn and the longer term Adult Social Care strategic review are the key factors to ensure the Council is able to fulfil this duty.

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

Report of: Sara Storey - Interim Director of Adult Health and Social Care (Sheffield City Council)

Alun Windle – Chief Nurse (Sheffield Clinical Commissioning Group)

Subject: **Winter Planning for the City and a Summary of Operational Delivery of Continuing Healthcare Over the Coming Months.**

Author of Report: Alastair Mew – Head of Commissioning (Urgent Care) Sheffield Clinical Commissioning Group

Dani Hydes – Head of Continuing Health Care (Service Development, Improvement and Business Delivery) and Head of Contracts (SHSC / Care Homes / R&D) Sheffield Clinical Commissioning Group

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Summary:

This report provides a summary of Sheffield's overarching approach to winter planning this year through the city's accountable care partnership and also details a summary of recovery planning and operational delivery for Continuing Healthcare over the coming months.

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:

Receive the briefing paper regarding the city's arrangements for winter and the areas of focus for continuing healthcare over the coming months and feedback any comments.

Category of Report: OPEN

Winter Planning for the City and a Summary of Operational Delivery of Continuing Healthcare Over the Coming Months.

14th of October 2020.

1. Introduction/Context

This report provides a summary of the city's overarching approach to winter planning this year through the city's accountable care partnership.

The partnership recognises that the detailed capacity and demand planning and organisational actions required to prepare for winter are best held at an organisational level.

However, it is acknowledged that partnership working is key and so this document highlights system wide priorities that will complement individual organisational plans. These will enable collective signposting of the people of Sheffield to the most appropriate services in the most appropriate and safest places to meet their needs.

Along with shared system priorities the report will also confirm citywide governance arrangements. System triggers and escalation processes will also be outlined providing assurance that planning and responding to the city's needs will continue to be undertaken in a coordinated and timely way.

In addition, it is understood that the committee wish to understand how continuing health care (CHC) is being reinstated and where applicable using and building on the good practice that was developed during COVID 19. A summary of how this is incorporated into recovery planning and operational delivery over the coming months is detailed below.

2. Winter in a COVID19 Context

COVID 19 has obliged winter planning this year has to take a number of additional factors into account:

- Treatment and care environments need to be COVID secure
- The need to minimise the need for travel for both patients, service users and staff
- The requirement to minimise the numbers of people in situ at any one time
- The need to reduce the risk of onwards transmission of infection

The collective impact of these factors has in some cases reduced overall capacity within individual services when compared with previous years.

Mitigating the impact of this reduction in capacity (and returning to historic levels) is a core element of individual partner's operational and winter plans over the coming months.

Also, given the potential impact on the wider Sheffield system demand for key services compared with available operational capacity is included in key information shared across the city on a daily basis with system partners (see section below for more details.)

3. Principles and Priorities of the Sheffield Accountable Care Partnership

In order to support effective system wide working and resilience the Sheffield ACP has agreed the following principles of working together:

- The ability to move staff across organisational boundaries to support delivering care where it is needed
- Working in a way that provides care that meets patient needs rather than system counting
- Working practices that are open and transparent

In addition, the ACP has also agreed the following priorities:

Primary Urgent Care

- Talk Before You Walk
- Bookable System to manage volume in a covid secure way across all sites
- Flexible use of resources to optimise citywide capacity
- Includes GP Collaborative, Extended Access, Walk in Centre, Minor Injuries, Walk in A&E

Local Care Coordination Centres

- Virtual MDT approach for complex/frailty in community: responding to escalating and deescalating needs
- PCN footprints
- Community Minimum Dataset via a shared digital platform

Mental Health

- Improved Crisis Response
- Support to Children Returning to School
- Accelerated roll out of the Community Mental Health Transformation Programme

Planned Care

- Clear shared principles for prioritising planned care
- Principles to support access to diagnostics
- Shared care pathways cross primary and secondary care

Discharge & Transitions

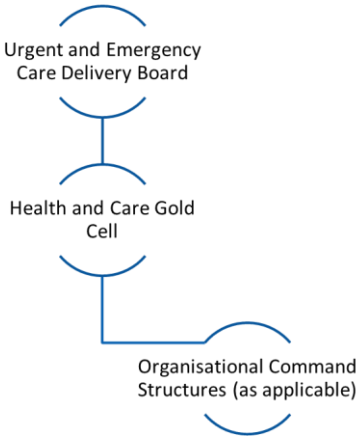
- Embed agreed discharge principles
- Implement national guidance
- Surge/capacity plan for bedded and non-bedded support

