SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 25 November 2015

PRESENT: Councillors Cate McDonald (Chair), Sue Alston (Deputy Chair), Pauline Andrews, Mike Drabble, Shaffaq Mohammed, Peter Price, Jackie Satur, Geoff Smith, Brian Webster and Joyce Wright

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Jenny Armstrong, George Lindars-Hammond and Katie Condliffe and Alice Riddell (Healthwatch Sheffield).

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 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 23rd September 2015, were approved as a correct record and, arising from their consideration, it was noted that the final version of the Carers' Strategy and Action Plans, referred to at paragraph 6.16(e), would be circulated imminently to Committee Members for comment.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 There were no questions raised or petitions submitted by members of the public.

6. BETTER CARE FUND - ACTIVE SUPPORT AND RECOVERY

6.1 The Committee received a joint report of the Director of Commissioning, Communities, Sheffield City Council, and the Chief Operating Officer, NHS Sheffield Clinical Commissioning Group, which provided details of the Sheffield Integrated Commissioning Programme (ICP), which had been established by the City Council and Sheffield Clinical Commissioning Group and was to be delivered over a three year period. The Programme was supported by a £270m pooled budget between Sheffield City Council (SCC) and the NHS Sheffield Clinical

Commissioning Group (CCG). This pooled budget was commonly described as Sheffield's 'Better Care Fund'.

6.2 The report was introduced by Idris Griffiths (Chief Operating Officer, NHS Sheffield CCG) and Joe Fowler (Director of Commissioning, Communities, SCC). Also present for this item were Anthony Gore (Deputy Clinical Director, NHS Sheffield CCG), Peter Moore (Integrated Commissioning Programme Director, NHS Sheffield CCG) and Lorraine Jubb (Strategic Commissioning Manager, Communities, SCC).

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

- The Council's website gave details of the availability of equipment to help people live in their own homes and the Adult Access Team could be contacted on telephone number 0114 2734908. It may be though that physiotherapists or district nurses were better placed to assess what equipment was required and were able to order such equipment.

- Preventative work, such as activities, would come under the 'People Keeping Well in their Community' workstream, which sought to identify those at risk of declining health and wellbeing. The NHS used a risk assessment tool to identify those at risk of admission to hospital or, if someone was identified as needing help, they would be put in touch with the appropriate people.

- In relation to mental health wellbeing, employment had been identified as an important preventative activity, as was stopping smoking.

- Information on local Community Support Workers would be circulated to Committee Members.

- The Better Care Fund was a collection of existing budgets which included Social Care, Continuing Care and Ongoing Support.

- Attempts were being made to introduce systematic change through initiatives and area based funding, with risk scores being used in the different areas. In the poorer areas, these risk scores had identified people in their 50s, whilst in others it was people in their 70s.

- Monitoring was about understanding solutions and, in relation to ongoing care, a small set of Key Performance Indicators were being looked at, eg. staff employed in reactive care and the proportion of people being cared for in the community.

- The service for the provision of equipment included having people to fit such things as handrails.

- The intention was not to replace informal care but to support it and to create an environment of support.

- Outreach work had resulted in approximately 250 people being helped to claim allowances and a few hundred people being given access to local activities.

- Community Support Workers across the City were attached to clusters of GP surgeries.

- Hidden carers were now being reached by engaging with the community, through contacts such as hairdressers and shop workers.

- The cost of elective hospital admissions was about £100m and it was thought that 15 to 20% could be cared for outside hospital.

- Access to A&E was a complex issue, with admissions being skewed to the old and frail. It was often the case that admissions occurred during the day when someone had been visited by a relative or carer. The number of patient visits to A&E was influenced by such things as the patient's closeness to the facility, the number of young people in the area, the prevalence of Chronic Obstructive Pulmonary Disease in the area and the age profile. It was noticeable that those admitted to hospital from the South West of Sheffield tended to stay in longer, which appeared to reflect the fact that people in that area lived longer.

- The Keeping Well programme was tailored to areas where people were most at risk from declining health and wellbeing, with more district health nurses being allocated to such areas.

- The Public Health budget was £10m and this included funding for health trainers and champions.

- In relation to community based development, officers were looking at mature partnerships and learning a lot from conversations with people. Devolved funding was being provided for community asset development, which involved such initiatives as the provision of activities for those with dementia in Northern Sheffield.

