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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 24 November 2021 at 4.00 pm

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Steve Ayris (Chair), Talib Hussain (Deputy Chair), Sue Auckland, Vic Bowden, Lewis Chinchen, Alan Hooper, Francyne Johnson, Bernard Little, Ruth Mersereau, Ruth Milsom, Abtisam Mohamed, Garry Weatherall and Alan Woodcock

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
24 NOVEMBER 2021

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 - 20)
To approve the minutes of the meeting of the Committee held on 29th September, 2021.

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

7. Covid Update and Forward Look (Pages 21 - 30)
Report of the Director of Public Health.

8. Social Care Update
Report of the Director of Adult Health and Social Care to follow.

9. Public Questions Report (Pages 31 - 34)
Report of the Policy and Improvement Offcer.

10. Work Programme (Pages 35 - 40)
Report of the Policy and Improvement Officer.

11. Date of Next Meeting
The next meeting of the Committee will be held on Thursday, 26th January, 2021 at 4.00 p.m., in the Town Hall.

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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 29 September 2021

PRESENT: Councillors Steve Ayris (Chair), Talib Hussain (Deputy Chair), Sue Auckland, Vic Bowden, Lewis Chinchen, Alan Hooper, Bernard Little, Abtisam Mohamed, Garry Weatherall, Alan Woodcock, Martin Phipps (Substitute Member) and Sioned-Mair Richards (Substitute Member)

Non-Council Members (Healthwatch Sheffield):-

Lucy Davies

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Francyne Johnson, Ruth Mersereau and Ruth Milsom. Councillors Sioned-Mair Richards and Martin Phipps attended as substitute Members for Councillors Mersereau and Milsom, respectively.

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 In relation to Agenda Item 7 (Item 6 on the minutes), (Adult Dysfluency and Cleft Lip and Palate Service) the following declarations were made:-

Councillor Vic Bowden declared a personal interest by virtue of her having a long connection with the Service and had served as a Trustee. Councillor Talib Hussain also declared a personal interest in the item due to him having a child who attended the Service. Councillor Garry Weatherall declared a personal interest due to him having attended the Service as a child.

3.2 In relation to Agenda Item 8 (Item 7 on the minutes) (Primary Care in Sheffield - NHS Sheffield CCG), Councillors Sioned-Mair Richards and Martin Phipps declared a personal interest due both Councillors attending one of the GP surgeries mentioned in the report.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 1st September, 2021 were approved as a correct record.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 **Helen Moore**

My name is Helen Moore. I am a carer for my youngest son, Tom, who lives with us and is in his 40s. He has learning difficulties and autism. He has never been employed. I am in my 80s. It is essential that we, as lifelong elderly carers, raise awareness to try and prevent the closure of this valuable and unique service for elderly carers in the city.

Please understand and recognise that with the emphasis on "elderly" carers, we have been lifelong carers and as such are pretty well exhausted, many even too exhausted to complain about the possible loss of this service.

We understand that we will be able to go to the KIT offices for help, a visit to town, talking our son or daughter with us, to make sure they are safe, is impossible. Cathy Oliver and Kirsty Worstenholm will visit us at home. This is very important. They know our families and us and I cannot emphasise enough how important this is to us, the visits at home and knowing they will understand, offer help and support and kindness so that we feel we can carry on. Social workers tend to change very frequently and going over are children's history again and again each time is upsetting and tiring.

Cathy and Kirsty are the only people we can turn to in times of extra difficulty, even only to hear an understanding voice. It is enormously comforting to know they are there. Please, do all you can to save this vital service. Once gone, like the Elderly Carers Service, it will never return.

We are not asking for more money, we love our sons and daughters, in fact many of us do not receive a carers allowance if our husbands have a private pension, but we are asking, nay, pleading with you, not to take away our **only** constant source of help, support and reassurance which Cathy and Kirsty have given to us and without which, our advancing years, will be hard and more difficult to bear.

I believe it is a mark of a civilised society that the silent, unpaid carers, are helped, supported and recognised for their valuable contribution. As my daughter texted when I told her about this news (she lives far away), "What a terrible shame. It seems that anything good and valuable is melting away to leave only difficult hurdles to be managed without support".

5.2 The Chair thanked Helen Moore for attending the meeting and stated that the officer dealing with this, would provide her with a written response.

5.3 The Chair stated that three questions had been received from members of the public, all relating to Item 7 on the agenda (item 6 of these minutes) (Adult Dysfluency and Cleft Lip and Palate Service) as follows:-

5.3.1 **Kirsten Howells - Programme Lead and Helpline Support Manager for STAMMA (British Stammering Association)**

I'd like to briefly read a few comments from just four of the concerned individuals who have contacted us at STAMMA, the British Stammering Association, with

regard to the possible closure of the adults stammering service in Sheffield. The individuals have given me permission to share their comments.

Referral rejected in April when the service closed
"I am an NHS nurse and have always stayed as a band 5 grade as I don't feel able to perform well in interviews, due to my stammer, so won't put myself forward for promotion."

Parent of a young person who stammers concerned about the possible loss of the service
"Think of how hard it must be to face an English oral exam, Modern Foreign Language orals, or any assessment requiring verbal responses, if you stammer or stutter. It would not be right to restrict subject choices to avoid these exams because of speech. What about those applications for college/apprenticeships/work placements? All of these will require interviews in person, over the phone or through video conferencing. These activities are challenging for all young people but are so much more difficult if you have a speech difficulties. What if, the very person who could help you to prepare for these situations, with whom you have built up trust, having exposed the difficulties you face in daily life, is suddenly no longer allowed to support you through these new, anxiety provoking experiences."

Previously accessed the service
"Being a doctor was always a dream of mine, and the support I received at Sheffield Children's has helped me tremendously with my life's ambition, by teaching me how to live with my stammer. I am now a qualified doctor who does not shy away from how he speaks."

Previously accessed the service
"I requested to be referred to speech and language therapy in my early twenties. I was very unhappy and suicidal. My speech was something I could see was affecting me and my ability to live my life successfully. Looking back, therapy was a great experience for me. Before that, I had never spoken about my speech difficulties, let alone been with others who also had the same experience. It was life changing to express something so private and hidden, and have that met and supported, and understood."

These comments give an insight into the need for a service for adults aged 16+ who stammer, and the potential impact of the loss of such a service. The consultation is likely to unearth more, similar feedback, yet Sheffield Children's NHS Foundation Trust are intending to close the service again from mid-January. **What options have been considered to keep such provision *within* Sheffield, optimising the existing personnel who have developed their specialist clinical skills over years?**

5.3.2 **Isobel O'Leary**

I want to be clear that the decision to close the Speech and Language Therapy service to adults with disorders of fluency (usually stammering) was made with no consultation, let alone agreement by the specialist clinicians that provide this

service. This is very disappointing.