Communication & PR

- Managing Expectations
- Simplifying Access
- Explaining covid secure arrangements and how to access care and support safely

4. Supporting Governance

Whilst it has been agreed that individual organisations will take responsibility and ownership of internal issues where there is a requirement for wider system awareness and governance the following structure has been agreed:



Overarching oversight and governance (including ownership of system risks and their mitigation) will be provided by the Urgent and Emergency Care Delivery Board which has senior representation from partners from across Sheffield's health and social care system.

Significant individual organisational pressures that cannot be resolved either internally or via partnership working will be escalated to the Health and Care Gold Cell for discussion with citywide partners for identification and agreement of mitigating actions (also with senior representation from system partners.)

It is also expected that partners will share key internal issues and emerging risks especially those potentially impacting on delivery of their services or on pathways supported by partners with the Health and Care Gold Cell.

In addition, there will also be escalation to the Health and Care Gold Cell on behalf of the Sheffield place (by the CCG) where a number of individual partners are indicating increased levels of pressure which in totality are likely to lead to wider system impact (note see below for more details of triggers and forecasting.)

5. Key Areas for Development and Delivery for Continuing Health Care (CHC)

In line with Government guidance (specifically Department of Health and Social Care) the Continuing Healthcare Framework was reinstated with effect from the 1st September 2020. This was on the basis that from the 19th March 2020 and up to the 31st August 2020 the framework was suspended in response to the covid pandemic and mandates from the government. During this time and in working with the Acute Hospital Discharge Hub, the CCG CHC team managed all new referrals where a health need was present until they could be assessed under the framework, these individuals were classed as "NHS Covid funded". In

parallel SCC managed all new referrals that were deemed to be social care only.

In recovery planning for the reinstatement of the framework the CCG CHC team will address three specific key work streams (which commenced from the 1ST September) these are:

1) The COVID backlog – This is the undertaking of an assessment under the framework for all individuals who were COVID funded during March to August 2020 to determine their eligibility under the framework; specifically CHC fully funded, Funded Nursing Care Only, Joint Package of Care with SCC, Social Care only, or where a contribution to care by the individual is required. This is being actively monitored by NHSEI who are requiring CCGs to work at pace to undertake the assessments in the return to business as normal operational and funding processes for both health and social care. A bi-weekly return is being submitted nationally to NHSEI to monitor and individual CCGs progress against current numbers awaiting an assessment and the numbers of designated staff supporting this work stream.

2) The Discharge Support Fund – This is all new referrals under the framework with effect from the 1ST September whereby the CHC Assessment and Care Act Assessment (if individuals are not eligible for full CHC funding) have to be completed within 6 weeks of discharge. Currently the six weeks assessments period will be funded by the government (max) and then will move to business as usual funding streams across health and social care. This process supports the return to operational and legislative guidance under the National CHC Framework.

3) The CCG CHC team have a third work stream to address with respect to outstanding assessments pre COVID in line with operational and legislative requirements under the framework.

Both CCG and SCC staff are flexing their workforce in order to respond to the recovery planning and specifically the COVID backlog work stream. The assessments are being undertaken in line with need as a priority and then completed in date order, where possible, and supported by information provided by Care Home and Home Care providers.

In line with NHSEI guidance assessments are being undertaken virtually, where possible, in order to mitigate and manage infection control. Families and individuals are being actively involved in the process but we recognise that this is significantly different and an emotive time and therefore the CCG CHC team are reinstating the post assessment questionnaire to seek family views in order to influence the process and to support communication and understanding.

Work is ongoing with Sheffield Teaching Hospitals as to how CHC continue to support the hub and discharge pathways. This is feeding into the wider discharge planning work of the wider system partners both from an Acute and Mental health perspective and in conjunction with social care. This includes

working with Providers to determine availability and capacity for winter planning and in parallel offering training to ensure referrals are appropriate and right first time for the individual.