- Officers were already talking to representatives of the South Yorkshire Fire and Rescue Authority with regard to wellbeing.

- In relation to barriers to progress, data sharing was an issue but this was a national as well as a local issue.

- The biggest challenge was long term care support.

6.4 The Committee then received a presentation, given by Idris Griffiths and Anthony Gore, which focused on the Active Support and Recovery (ASR) workstream of the ICP. This covered the aims and objectives of ASR, future pressures on services,

the results of consultation, outcomes of consultation, how success would be measured and how it was intended to achieve the aims and objectives.

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

- ASR was coming more from the GP side in terms of ensuring that the correct care was provided in a crisis and that services were joined up in these situations.

- If one service had a care plan for a patient, then this would improve the identification of what care was needed.

- Positive responses had been received from care providers in relation to them thinking more widely. This involved them talking to organisations, such as Housing Associations and the third sector, to create a more joined up framework, so if care needs escalated there would also be a plan in place for their de-escalation.

- Whilst there was a need to intervene in crisis situations, there was also a need to intervene prior to any crisis. A more proactive approach was required with more information sharing.

- The Sheffield Health and Social Care Trust, which was a member of the provider group, had been asked to include mental health funding in the Better Care Fund, as this was presently not the case.

- Care plans were usually written by GPs, who were now involving practice and community nurses in this process. There was a general upskilling of staff, but it was acknowledged that there was much more to do and that this needed to be broadened.

- It was the intention that people delivering care on a day to day basis would have their roles widened and that appropriate training would be provided. However, this would take time, with the challenge being how to train a different workforce.

- The best people to assess a patient's requirements were those who knew them best, such as those who provided local services. The challenge was how to get whole system workforce development.

- The healthcare system had become increasingly more complicated, creating a different environment for both professionals and patients.

- The health and social care system was under pressure and was not sustainable in its present form. There was a need to change the contractual setup, but the focus should remain on patient outcomes

6.6 A brief discussion then took place, during which Members commented on the report, presentation and responses to questions. This discussion included reference to public access, prevention, communications, health inequality, carers, loneliness, mental health, budgets, funding and barriers to progress.

6.7 RESOLVED: That the Committee:-

(a) thanks those attending for their contribution to the meeting;

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

(c) agrees that the comments made by Committee Members be considered by the Chair (Councillor Cate McDonald), in conjunction with the Policy and Improvement Officer, and summarised in a paper to be circulated to Committee Members and included in these minutes.

(NOTE: Subsequent to the meeting, the following was agreed between the Chair (Councillor Cate McDonald) and the Policy and Improvement Officer:-

"The Committee welcomes the aims and objectives of the Integrated Commissioning Programme (ICP), and the opportunities it affords – particularly around prevention and reducing health inequalities. We would like to see the following issues addressed:

- Public access– we recognise that a lot of the improvements are about joining up the 'back-end' of service delivery, but we need to ensure that people know how to access services.

- Communication - it is important that we communicate the changes in the right places – particularly around the role of Community Support Workers. We need to ensure that members of the public, as well as Councillors and community groups know about them, how to access and signpost people to them.

- Linking in to other changes – we need to ensure that the integrated commissioning programme is linked in and integrated with policy and strategy changes and developments across the Council – for example the Carers Strategy.

- The ICP presents us with an opportunity to tackle important issues such as mental health and loneliness which are key to people's health and wellbeing. The Committee would like to see this opportunity maximised.

- We recognise that it is too early to 'measure success', but the Committee would like this to come back in the future with a focus on whether both the desired outcomes and financial savings are being achieved.

In terms of the Active Support and Recovery strand of the ICP, the Committee

welcomes the aim to achieve person-centred, flexible services and looks forward to seeing how providers work together to achieve this.

The Committee commends the 'whole system workforce plan' approach and is interested to see how this will work in practice.")

7. WORK PROGRAMME 2015/16

7.1 The Policy and Improvement Officer submitted a report attaching the draft Work Programme 2015/16.

7.2 RESOLVED: That the Committee notes:-

(a) the draft Work Programme 2015/16; and

(b) that any comments or suggestions on the draft Work Programme 2015/16 be communicated to the Policy and Improvement Officer.

8. DATE OF NEXT MEETING

8.1 It was noted that the next meeting of the Committee would be held on Wednesday, 27th January 2016, at 10.30 am, in the Town Hall.