In a separate document I have explained how the reasons given for ending the service are largely spurious. The only point on which I agree is that there is a shortfall in funding to the overall paediatric Speech and Language Therapy Service to manage the increasing demand, and a need for additional funding to provide the specialist service to adults with disorders of fluency.

This specialist Speech and Language Therapy team has worked effectively and efficiently in an integrated way with children and adults since 1992, with 2.5 days a week initially allocated to working with adults. We have managed the waiting lists between adults and the relatively higher number of referrals of children by taking time from the adult allocation to manage children, thus effectively cross subsidising the paediatric service.

We have always been innovative, for example holding evening clinics to fit with the needs of older children, teenagers, parents and adult patients and running intensive therapy group courses for various age groups at NHS and non-NHS sites when clinically appropriate. Throughout the pandemic we very quickly adapted and have provided a largely telephone or video service for all ages, only gradually bringing back face to face clinics when it has been safe to do so. It is likely that the service will continue to offer a hybrid service long term as remote appointments are sometimes preferable for patients as they save travel time and cost, and this way of working can sometimes be better clinically.

I care passionately about helping people with communication difficulties, as the ability to communicate is central to human life and wellbeing. I don't stop caring when someone reaches the arbitrary age of 16 years.

I will continue to contest any permanent cut to the current Sheffield based specialist SLT Service for those over the age of 16 who have disorders of fluency despite my recent retirement. Elected Members may understand when I say that as a Sheffield street tree campaigner, I have a habit of not giving up.

My question is: **Why are you persisting with an expensive and wasteful Consultation process when a simple solution exists that would be better for everyone and most especially patients? That is, maintaining the current specialist Service, with funding for the adult part through a Service Level Agreement with the Speech and Language Therapy Service?**

5.3.3 Emily Standbrook-Shaw read out the following question received from Kate Williams. From 1993-2019 I worked as Co-Lead in Disorders of Fluency, employed by SCHNHSFT. I am now retired.

Question: To what extent is the decision to potentially axe the service to people who stammer, aged 16 years and above, driven by SCHNHSFT and/or the CCG, given the likely replacement of the CCG, next April by the South Yorkshire wide Integrated Care System?

5.4 The Chair stated that he would respond to the questions during the Committee's

discussion on the next item of business and thanked Kirsten Howells and Isabel O'Leary for submitting their questions and attending the meeting.

6. ADULT DYSFLUENCY AND CLEFT LIP AND PALATE SERVICE UPDATE AND DRAFT CONSULTATION PLAN - NHS SHEFFIELD CLINICAL COMMISSIONING GROUP

6.1 The Committee received a report from the NHS Sheffield Clinical Commissioning Group giving an update on the Adult Dysfluency and Cleft Lip and Palate Service and the request for a review of the consultation plan for potential changes to the provision of dysfluency and cleft, lip and palate services for adults in Sheffield.

6.2 Present for this item were Kate Gleave, Deputy Director, Commissioning, NHS Sheffield Clinical Commissioning Group (CCG) and Lucy Ettridge, Deputy Director, Communications, Engagement and Equality NHS Sheffield CCG.

6.3 Kate Gleave apologised to the Committee, stating that representatives of Sheffield Children's Hospital were unable to attend the meeting. She then referred to the report and said that she had met with NHS England as part of the Major Service Change Assurance Process on 17th September and it was anticipated that NHS England would advise the CCG could self-assure itself regarding this proposed change.

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

- The decision to make the changes to and serve notice of such changes to the Adult Dysfluency and Cleft Lip and Palate Service had been taken by the Sheffield Children's NHS Foundation Trust (SCNHSFT) and not the CCG. It was stated that the changes were in no way connected to the changes to be made to the Integrated Care System (ICS) in April, 2022.

- The options available were for the CCG and the NHS Trust to work together to develop the options and it was anticipated that there would be an option to provide the Service within Sheffield as well as outside the city. There was also a "no service change" option as well as a "no change" option.

- The CCG had worked with the Sheffield Children's Hospital in developing the consultation plan. The CCG has a legal duty to bring any substantial change of its services to this Committee and it had been unanimously agreed at a previous meeting that a formal public consultation process be carried out.

- To date, there had been no formal consultation, but part of the process would be to engage with staff. An Equalities Impact Assessment (EIA) has been undertaken around some of the options, but it should be noted that the CCG was still working through all of the options available.

- It was largely men of white backgrounds that were affected by dysfluency. As this was a relatively small service, some of the information gathered

could look skewed and the CCG was mindful of that and would be monitoring data gathered to determine who they were engaging with.

- With regard to concerns raised about the Service being taken outside Sheffield, consideration was being given to determine what options were viable and to look at what was available both locally and nationally. A number of services have been carried out around the country via video-links, webchats or telephone calls rather than face-to-face and favourable feedback had been received on this and it was felt it would be wrong to rule these options out. The CCG and Trust were aware of general issues and specifically the potential impact of travel on patients should they be asked to attend face to face appointments outside Sheffield.

- Feedback from this Scrutiny Committee would be fed into the consultation process and it was anticipated that further feedback from this Scrutiny Committee would form part of a formal written response from the Council.

- In response to the question "what was the point of the consultation". The SCNHSFT felt that it was no longer viable to offer the Service to those over 16 years of age and had to decide on how best to meet the needs of children if the Service as it stands, was no longer viable.

- Consideration had been given to options that were viable, and so far, the best options and best outcomes for the public, were unknown.

- Workforce challenges and wider pressures were similar to those faced in other areas around the country, as children developing speech and language difficulties was on the increase which in turn had an impact on the demand for speech and language services.

- Not all CCG's around the country commission a service for adults with dysfluency, and there were some areas where an "as and when" service should a patient present with exceptional needs, was commissioned. The range of age groups in other areas was very mixed, some areas only having one hospital that could provide services for adults and children combined, others have adult specific and children specific services.

- "No change" will remain an option in the consultation process although it was not considered to be viable. An all-age approach would be part of the consultation as the transition from child to adult would be key to the options available to determine how their needs might change and be managed through transition. There was a need to test the views of patients.

- Based on the fact that the Service had informed the CCG that it could not continue to provide the service as it stood, the CCG had a responsibility to work out the best way forward, following a standard matrix of quality of service, value for money and the wider impact on children's paediatric services. The CCG have had a conversation with the Children's Hospital, and it was felt that there was a case for change, and this would be set out when the proposals go out to wider consultation.