The Care managers within the CHC team continue with their care management responsibilities in support of individuals, families and the Providers, both from a Care Home and Home Care perspective. This includes regular communications and risk management of individuals and their families, who are most vulnerable, need support or reassurance during this time. Especially in cases where services may be affected by COVID or additional support may need to be sourced in order to ensure that safety and quality of care is not impacted or compromised.

The CHC will continue to fully represented in the governance structures outlined above and will adapt and respond to the necessary changes required during the COVID 19 pandemic and in association with the wider needs of the system and underpinned by government guidance and legislation.

6. System Wide Pressures - Escalation and Forecasting

Finally, with regard to monitoring system wide pressures each partner organisation will be responsible for managing their own internal operations and also for identifying issues that require escalating for citywide awareness and/or action.

However, given the interdependencies of the Sheffield health and care system a daily oversight report will be shared with all partners. This report will be used to highlight current issues with regard to demand and performance across the system and also to predict building pressure and identify where there may be a need to take a coordinated city wide approach to mitigate.

The report will highlight areas of high demand over the previous seven days in order to highlight areas of sustained pressure and in previous years this has been shown relative to historic demand/activity. However, given the impact of COVID on demand (potentially changing historic demand patterns) and the requirement for social distancing, going forward the tool will reflect demand versus revised and potentially reduced operational capacity (informed by partners as part of their individual winter plans).

The report will also draw intelligence from the Yorkshire and Humber tool provided by NHS England which forecasts demand across the region. This will inform the system with regard to likely increases/decreases in pressure over the coming days/weeks in order to support proactive planning and agreement/implementation of supporting actions.

7. The Scrutiny Committee is being asked to:

Receive the briefing paper regarding the city's arrangements for winter and the areas of focus for continuing healthcare over the coming months and feedback any comments.

Report to Healthier Communities and Adult Social Care Scrutiny Committee

14th October 2020

Report of: Policy & Improvement Officer

Subject: Continence Services Scrutiny Working Group – Final Report

Author of Report: Emily Standbrook-Shaw
Policy & Improvement Officer
emily.standbrook-shaw@sheffield.gov.uk

Summary:

In October 2019, the Healthier Communities and Adult Social Care Scrutiny Committee started a piece of task and finish work looking at Continence Services in Sheffield, through the Continence Services Scrutiny Working Group. The working group was due to report its findings and recommendations to the March meeting of the Committee, however this was cancelled as we went into lockdown.

The group's draft final report, setting out the process the group went through, and its findings and recommendations, is now attached for the Committee's comment and approval.

Once approved, the report will be submitted to the relevant bodies for a response.

Type of item:

Reviewing of existing policy	**x**

The Scrutiny Committee is being asked to:

- Consider, comment on, and approve the report of the Continence Services Working Group.

Category of Report: OPEN

1. Introduction/Context

1.1 In October 2019, the Healthier Communities and Adult Social Care Scrutiny Committee started a piece of task and finish work looking at Continence Services in Sheffield, through the Continence Services Scrutiny Working Group. The Working Group set out to:

- Consider how current continence services are commissioned and delivered, how people access services and how care pathways work.
- Consider people's experience of incontinence and using continence services.
- Consider how services promote independence, dignity and fairness; particularly the number and quality of continence pads provided.
- Consider ways of improving prevention, and access to preventive services with particular reference to tackling health inequalities.

2. Continence Services Scrutiny Working Group Report

2.1 The working group was due to report its findings and recommendations to the March meeting of the Committee, however this was cancelled as we went into lockdown. The Working Group's report is now attached. The report sets out the process that the group undertook, as well as their findings and recommendations. Once approved, the report will be put to the relevant bodies for a response.

2.2 Summary of Findings and Recommendations.

The findings are grouped into four themes: Prevention, inequality, a person centred approach and communication. The recommendations are summarised below.

2.2.1 Prevention

- The Health Service should give consideration to taking continence prevention services out into communities, especially in areas where there is low take-up, and work with the Council and the VCF to develop approaches to delivering continence prevention services that are tailored to the needs of local communities.
- The Health Service should ensure that consistent messages about continence prevention come from all parts of the health service that come into contact with new mums – particularly health visitors and community midwives - and that they are equipped to support and signpost people to the appropriate services.
- The Health Service should consider how it could work to target pelvic floor education and raise continence awareness in schools by working with organisations such as Learn Sheffield, and Sheffield City Council.