- In terms of whether a Service Level Agreements (SLA) would be a viable option, the CCG have contractual arrangements for this Service and it doesn't use SLAs. The CCG is the commissioning service for adult provision as well as children and the Service in Sheffield was comparatively well funded against national benchmark with more investment per service users than other providers across the country.

- The CCG and the SCNHSFT were working on a speech and language review, taking account of wider issues and consulting with those in education, schools and the voluntary sector. With regard to face-to-face consultations, it was anticipated that one of the options would be for a mixed service which provided telehealth appointments as well as face-to-face appointments to determine the needs of service users.

- In layman's terms, someone with a cleft palate would be diagnosed pre-birth and the majority of patients were usually discharged at around 20 years of age. Dysfluency in adults could continue for some patients well into their 50s, with some being re-referred into the service, for differing health reasons, sometimes these could be life-changing. Dysfluency patients transfer from the age of 16, whilst those with cleft palates would be retained until the age of 20, unless they still required some type of intervention.

6.6 Whilst it was noted that representatives from the Children's Hospital did want to attend the meeting, but unfortunately no-one was available, Members felt there was a need for representatives to attend a further meeting, so that the questions asked at this meeting could be answered and when more information was known, but this would have to take place before the scheduled meeting of 24th November, due to the commencement of consultation period.

6.7 RESOLVED: That the Committee:-

(a) thanks Kate Gleave and Lucy Ettridge for attending the meeting;

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

(c) expresses its deep regret that representatives from the Sheffield Children's Hospital NHS Foundation Trust were unable to attend the meeting and requests that a further meeting be arranged as soon as possible when they are available to attend.

7. PRIMARY CARE IN SHEFFIELD - NHS SHEFFIELD CCG

7.1 The Committee received a report on the progress of the South Yorkshire and Bassetlaw Integrated Care System bid for primary care capital developments under Wave 4B of the Capital Scheme and also progress on the development of Primary Care Transformational Hubs and other schemes to improve capacity in general practices.

7.2 Present for this item were Jackie Mills, Director of Finance, NHS Sheffield Clinical Commissioning Group (CCG) and Lucy Ettridge, Deputy Director, Communications, Engagement and Equality NHS Sheffield CCG.

7.3 Jackie Mills presented the report and outlined some key points, stating that the bid to deliver transformational change in the region had been successful, and that an overarching Programme Business Case had been developed and approved and was awaiting ministerial approval. She said that two-thirds of the £57,459 investment into primary care facilities had been earmarked for Sheffield and the three key elements of this was the development of Primary Care Transformational Hubs for GP practices to bring together small practices, develop capacity within eight GP practices and avoid underutilised and void spaces within such premises. Jackie Mills stated that some of the existing premises within the scheme were out-dated, residential properties which by their nature, created a number of problems such as access and expansion potential. The scheme would use capital grant monies under Section 2 Agreements, which allowed local authorities to build, own and operate such premises in return for a long-term, rent-free period for NHS services. She then went on to outline the potential sites in the north of the City and how the service was to be delivered and she said that she would bring back detailed plans to a future meeting of the Committee.

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

- A trawl of practices had been carried out and bids had been put forward to meet the criteria, with priority being given to those that could be up and running within the timescale of December, 2023. Also, consideration would be given to those practices which would deliver the best service for the local patient population.

- Consultation had been carried out around each potential hub and it was acknowledged that some patients felt that they would be disadvantaged with the clustering of practices. However, bringing together several practices into one large multi-practice, multi-service hub offering a wider range of services could reduce the number of sequential trips and healthcare appointments and offer greater flexibility.

- The shortage of GPs, the infrastructure within primary care and the development of the digital infrastructure created challenges but the CCG were working to meet these challenges. GPs have a broad range of views and buying into a practice in some areas was considered to be the best option for them, but in the areas included within the scheme, where there was negative equity, so this was felt to be a good an opportunity for GPs to buy into this type of service. However, some GPs feel they can deliver the best service from their own premises.

- It was unknown whether there would be more schemes in the future, as the focus was on new build hospitals with more acute facilities. The region was only one of two areas where this type of investment was to be made.

- The city centre was more developed in terms of central practices which included the Devonshire Green, Mulberry and the asylum seeker city centre practices.

- With regard to transport links, there was a balance to be sought so that patients didn't have to travel to several and alternative places for appointments. The city council is helping with the traffic planning scheme as part of this. Conversations have been held with the voluntary and community sector to look into many issues including travel and accessibility to buildings.

- The plan was not to close practices. Premises will close but the practices will be relocated. When all avenues have been considered regarding relocation, the Trust scheme will go out to full consultation with the public.

- In terms of the development of a strategic outline case in order to consult and engage with the public, it was looking more likely that the CCG would be able to proceed, however the timescales set were really demanding, and decisions have to be made by December 2023, but it was considered that there was enough information to be able to carry out a full consultation process. One of the ways to reach people, particularly in those areas where there was a high number of people with a BAME background, and to get their views on the proposals, would be to work with Healthwatch, voluntary and community sectors, Public Health and some BAME led organisations.

- The future of primary care will be delivered from the new hubs and will benefit not only the practices and Primary Care Networks involved, but also to patients in some the most deprived communities in the City.

- The CCG felt it would be beneficial to seek the views of the Local Area Committees in the areas affected and that they would come back to the Scrutiny Committee with an update.

7.5 RESOLVED: That the Committee:-

(a) thanks Jackie Mills and Lucy Ettridge for attending the meeting;

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

(c) asks officers to draw this issue to the attention of Local Area Committees.

8. CARE QUALITY COMMISSION INSPECTION UPDATE - SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST

8.1 The Committee received a presentation giving an update on the inspection carried out by the Care Quality Commission of the Sheffield Health and Social Care NHS Foundation Trust.

8.2 Present for this item were Jan Ditheridge, Chief Executive, Sheffield NHS Health and Social Care Foundation Trust and Dr. Mike Hunter, Executive Medical Director, Sheffield NHS Health and Social Care Foundation Trust.

8.3 Dr. Mike Hunter highlighted the main points in the presentation, outlining in particular, the improvements that have been made. He stated that due to improved staff training, appraisal and supervision, there was greater consistency of care on wards keeping patients much healthier and safer during their stay in hospital, particularly on older adult wards. Dr. Hunter said that focused improvements on wards for people with learning disabilities and autism, had been the removal of dormitories, providing better dignity and safety, and the adult wards had changed to single gender wards. The Care Quality Commission (CQC) had said that the Trust was heading in the right direction, that leadership arrangements had improved and the Trust was providing kind and compassionate care, but there was no room for complacency as there was still much more work to be done. He said buildings were not in great shape and plans were underway to build new facilities and work was being carried out with staff in social care and housing organisations to provide the right accommodation and housing for those with mental health problems when discharged from care. He stated that mental health issues had significantly increased over the last 18 months and whilst recruitment plans were in place, it was still difficult to get the best qualified nurses in post.

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

- There was a renewed commitment for smoke free hospitals and there was a major drive to make vapes readily available to those who were detained in hospital and were addicted to nicotine. The combination of replacement of nicotine and training of staff, has meant that some who enter the ward as a smoker, could possibly leave as a non-smoker.

- The normal practice on hospital wards was for medication to be written up on drugs cards and dispensed by staff. In some short stay settings, it had been found to be beneficial if a patient was admitted with their own medication, they should continue to take it.

- The Unit at Firs Hill was a seven-bed crisis unit for people who require long-term care and with no discharge plan, but this was type of unit doesn't fit with modern effective care. The Service at the unit was currently paused so that recruitment can take place to a number of vacancies that have arisen. The Unit focuses on specific interventions with time limited and measurable outcomes, so patients weren't staying there for protracted periods of time. Discussions were taking place in the short term to try and bolster community placement and crisis care.

- With regard to the implementation of single rooms, this was to ensure that there was no sharing of space, although it possible that someone could be in a dormitory, which wasn't ideal as there could be a feeling of solitude. Previously, there had been mixed wards, now there was a male ward and a

female ward.

- A lot of work has been done across the board around safeguarding, due to staff employed within the Trust, would be working amongst vulnerable people. Some learning events with local authorities and other partners have been carried out so that staff can reenergise and refocus on this matter.

- It was acknowledged that people from different cultural backgrounds don't always get the same level of care as those from a white background, particularly around retention and in-patient admissions. It would appear that patients of BAME backgrounds would be detained in hospital for longer and restraint seemed to feature in their care plan. Staff at levels 3 to 6 were representative of communities in Sheffield culturally, so often people from BAME backgrounds would be cared for by someone from the BAME community. However, that was not always the case at leadership levels and whilst this was acknowledged, work to change this would be carried out although this would take time. There was still a lot of work to do to make things culturally appropriate.

- Work was ongoing with ethnically diverse groups and it was felt there was a need for more diverse people to be involved on interview panels. In the north of the City, Sheffield IAPT Improving Access to Psychological Therapies (IAPT) has a good reputation and people have good experiences of that Service being accessible to everyone with different backgrounds. Sheffield was one of a number of early implementor sites, taking expertise in secondary care and weaving that expertise into primary care networks in its services. By April next year, early intervention sites will be accessible and on offer in half of Sheffield, which if something can be done fresh and approached in the right way, services can be more accessible.

- Training was available for nursing staff to enable them to treat patients with learning disabilities more effectively. Consultants have a level of training, but there was a need to support staff and keep training fresh and up to date with modern care, and not focus solely on mandatory training, but get refresher training in areas of expertise.

- It was recognised that people with autism should not be classed as people with learning disabilities, and there was a need to look at how best to support someone with autism, especially in an in-patient setting to be able to address their needs.

- Through primary care and IACT, improvements were required to be made as it was known that males within the BAME communities for a number of reasons do not access services at primary care level and there was a need to make sure, with advocacy and the voluntary sector within those communities, that they were confident to get the help they need early on.

- The general approach was to understand the needs, histories, backgrounds and cultures, which significantly vary amongst communities. The Roma Slovak community was one of the most disenfranchised communities, their

needs were very different to other ethnic communities and there was a need to understand that one size doesn't fit all.

- Translation and Interpretation Services were always made available as it was never appropriate to think that someone might be able to translate or interpret. There was a need to build a linguistic and diverse workforce.

- Significant numbers of staff were registered, qualified professionals. Staff were paid in accordance with the national pay grade, depending on qualifications, there was little control at a local level on staff pay.

8.5 RESOLVED: That the Committee:-

(a) thanks Jan Ditheridge and Dr. Mike Hunter for attending the meeting;

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

(c) notes and welcomes the improvement since May 2020 to August 2021.

9. WORK PROGRAMME

9.1 Emily Standbrook-Shaw, Policy and Improvement Officer, gave an update on the Work Programme and Members were asked to identify issues they are interested in discussing with regard to mental health. Members asked for a briefing on Covid in the run up to winter with the Director of Public Health at the next meeting; and suggested that an all-member seminar be set up to look at the same. Emily Standbrook-Shaw said she would contact members in relation to establishing a group to look at ICS developments in more detail.

9.2 RESOLVED: That the Committee approves the contents of the Work Programme.

10. DATE OF NEXT MEETING

10.1 It was noted that, as a special meeting was to be arranged, the date of the next meeting was to be confirmed.

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
24th November 2021

Report of: Director of Public Health

Subject: Covid Briefing & Forward Look - Winter 2021

Author of Report: Greg Fell, Director of Public Health

Summary:

At its meeting in September 2021, the Healthier Communities and Adult Social Care Scrutiny Committee requested that the Director of Public Health attend this Scrutiny meeting to give an update on Covid as we move into the winter period.

This paper provides the Committee with a comprehensive briefing and forward look at Covid (whilst noting that it is impossible to predict the future) to inform the Committee's discussions and questions.

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:

Note the briefing.

Category of Report: OPEN

Updated forward look 15/11

1 Epidemiology

1.1 Nationally and internationally

Some areas of East of England have very high rates. Might become what is known as Enhanced Response Area

Rising rates in South West – particularly in school age population

Children and <18 rates coming down fast ?half term or real effect

prior infection + vaccination coverage of 25%. Likely to see a sustained fall. Evidence is beginning to bear this out.

Yorkshire & Humber rates stabilising. Definitely peaked in school age pop. Well past the "half term effect" window. Sustained fall since half term.

Older people - boost from top age down - see impact on hospitalisations in next 2 weeks?

Some falling of>75 rates - >50% of >75s have had booster. Boosting gives significant benefit in terms of getting and outcomes.

Increasing pressure on NHS across the UK, not just Covid, but routine work as well. Expect to continue for next 2 - 4 weeks as rates in over 60s feed through.

Inbetweeners - harder to judge

Ages between 16-50 largely static rates. This is where govt action likely to have biggest effect.

What is going on internationally

A lot of the commentary on why has been plain wrong. This is a good thread, as is this. Testing rates, bed capacity, timing and nuances of measures including vaccination, timing of epidemic wave.