2.2.2 **Inequality**

- The Health Service should consider how it can address inequalities in accessing continence services, and look at how working with the Council and the VCF, as well as through the developing Primary Care Networks – who are experts in what works in their local areas - could help.

2.2.3 **A Person Centred Approach**

- The Health Service should consider how it can resolve the tension medical service model which focusses on the clinical effectiveness of products, and the lived experience of service, users to ensure a person-centred approach.

- The Health Service should consider how it could encourage better feedback from service users, and use existing forums to gather evidence and intelligence to inform service development.

2.2.4 **Communication**

- The Health Service should consider how it can promote and incentivise take-up of continence product training amongst care providers.

- The Health Service should consider how it could improve people's experience of waiting for a continence assessment after being discharged from a hospital stay.

- The Health Service should consider what actions could be taken to raise awareness and tackle stigma around incontinence.

3. Recommendation

3.1 The Committee is asked to consider, comment on, and approve the report of the Continence Services Working Group.

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Continence Services Scrutiny Working Group – Final Report

Report of the Healthier Communities and Adult Social Care Scrutiny Committee

March 2020

1 Introduction from the Chair

"Councillors come across a wide range of issues on the 'front - line', through casework, surgeries and campaigning. Several constituents have raised concerns with me about their experiences of living with incontinence. Most recently, I came across an elderly couple in crisis due to a combination of health issues. Once their health and social care needs had been assessed and addressed, they were still left with a problem of how to afford additional continence pads. This was a matter of concern because they were reliant on the state pension and they were distressed about it.

Other Councillors have had similar experiences. For us, living with incontinence is about promoting independence, social justice and dignity. This is why Scrutiny decided to look at the reasons why some service users do not feel that the service is meeting their needs. This report sets out our findings."

Cllr Cate McDonald, Chair, Healthier Communities and Adult Social Care Scrutiny Committee, Sheffield City Council.

2 Our approach

2.1 In October 2019, the Healthier Communities and Adult Social Care Scrutiny Committee established a working group to 'lift the lid' on Continence Services in Sheffield. The group set out to:

- Consider how current continence services are commissioned and delivered, how people access services and how care pathways work.
- Consider people's experience of incontinence and using continence services.
- Consider how services promote independence, dignity and fairness; particularly the number and quality of continence pads provided.
- Consider ways of improving prevention, and access to preventive services with particular reference to tackling health inequalities.

Our aim was to make recommendations that would improve outcomes for people using continence services, and put these recommendations to the NHS for a response.

2.2 We met with NHS Sheffield Clinical Commissioning Group, who commission continence services in Sheffield; and the Continence Advisory Service and Community Nursing Service from Sheffield Teaching Hospitals who deliver Continence Services, to understand how the service works.

2.3 We wanted to put people's stories at the heart of our work, to try and understand the experience that people using the service, and caring for people who use the service, have. This was a challenge – continence is still not something people are comfortable talking about.

We set up an online questionnaire and invited people to contact us if they wanted to share their experiences. We had a very limited response, and so we approached organisations who work with people who use the service – the Carers' Centre and Disability Sheffield advocates. They were able to give us an overview of the issues their clients have had with continence services, as well as specific case studies.

2.4 We spoke to a PhD student from Sheffield University who is researching continence, and also attended the Home Care Providers Forum, and the Care Home Managers Forum to gather views and experiences, and 'triangulate' the information we collected.

2.5 Links to the information we considered, and notes of our meetings are listed in appendix 1.

3 What We Learned

3.1 The Service

We wanted to start out by understanding how Continence Services work, so we invited NHS Sheffield CCG and the Continence Advisory Service in to explain how services work in Sheffield.

3.1.1 Continence Services in Sheffield are commissioned by NHS Sheffield Clinical Commissioning Group and are delivered by Sheffield Teaching Hospitals as part of the block contract for Community Services.

The aim of the service is to assess, treat and manage urinary and faecal incontinence in clinics across the city with specialist nurses and physiotherapists, and home visits for housebound users. The Community Nursing Service delivers continence assessments to housebound patients with other nursing needs. The stated focus of the service is on prevention: helping users to achieve continence, rather than on the supply of continence products. However at any given time there are around 8000 people using prescribed continence products in the city. Around 5500 are in their own homes, and 2500 in residential and nursing homes. Around 5500 of these are women - continence issues are more likely to affect women than men as having given birth is a significant factor in continence problems.