HAS it been worst – is it CURRENTLY worse than in Europe, this is pivoting now. Higher rates in UK than other countries. Ours are high and going up, E Europe now starting to go up. W Europe will follow. Probably unlikely we will not be an outlier over the next week or so.

1.2 Sheffield

Summary

Case rate falling <300 / 100k. Impossible to call where it will flatten. Either oscillate or slow drift downward. Will be v slow as not much restriction on movement.

School age

Mostly our cases are in secondary school age. Expected. Mixing pattern is pre pandemic, and not vaccinated. Rates in Sheff school age lower than elsewhere in South Yorkshire

Benefits of 12-15 vaccination will be delayed as won't get coverage high enough – so we will still get outbreaks into Nov and Dec

Nothing to stop primary school.

The all-age 7-day case rate has flattened out at a high rate, linked to high but slightly reducing rates in 5-17 year olds and onward transmission within the household.

Although numbers are high in this cohort, related harms are low.

Adult

A bit of bleed through to parent age and stacking upwards through the age cohorts. Gentle rise.

Older

Time proximal to vacc is an issue – waning immunity in older adults. >60s at highest rate since Jan (waning immunity a concern). Pretty decent immunity in middle age and young age.

Rates in older age groups had also shown an increase. Recent increases in cases among some older age groups (including the over 60s) and some increases in hospitalisations.

Now falling again. Definitively the impact of boosters.

Numbers remain lower than other groups however and there has been an increase in admissions to hospital from the community. This is a mixture of greater mixing in this age group and some impact from waning.

1.3 Hospital

Numbers in hospitals ticking up slowly. Bed occupancy increasing again. ICU/HDU cases - clinically vulnerable / immunocompromised/ unvaccinated. Average length of stay remains shorter than in previous surges.

Most cases in acute and care settings are incidental/case finding and are in people who are not ill due to COVID. There is evidence of vaccination effect on this cohort.

Over 60s rate now driving rise in admissions and occupancy- likely this will continue for a few weeks based on over 60s rates.

High baseline and all bits of NHS and social care are under exceptional pressure. All bits of NHS and Care system. Ambulance, A&E, primary care are exceptionally constrained.

Wave of respiratory infections hitting Emergency Departments. Not covid, not flu. RSV a bit, NV calmed down but will go up. Parainfluenza. When flu hits – will exacerbate. Possibility that flu jab isn't good match (combined with lack of general protection)

1.4 Deaths

Low numbers – 1 a day.

2 WHY is this going on

Behaviours are currently estimated to be closer to pre-pandemic norms than at any point previously since March 2020. But, how behaviours (contact rates, networks, precautionary behaviours) change over the coming months, and how quickly/whether they return to pre-pandemic norms is a key uncertainty in the modelled scenarios.

CoMix data indicate that mixing patterns for children are comparable to pre-pandemic levels, but those for adults remain considerably lower.

Very little adherence to preventive measures.

Mood music messaging = its all ok ….. thus public behave as if it is all over

Best explanation I have seen recently – 1) The UK has a big waning immunity problem. Bigger than Western Europe because of starting vax earlier. Much more likely than masks to explain UK's ongoing higher case & death rates, 2) Indoor mixing / large gatherings or large numbers of small gatherings. % of people attending large gatherings in UK is surging way ahead of elsewhere, 3) % of people never wearing masks has rocketed in UK but stayed very low elsewhere

3 Future / winter

NHS and Social Care system remain in an exceptionally difficult position. Now. It is NOT just hospitals.

The care being (rightly) provided to someone with acute illness from a respiratory infection (flu or covid) means someone else gets their care delayed and THAT has consequence

Pre winter winter phase. Because of pressures, relatively small rises in COVID admissions can have a disproportionate impact (Adult Social Care and Hospital are now in deep winter pressures in Oct). OPEL Alert system is in place. Plan for 40-50% of prior peak into Dec and Jan

Hard to know what will happen over winter

As there is very large residual immunity - Not likely to be a big spike, that fact makes it harder to get public support for greater intervention.

Although there remains uncertainty about the timing and magnitude of any future resurgence, these scenarios suggest hospital admissions above those seen in January 2021 are increasingly unlikely, particularly in 2021. A slower return to pre-pandemic behaviours and reduced waning are both expected to reduce and delay any further wave, although there remains potential for a rapid increase in hospital admissions if behaviours change quickly, and if waning is more significant and occurs after boosting.

Impact of flu

> Social distancing measures over the last 18 months reduced the circulation of all respiratory viruses (ALMOST CERTAIN) and we are now seeing altered respiratory viral seasonality. Therefore, there is uncertainty about the epidemiology this winter and
>
> whether concurrent transmission of other respiratory virus with SARS-CoV-2 will occur.

The magnitude of any influenza outbreak this winter is dependent upon the dominant strain (and prior population exposure to similar strains), vaccination levels, vaccine-strain match, and social contact patterns (which in adults remain below normal levels).

This makes it difficult to predict what will happen with influenza this season. 50:50 on whether flu vaccine will be good match for flu virus.

Due to waning population immunity, the next influenza season (whenever it occurs) is likely to be associated with a larger disease burden than would have occurred if

We are trying to avoid co infection with flu AND covid – much worse outcomes if become acutely unwell

SAGE recommend that individuals with symptomatic respiratory infections self-isolate, even if they receive a negative test result for SARS-CoV-2, as this will reduce respiratory virus transmission and potentially societal burden. Multiple factors at play - absence of sick leave, organisational culture, lack of cover for work, a sense of professional obligation, not feeling sufficiently ill and financial worries.

4 Plan B

A remarkably "strategic document" ….. very light on tactical detail. We need to work out what plan b actually looks like

A way of shifting the narrative ….. trying to avoid it being long and prescriptive and full of convoluted rules / pages of guidance that all conflict.

Hard to call likelihood. Q is whether to do step by step or all in a big bang. There is no obvious answer from an epidemiological view point

Plan b will be politically and media unpopular

Still no enthusiasm from Govt re imposing measures regionally

Modeller view – doesn't need a massive shift in behaviour to shift from R bit above 1 to R bit below 1. If implemented unlikely to have a dramatic effect (unless EVERYONE, all 60m of us, get into the measures). Effect will be slow decline.

4.1 What measures in plan B

In the event of increasing case rates, earlier intervention would reduce the need for more stringent, disruptive, and longer-lasting measures. Measures are not likely to be simply additive but to interact, resulting in a greater cumulative effect.

That effect is influenced by the context in which they are introduced, how they are introduced and by adherence. Measures have associated harms and potential for unequal impacts that should be considered prior to implementation.

Face mask use- ("a restriction" Vs an intervention that has reduced transmission)

Mask itself isnt going to swing the difference, but it will contribute.

What is “crowded” – trains and busses yes, warehouses no

reduce transmission through all routes by partially reducing emission of and exposure to aerosols and droplets carrying the virus, reducing transmission risk at both close proximity. Effectiveness is dependent on the quality of the covering, and fit and ensuring both the nose and mouth are covered. Likely to also have benefits for reducing transmission of other respiratory viruses.

Work from home. The plan B measure that has biggest effect

will be resisted by many – right wing media, some in some industries, coffee industry etc

Impact would be dependent on effectiveness of communication and guidance, employer response, and the proportion of workers able to work from home who were not already doing so at the time of implementation.

Vaccine passports

Will be a real disagreements about vacc passports. Will it be the thing that makes the difference, not likely

4.2 Threshold and timing for plan b

All pressure in NHS matters, not just hospital. Doubling times of case rate and NHS pressure

Mood music shifting just before half term. Media narrative shifting from a “ignore it, it is going away” to a “ahhh it is a growing issue and not getting better”

There won’t be a moment where the time for plan B is obvious. Not going to get to the doubling every 3 days, big spike… will be slower than that. Get to point where enough of our leaders say “this is the right thing to do”.

5 Vaccines

Rate of primary vaccination has slowed (not unexpected). There are still 10s of thousands who haven’t had primary 2 doses. Still leading of the core cities

Still a gap between east and west / BAME and white. Not as bad as I had feared but still there

Hard to know what we MIGHT do that we aren’t doing

12 – 15 continues.

JCVI on second dose for 12-15 and 16/17. Data on myocarditis has matured well in favour of being vaccinated (c/f risk of myocarditis following infection)

High degree of pressure on NHS to accelerate. It isn’t hesitancy (see Scotland), it is access and capacity.

Booster rollout is happening - absolutely critical – same priority order as 1st. Good uptake

Dose 1 and 2 remain primary importance - a booster is no good if you've not had dose 1 – never too late.

5.1 Numbers

The way in which vaccination is being reported has changed and now includes all eligible cohorts as well as uptake of the booster.

Almost 70% of the eligible population (12+) in Sheffield is fully vaccinated

Uptake in 16-17 year olds is 51% and 23.16% of 12-15 year olds (including those at risk).

Care Home residents - 94% of care home residents are fully vaccinated (37% booster), and 89% of care home staff (16% booster).

5.2 Vaccination & waning Immunity

Waning immunity is a concern – particularly >65s. A lot of nuance in this (antibody in blood vs immune memory). Nationally just under 60% of over 80s now received booster.

The biggest risk remains unvaccinated people, especially older

6 Implications for local interventions and messaging …..

National mood music on this likely to build over next few weeks

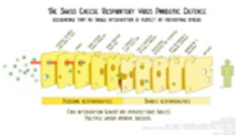
6.1 Basic interventions

Stuck record territory. Core messages remain the same the core interventions remain as they were and the machinery is working pretty well

Very little adherence to any NPIs anymore (masks, working from home has dropped, more large gatherings). Important to not allow masks to become a single flashpoint

6.2 The basic strategy is largely unchanged

Combination strategy



- **Prevention** – messaging, comms, approach to events and gatherings
- **Managing individual incidents** across multiple settings
- **Minimising testing delay** - had the largest impact on reducing onward transmissions. Making testing as accessible as possible.
- **Consistent push on getting tested, even mild symptoms** - people need to understand why, and really believe it. How to get a test
- **Optimising testing & tracing speed and coverage** – especially in some of our communities where we know we have rates of infection. These latter three things have potential to prevent up to 80% of all transmissions
- **Optimising isolation** - we know 80% of people recommended to self-isolate don't- supporting people ++
- **Vaccination** - Support NHSE programme with logistics, network connections, mass vaccination expertise
- **Focus on consistent messaging, simplifying communications, consent and consensus.**
- **Enforcement and compliance** (hard and soft)
- **Outbreaks**

Outbreak plan https://www.sheffield.gov.uk/home/yourcity-council/preventing-and-managing-covid-19
SCC Cabinet paper on implementing the plan http://democracy.sheffield.gov.uk/mgIssueHistoryHome.aspx?IId=31389

Test - If symptomatic get a PCR test and isolate.

Mask – never been a bad thing

Distance

Ventilate - all focus on better ventilation in indoor spaces

Wash hands

work from home if you can– REDUCE CONTACTS

some of the other fundamentals remain - better sick pay, financial support for isolating.

6.3 School interventions - Education/School COVID update: November 2021

Sheffield continues to have lower school age case rates than neighbouring South Yorkshire areas and most West Yorkshire areas.

Pre the half term back in October locally we did start to get a sense of a gradual rise in school age cases but it then plateaued and the figures started to come down just before the holiday.

The half term break has been timed well for us and will act as a circuit break. Now pupils have returned to school cases will increase.

Sheffield continues to have lower school age case rates than other neighbouring areas.

This reaffirms our position and reassures that at this time the priority should remain for face to face education and continued outbreak management support where required. Those other areas (Wakefield, Calderdale, Barnsley, Doncaster) introducing additional measures have had higher case rates than Sheffield.

We will continue to monitor and review the situation and if rates appear to be increasing we will consider additional local measures.

We are advising the new measure of daily LFD testing for secondary age pupils whilst they are awaiting their PCR results (in households with positive cases).

Sheffield settings have been managing outbreaks really carefully over recent weeks and to date we have not seen the disruption and school age case rates that some other areas have seen. The settings are working to put in place measures and working closely with UKHSA and the LA Public Health Team. Many are implementing additional measures already. Where they are receiving direct support from us they are also identifying additional contacts and advising targeted individuals/classes to go for PCRs. This is always considered as an intervention on a case by case basis and following technical risk assessment from us. The model is appearing at this time to be managing things and we are keen to maintain this approach.

Having a robust outbreak management support response set up by the LA PH team from the start of the pandemic has provided settings with a consistent model of outbreak support. Settings have managed things really well and this will hopefully have contributed to the lower school age case numbers locally.

Up to 80% of cases household transmissions in some areas.

Need to highlight risk from those you know and love, and risk to them too. You mostly get it from folk you know. SPI-B & SPI-M paper set out some helpful interventions that are built into our local approaches.