3.1.2 People are referred into the service by GPs and health professionals. They will have an assessment, treatment and, where ongoing management and continence products are required, reassessments are carried out on a 6 monthly or 12 monthly basis. Service users can also contact the Continence Advisory Service or Community Nurses to discuss continence issues at any point. The service operates within the National Institute of Health and Care Excellence guidelines.

3.1.3 The service delivers preventive ‘new mum’ classes monthly, targeting pelvic floor education at women who have recently given birth, as well as providing education and training for health and care professionals.

3.1.4 The budget for the service in 2019/20 was £533,334 for continence clinics, and £1,954,380 for continence products. To respond to the challenge of rising demand and rising product costs the service has:

- Reduced the delivery cycle from 8 to 12 week for service users in their own homes, and from 4 to 8 weeks for residential and nursing homes.
- Removed two of the light incontinence products for new patients
- Limited the number of pull-up products to 2 per day for service users who fit the criteria
- Reduced daily product allocation to 3 pads per day – other than for those who meet the clinical exclusion criteria.

3.1.5 The service has done a lot of work with pad manufacturers and has told us that the pad technology is sufficient that is the prescribed number of pads should be enough

to keep people dry and comfortable. The service explained that continence products are allocated on the basis of 'clinical need'. In view of our focus on service user experience, we were keen to understand the way in which 'need' was defined. In this case, evidence about the effectiveness of continence products is the core component of clinical need, rather than lived experience.

3.2 Service User Feedback

We wanted to make sure that the experience of people using the service, and caring for people who use the service is at the heart of our work.

From the conversations we had, a range of issues emerged including:

- Mismatch between technical abilities of the product and lived experience – some service users feel sitting in a wet pad compromises their dignity – regardless of technical properties of the pad
- Some service users go through more than 3 pads a day and families and carers are 'topping up' provision at their own expense as a result.
- Difficulties in managing 3 month supply – especially where service users have multiple carers coming in daily, and complex conditions such as dementia. We were given an example of a service user suffering from dementia, who removed her pad every time she became aware of it – leading to significant top up costs for the family.
- Some service users feel that inflexible clinical criteria for some products reduces their choice, and doesn't help promote independence. We were given an example of a service user who can use pull ups independently, but is only permitted a limited number of these. As a solution, she has been offered ordinary pads, but she can't use these without help from a carer. It's important to the service user that she stays as independent as possible. She spends between £50 and £60 a month on extra products.
- Care Home and Home Care providers talked to us about difficulties around hospital discharge, with interim product provision not sufficient to cover the period between discharge and assessment.
- Difficulties in storing 3 months supply of products – both in people's homes and residential settings.
- Disposal of continence waste remains a problem for some people.
- Positive feedback from Care Homes about the responsiveness of continence leads, and efficiency of the service in terms of timely delivery of products and responding to changes.

4 Our Findings and Recommendations

Our aim was to make recommendations on how we can improve outcomes for people using continence services in Sheffield. Whilst there is a lack of 'hard data' on this subject, the qualitative evidence we gathered has led us towards four key themes– **Prevention, Inequality, Person-Centred approach** and **Communication.** The key finding for us, and one that we kept coming back to throughout the process is what we believe to be a fundamental tension between the service model – limits on continence products based on a technical understanding of product's absorbency – and service user experience. We have set out our recommendations below.

4.1 Prevention

4.1.1 'Promoting Prevention' lies at the heart of the Shaping Sheffield plan, signed up to by all health and social care partners in the city, recognising that prevention activity now will help to manage demand for services in the future.

4.1.2 The service was clear that its focus is on prevention, and that targeting pelvic floor education at teenagers and younger women, particularly new mums, is important in preventing continence issues post menopause, and in promoting the message that incontinence is not an inevitable part of getting older.

4.1.3 'New Mum' workshops are held in the city centre at Central Health Clinic, and advertised through flyers in discharge packs from Jessops, although take-up is variable across the city.

Recommendations

4.1.4 The Health Service should give consideration to taking prevention services out into communities, especially in areas where there is low take-up, and work with the Council and the VCF to develop approaches to delivering continence prevention services that are tailored to the needs of local communities.