6.5 Vaccinate

Boosters/3rd doses - speed up booster roll (easier said than done)

Booster vaccinations are being offered to the same high priority groups as previously, if you are over 50, health and care staff or people in care homes you should have been offered a booster six months after you second dose.

Booster is by far more clinically important than 12 – 15 cohort. Exception = immune compromised kids 12+.

Booster vs unvaccinated people. By far the most important intervention is primary vaccination in the as yet unvaccinated adults, especially older. If you haven't yet had dose 1 and 2 then 1) never too late, 2) please reconsider

Flu jab

6.6 Overall message is that there is an exceptionally difficult winter ahead.

It's not just covid. By a long way. We are also seeing the impact of other winter illnesses and we haven't yet got to the flu season.

GPs, ambulances and A&E departments are seeing record numbers of patients.

That matters as routine care may be delayed or put off and even emergency care services will become more pressured with longer waiting.

There aren't easy fixes.

Obviously covid isnt helping but we need to remain cautious. Nobody wants the return of restrictions, that is in nobody's interest. We shouldn't wait for the government to mandate us to act

Simple things we can do

getting vaccinated – against covid and flu, which is the single most effective thing you can do to protect yourself and others. In this the single most important thing is if you haven't had the primary vacc (dose 1 and 2). Many clinics all across sheffield, no need to book, no need to be registered with a GP. Especial concern re pregnant women.

Get your booster jab if you are invited, as protection from the vaccine may decrease over time.

Working from home if you can, wearing face coverings, washing your hands more often and letting in fresh air can also make a big difference.

if you have symptoms you suspect is covid 19, arrange a PCR test gov.uk or by calling 119. Even if the result of that test is negative, please don’t go into work that risks spreading flu or other viruses

wear a mask. Made and enormous difference.

Please be patient with the NHS if you are finding it difficult to access care, they are working under incredible pressure.

help medical staff prioritise patients with the most urgent needs - residents should first seek advice from a local pharmacy or 111.nhs.uk, and only call 999 or attend A&E in an emergency. You can also use the NHS app to book appointments, ask for medication or get medical advice, or use the eConsult option on your practice's website to get a response the next day

Pandemic far from over. We don’t want to see return of any restrictions so important we do all we can to prevent this.

take care of your family and friends this winter

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

Report of: Alexis Chappell, Director of Adult Health and Social Care

Subject: Adult Health and Social Care Update

Author of Report: Alexis Chappell, Director of Adult Health and Social Care

Summary:
The purpose of this report is to provide an overview of Adult Health and Social Care performance, self-assessment, and progress of change programme.

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

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

The Scrutiny Committee is being asked to:

1. Note introduction of an assurance framework for Adult Social Care through the passage of the Health and Social Care Bill at section 2.4.

2. Agree that regular updates on the implementation of the Adult Social Care Assurance Framework and Sheffield City Council preparations are provided to Committee.

3. Agree that regular updates on then progress of priority actions arising identified from the self assessment are provided to Committee.

Background Papers:

None.

1. Introduction/Context

1.1 The purpose of this report is to provide an overview of and update about Adult Health and Social Care including information about the proposed inspection programme and key change programmes designed to improve lives and outcomes of people of Sheffield.

2.0 Background to Adult Social Care

2.1 Our ambition is that we deliver excellent quality, personalised services in communities across Sheffield, and work in partnership with colleagues and partners across the City to end inequalities and enable people to live independently, well and safely so that they can live the life they want to live in their local communities.

2.2 We do this by providing information, advice, and guidance as well as support and services to people who are over 18 with physical disabilities, sensory disabilities, learning disabilities, autism, experience of mental ill health and older people. We also support people who provide care and support to friends or family and young people supported by Children's Social Services who are approaching 18 years old and may require adult social care support.

2.3 The main responsibilities of Adult Health and Social Care are set out in three main pieces of legislation: the Care Act 2014, the Mental Capacity Act 2005, Human Rights Act 1998, Domestic Violence, Crime and Victims Act. These legislation direct Adult Health and Social Care to:

- promote wellbeing
- protect (safeguarding) adults at risk of abuse or neglect
- prevent the need for care and support
- promote integration of care and support with health services
- provide information and advice
- promote diversity and quality in providing services

2.4 In addition to this, the Health and Social Care Bill 2021 sets out a framework for integrating health and social care starting with the development of Integrated Care Systems (ICS) to tackle inequalities, improve population health and wellbeing, deliver excellent care, and maximise use of resources.

2.5 A key part of the Bill is the introduction of an enhanced assurance framework for adult social care, working alongside the Care Quality Commission (CQC) and local authorities to improve adult social care oversight, access, and outcomes across England. The assurance framework will likely consider our impact on people of Sheffield as well as how we are delivering on our legal obligations, our performance, our quality.

2.6 To deliver upon our ambition, our legal requirements and prepare for the introduction of an enhanced adult social care assurance framework, a Self-Assessment was undertaken between December 2020 and March 2021 to recognise our areas of strength, improvement and identify our key priorities for action.

2.7 The areas of priority identified can be summarised as implementing a:

- Vision and strategic direction which unites social care and sets out a long-term strategic direction and delivery plan.
- Care Governance Framework which sets out how we will drive excellent quality, performance, governance, and financial sustainability across all aspects of adult health and social care.
- New model for homecare delivery to enable people to live well and independently at home which enables us to respond to increased demand.
- New model for enabling young people to transition well into adulthood and adult services so that young people have the best start in life.
- Strengthened approach to safeguarding and mental health.
- Workforce plan which sets out how we value and empower our social care workforce across the City by implementing the foundation living wage, a career pathway and incentives for working in social care.
- Formal relationship with new NHS structures and build upon our positive working relationship with health so that we integrate care and through this end inequalities.
- Series of invest to save which builds workforce capacity within Adult Health and Social Care to deliver long term financial sustainability, new ways of working and with that our ability to meet our legal and statutory requirements.

2.8 These areas of priority formed the basis of an Adult Health and Social Care Change Programme, the Adult Health and Social Care actions entered within the Sheffield City Council 1 Year Plan and our key priorities for action during 2021 – 2022.

2.9 Since March 2021 we have made good progress in taking forward these actions which includes developing:

- A strategic plan for Adult Social Care alongside joint strategic commissioning plans - It is planned to consult on a draft Strategic Plan throughout December to January.
- A Care Governance Framework – It is planned to launch a framework throughout December to January.
- A new model for homecare – This is to be discussed at Education, Health and Care Transitional Committee on 2nd December 2021.
- A new model for supporting for enabling young people to transition well into adulthood and adult services so that young people have the best start in life.