4.1.5 The Health Service should ensure that consistent messages about continence prevention come from all parts of the health service that come into contact with new mums – particularly health visitors and community midwives - and that they are equipped to support and signpost people to the appropriate services.

4.1.6 The Health Service should consider how it could work to target pelvic floor education and raise continence awareness in schools by working with organisations such as Learn Sheffield, and Sheffield City Council.

4.2 Inequality

We recognise that health inequality is an important issue for the city - one that is not easily solved, but one that all organisations in Sheffield's health and care system are committed to tackling - a focus on reducing health inequalities is a principle of the Shaping Sheffield plan.

The service told us that:

- prevalence of continence issues is higher in the north of the city, yet take up of continence services is lower than in other areas
- there are higher 'Did Not Attend' rates at the continence clinic amongst Black, Asian and Minority Ethnic communities
- there is lower take-up of the 'New Mum' classes in deprived communities.

We recognise that the reasons for this are complex and multi-faceted, but we believe that we need to understand and tackle this, and ensure that people across Sheffield are able to access continence services that are appropriate for them.

Recommendation

4.2.1 The Health Service should consider how it can address inequalities in accessing continence services, and look at how working with the Council and the VCF, as well as through the developing Primary Care Networks – who are experts in what works in their local areas - could help.

4.3 A Person Centred Approach

4.3.1 Through our scrutiny work, we consider many health and care services and issues, and something that we keep coming back to is the importance of a 'person centred' approach. A key priority of the CCG in its 2019/20 commissioning intentions was to commission health services that promote person centred approaches, and ensuring that the "what matters to you?" approach is embedded in care pathways. A 'holistic, person centred approach' is set out as a value in the Shaping Sheffield Plan.

4.3.2 We recognise that the assessments carried out by the service, and the resulting level of 'clinical need' and prescription of products, is based on the technical properties of those products. The service assures us that where 3 pads are prescribed, they should provide an appropriate level of containment for the service user. However, the stories we have heard suggest that, for some service users and care providers, the 'lived experience' of this is different. Some feel that their individual needs and preferences are not taken account of, and with strict criteria and limits on pads and products, the service model doesn't always feel person-centred.

4.3.3 The routine feedback the service receives through the Friends and Family Test is positive, and no formal complaints have been received about the provision of continence products. However, from the conversations we have had, it appears that there is a level of dissatisfaction amongst some service users. Understanding this better could be useful in informing service development. We have found our conversations with the Home Care Providers Forum and the Care Home Managers Forum to be very informative and valuable – and no doubt there are other forums across the city that could provide useful intelligence and feedback for the service.

Recommendations

4.3.4 The Health Service should consider how it can resolve the tension between the medical service model which focusses on the clinical effectiveness of products, and the lived experience of service, users to ensure a person-centred approach.

4.3.5 The Health Service should consider how it could encourage better feedback from service users, and use existing forums to gather evidence and intelligence to inform service development.

4.4 Communication

4.4.1 The service highlighted that inappropriate pad usage can lead to service users going through products at a faster rate than their prescription allows. Training for carers and care providers on the use of continence products and barrier creams is available but not mandatory. Some of the care home managers we spoke to were not aware that this training was available, particularly in Learning Disability and Mental Health residential units.

4.4.2 Issues around hospital discharge were drawn to our attention by home care providers and care home managers. On discharge from hospital, service users are provided with continence products to last 7 days. At the time of writing, those service users were waiting an average of 2 weeks for a continence assessment, leaving a shortfall in products. Better communication between the hospital and the continence service could help to triage service users more effectively and ensure that the prescription of products on discharge is in line with likely waiting times for assessment.

4.4.3 There is still a lot of stigma attached to incontinence, and the service tells us that on average, people wait 5 years before seeking help. We need to break down this stigma, and help people to understand that incontinence is not an inevitable part of growing older.

Recommendations

4.4.4 The Health Service should consider how it can promote and incentivise take-up of continence product training amongst care providers.

4.4.5 The Health Service should consider how it could improve people's experience of waiting for a continence assessment after being discharged from a hospital stay.

4.4.6 The Health Service should consider what actions could be taken to raise awareness and tackle stigma around incontinence.

5 Conclusion

We'd like to thank all of the people who have given their time and energy to help us carry out this review – people who work for the NHS, voluntary sector organisations, care providers, service users and academic experts.

We have found it hugely interesting to get an insight into this issue that is rarely discussed, yet incredibly important. We hope that in doing this work, we will raise the profile of continence issues, get people talking about it, and start to break down some of the stigma surrounding it

We will formally put this report to the health service, and request a response to our recommendations within an appropriate timescale. We look forward to further discussions and seeing improved outcomes for the people of Sheffield.

Healthier Communities and Adult Social Care Scrutiny Committee

March 2020

Healthier Communities and Adult Social Care Scrutiny Committee
Continence Services Working Group
Evidence Gathering Sessions

Meeting 1 – 8th October 2019

Witnesses:
Sarah Burt, Deputy Director of Delivery, Care Outside of Hospital, NHS Sheffield CCG.
Tracey Standerline, Head of Commissioning, Care Outside of Hospital, NHS Sheffield CCG
Angela Stroughair, Continence Clinical Lead, Sheffield Teaching Hospitals Trust
Paula Crosby, Head of Therapeutics and Palliative Care, Sheffield Teaching Hospitals Trust

Documents:
Terms of Reference
Sheffield Continence Service Presentation
Meeting Notes

Meeting 2 – 27th January 2020

Witnesses:
Rachel Morecroft, University of Sheffield

Documents:
Follow up information from Continence Service
Service User Feedback Summary Presentation
PhD research information
Meeting Notes

Meeting 3 – 2nd March 2020

Witnesses:
Tracey Standerline, Head of Commissioning, Care Outside of Hospital, NHS Sheffield CCG
Angela Stroughair, Continence Clinical Lead, Sheffield Teaching Hospitals Trust
Paula Crosby, Head of Therapeutics and Palliative Care, Sheffield Teaching Hospitals Trust
Rachel Singh, Community Nursing Service, Sheffield Teaching Hospitals Trust

Documents:
Follow up information from January meeting
Feedback from Home Care Providers Forum and Care Home Managers Forum
Meeting Notes

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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Wednesday 14th October 2020

Report of: **Policy and Improvement Officer**

Subject: **Draft Work Programme**

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

The report sets out the Committee's draft 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

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.

1.2 Scrutiny Committees can operate in a number of ways – through formal meetings with 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

2.1 Attached is the draft work programme for the Committtee's consideration. The response to the Covid-19 emergency has implications for how scrutiny operates. There is a recognition that working through virtual meetings requires a different approach to traditional Town Hall meetings, and a suggestion that Committees should meet for a maximum of two hours, with a more limited number of agenda items. The draft work programme reflects this.

2.2 Given the constantly evolving nature of the Covid-19 emergency, we will take a flexible approach in planning scrutiny work, to enable us to respond appropriately as new issues emerge. 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 draft work programme

HC&ASC Draft Work Programme	
Date	**Issue**
November 11th 2020	***Health Inequalities and Covid*** *- To understand the impact of Covid19 on different groups in the city and to consider how this will be tackled moving forwards. (Greg Fell/Eleanor Rutter)* ***Update on Test, Trace and Isolate*** *– To consider performance and current issues – local focus but recognising some issues are national.(Greg Fell/Ruth Granger)*
December 9th 2020	***Primary Care*** *– to consider how Primary Care adapted during Covid and how it will operate moving forwards. (Brian Hughes NHS Sheffield CCG)*
January 13th 2021	***TBD***
February 10th 2021	***Sheffield Health & Social Care Trust – CQC Improvement Plan Progress Update –*** *focussing on what the changes will mean for people who use services****.*** *(Jan Ditheridge/Mike Hunter SHSCFT)*
March 10th 2021	***TBD***
Potential Issues for consideration	
Impact of lockdown and social isolation on health and wellbeing – possible working group - *To understand the impact of lockdown and isolation on wellbeing; to consider action the City is taking to minimise the negative impact of this.* ***Direct Payments*** *To consider the review of the direct payment model and help shape future direction* ***All Age Disability Approach -*** *Transition for young people into adulthood – improving outcomes. Initially focussed on social care. Possible joint work with Children and Young People Scrutiny Committee* ***People Keeping Well –*** *to consider how the People Keeping Well programme is operating and performing.* ***Changes to National Public Health Structures*** *– to consider local impact of national public health structure changes.*	

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