- Invest to saves to build workforce capacity and support long term sustainability of Adult Social Care.
- A strengthened approach to safeguarding and mental health.
- An inspection preparation plan to prepare for advent of a new assurance framework.

2.10 Underpinning each of the developments is strong ethos and approach towards embedding collaboration with partners across the City and a focus on co-production with people with lived experience, their family members and carers and a joint commitment to promoting inclusion and tackling inequalities. It is aimed that this value base and approach will support us to deliver improved lives and outcomes for the people of Sheffield.

3 Implications

3.1 A key part of the Health and Social Care Bill is the introduction of an enhanced assurance framework for adult social care, working alongside the Care Quality Commission (CQC) and local authorities to improve adult social care oversight, access, and outcomes across England.

3.2 In going forward, it will be important that Sheffield City Council is well prepared for introduction of the assurance framework and to that end an inspection preparation team and planning have been implemented.

3.3. It is proposed, due to this that regular updates about the enhanced assurance framework and our progress in delivering upon priority actions identified following on from the self-assessment at section 2.7.

4. Recommendation

4.1 The Committee is being asked to:

- Note introduction of an assurance framework for Adult Social Care through the passage of the Health and Social Care Bill at section 2.4.
- Agree that regular updates on the implementation of the Adult Social Care Assurance Framework and Sheffield City Council preparations are provided to Committee.
- Agree that regular updates on the progress of priority actions identified arising from the self-assessment are provided to Committee.

Report to Healthier Communities and Adult Social Care Scrutiny Committee
24th November 2021

Report of: Policy and Improvement Officer

Subject: Written responses to public questions

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

Summary:

This report provides the Committee with copies of written responses to public questions asked at previous meetings of the Committee.

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

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

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

The Scrutiny Committee is being asked to:

Note the report.

Background Papers: None

Category of Report: OPEN

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1 Response to Helen Moore.

Helen Moore attended the Healthier Communities and Adult Social Care Scrutiny meeting on September 29th 2021 to ask a question relating to lifelong carers and changes to the Carers' Support Services contract. The following information was sent to Ms Moore:

The current contract for Carers Support Services ends in December 2021 and due to this, a decision was made earlier in the year to reprocure the service.

The specification for the new service remains largely unchanged from the previous specification. It was strengthened in relation to carer identification, building resilience early in the carer journey, personalisation and partnering with health system to reach carers before crisis. Support for carers of families with learning disabilities is identified similarly as the current specification.

The Council respects and values all Carers in the city, particularly Carers role during the pandemic. In response to concerns received from Carers such as yourself, regarding the specification and service offer, the Council's Director of Adult Health and Social Care has been listening to Carers to inform a way forward.

Officers in the portfolio will be contacting her to update her on progress and listen to her concerns.

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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
24th November 2021

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
- Consider, comment on and agree the proposal to establish a Scrutiny ICS Liaison Group and appoint members to it.

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 funded 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 Committee's consideration. We will take a flexible approach in planning scrutiny work, to enable us to respond appropriately as new issues emerge.

2.2 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 Proposal to establish a Scrutiny ICS Liaison Group

3.1 The Committee has identified the development of the South Yorkshire Integrated Care System as an issue it would like to monitor. A draft proposal for how this could be undertaken through a Scrutiny ICS Liaison Group is attached at appendix 1 for the Committee's consideration and agreement.

3.2 If the Committee agrees the establishment of the Scrutiny ICS Liaison Group, it will need to appoint members of the Committee to sit on it.

4 Recommendations

The Committee is asked to:

- Consider and comment on the draft work programme
- Consider, comment on and agree the proposal to establish a Scrutiny ICS Liaison Group and appoint members to it.

HC&ASC Draft Work Programme 2021/22	
Date	**Issue**
November 24th 2021	**Social Care & Covid Recovery** – Committee to consider social care performance and key issues currently facing social care services in Sheffield (SCC- Alexis Chappell) **Covid Winter Briefing** – Committee to hear from Director of Public Health re plans and preparations for Covid going into winter.
January 26th 2022	**CCG Response to the Scrutiny Report on Continence Services –** NHS Sheffield CCG – Sarah Burt. **Adult Dysfluency Services** – Update on future service model – NHS CCG, Sheffield Children's Hospital NHS Foundation Trust.
March 23rd 2022	
Potential Issues for consideration:	
Mental Health Services– recovery from Covid; green prescribing/role of nature in mental health services; service provision for veterans; CQC progress. ***Impact of Covid on access to dental services*** – progress report following Committee's consideration of this issue in February 2021. ***Development of the South Yorkshire ICS*** – watching brief on the development of the ICS, including the ToR and the role of scrutiny. ***Primary Care Capital Transformation*** – to follow progress after discussion at September 20th Meeting.	

Draft Proposal

Sheffield Healthier Communities and Adult Social Care Scrutiny Committee – ICS Liaison Group

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Background

The HCASC Scrutiny Committee has set out views relating to the development of the ICS following its discussion in September 2021:

- The development of the ICS should not lead to increased privatisation of the NHS in Sheffield, and seeks assurance that private providers will not sit on the ICS Board.
- Stresses the importance of local accountability in the NHS, and is keen to see that mechanisms that allow local people and Councillors to engage with, and challenge, the NHS are a valued part of the ICS;
- Engagement with seldom heard groups should be a priority for the developing ICS;
- Should maximise on opportunities to deliver on the City's carbon reduction and ethical procurement commitments;
- Public Health expertise should be sufficiently represented in ICS structure;
- consideration should be given as to how the NHS will engage with Local Area Committees in the new system; and
- changes resulting from the development of the ICS should empower front line staff, not be detrimental to them.

The Committee is keen to develop a mechanism to stay abreast of the development of the ICS, and how the Committee's views are being taken on board. They are particularly keen to monitor:

- ToR / MoU of the SYICS as they are being drawn up (ensuring no private providers on Board; maximum local accountability; balance of power & interests on the Partnership membership)
- Future relationship of place-based Scrutiny and South Yorkshire-wide joint Scrutiny with SYICS

Proposal

Sheffield Scrutiny ICS Liaison Group

A small number of HCASC Scrutiny Members (cross party) meet monthly, virtually, with the relevant CCG, ICS and SCC officers, to receive updates on the development of the SY ICS and impact on Sheffield.

The Liaison group reports back into the main Scrutiny Committee, flagging any issues/concerns/recommendations that may be directed to –

- CCG/ICS/SCC Officers re development of the ICS and Sheffield's role in it
- South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee re role of joint scrutiny
- Sheffield City Council – Governance Committee re role of place based statutory health Scrutiny in Sheffield.