SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 17 April 2013

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, Katie Condliffe, Roger Davison, Tony Downing, Adam Hurst, Cate McDonald, Pat Midgley, Diana Stimely and Garry Weatherall

Non-Council Members (LINk):-

Mike Smith (Substitute for Helen Rowe)

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Helen Rowe (Sheffield LINk).

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 20th February 2013, were approved as a correct record and, arising therefrom, it was reported that:-

(a) it was believed that the Government had provided approximately £825,000 funding towards capital reconstruction costs at St Luke's Hospice; the Hospice had reiterated its invite for Members of the Committee to visit the Hospice; and

(b) further to the Council's proposal to no longer provide free of charge, individual small items of daily living equipment costing less than £50 and regarding the setting aside of funds, for a hardship fund, to assist those who could not afford daily living equipment, both issues, as requested, had been referred to the Cabinet Member for Health, Care and Independent Living (Councillor Mary Lea), but no response had yet been received.

RESOLVED: That Policy Officer (Scrutiny) be requested to:-

(i) make the necessary arrangement for the Members of the Committee to visit St Luke's Hospice, following the Hospice's invite; and

(ii) contact Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, to request that she provides a response on the two issues relating to daily living equipment, to this Committee.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 There were no public questions or petitions.

6. MAJOR TRAUMA - UPDATE

6.1 Ian Atkinson, Accountable Officer, NHS Sheffield Clinical Commissioning Group (CCG), accompanied by Daniel Mason, Sheffield Urgent Care Lead, provided an update on the progress regarding the implementation of the national strategy for major trauma within the Yorkshire and Humber region. The report provided details of what major trauma comprised, the number of people identified as major trauma cases in the Yorkshire and the Humber region, the plans for improving major trauma care in the region, how the CCG was ensuring that such improvements happened and what the changes would mean for local hospitals. The report also set out details of the progress made with regard to the transformation of major trauma treatment and care since April 2012, details of the CCG's approach from April 2013, and attached, as an appendix, details of all the Major Trauma Centres and Trauma Units in the South Yorkshire and the Humber region.

6.2 Members of the Committee and representatives of Sheffield LINk raised questions and the following responses were provided:-

- Sheffield has a Major Trauma Centre at the Northern General Hospital for adults and a Centre at the Children's Hospital for people under 16.

- The vast majority of patients with major trauma are taken directly to, and reach a Major Trauma Centre, within the designated 45 minute timescale.

- There were likely to be no problems in terms of capacity issues arising from the proposals to improve access to specialist services regardless of where in the region someone was injured.

- There were no major issues, in terms of performance comparisons with other core cities in terms of dealing with major trauma.

- Major Trauma Centres provided a very "front end" service and ensured that patients were clinically safe. The Centres were commissioned by NHS England.

- Rehabilitation was going to be more effective in Major Trauma Units as there was a wider range of services available to patients. The commissioning of Trauma Units and the rehabilitation of patients was the responsibility of CCGs. Every effort was made to ensure that patients were rehabilitated locally so they could be near friends/family.

- There were a range of rehabilitation services across South Yorkshire and work was underway to understand what services were currently being offered and what may be needed in the future.

- If a patient suffered a major trauma at a location in North Derbyshire, a decision would be made by East Midlands Ambulance Service, based on the 45 minute rule, as to whether they were referred to either a Major Trauma Centre in Sheffield or Nottingham.

- There were arrangements in place for Major Trauma Centres and all hospitals to collaborate in the event of a major incident where there are a number of people involved. All the centres and units will be aware of the planning arrangements, and all resources could be made available, with all routine elective services being suspended if necessary.

- There was a range of rehabilitation services across South Yorkshire and an analysis was currently being undertaken of all such services in order to identify whether there were any gaps in services for patients requiring them.

- In terms of the assessment of patients at the scene of an incident, progress was being made to ensure that all coding systems in terms of the patient's condition were consistent.

- In the event of a major incident, the Health Service was part of the Gold, Silver and Bronze command structure, in partnership with other emergency services, such as the Police.

6.3 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses provided to the questions raised;

(b) thanks Ian Atkinson and Daniel Mason for attending the meeting and responding to the questions raised; and

(c) requests that a further report on this issue be submitted to a meeting of the Committee in 12 months' time, focusing on the progress made with regard to the proposed improvements to rehabilitation services.

7. SHEFFIELD CHILDREN'S HOSPITAL NHS FOUNDATION TRUST - QUALITY ACCOUNT 2012/13

7.1 John Reid, Director of Nursing and Clinical Operations, Sheffield Children's Hospital Foundation Trust, reported on the Quality Account for the Sheffield Children's Hospital for 2012/13.

7.2 The report summarised the performance of the Trust in 2012/13 with regard to the quality of care, and also set out details of the quality priorities for 2013/14, in consultation with the Trust's families, governors and agency partners.

7.3 Mr Reid reported that Sheffield Children's NHS Foundation Trust was one of the best performing Foundation Trusts in the country, as recorded by Monitor (the Foundation Trust regulator) and the Care Quality Commission (CQC), and that the Trust had responsibility for most aspects of child health care in Sheffield, including hospital, community and mental health, as well as being a major provider of specialist hospital care for South Yorkshire and beyond. He reported that the reputation was built on the high satisfaction survey results and the quality of care provided. Reference was made to the construction of a new £40 million patient wing, which was due to commence in Summer 2013, and would result in material improvements to those areas of below average experience, such as parking, privacy and dignity, parental accommodation and way-finding.

7.4 He reported that the Trust's community services and its Child and Adolescent Mental Health Service (CAMHS) were key components of a holistic child health system in Sheffield and beyond, and the Trust had been working closely with local authority partners to ensure that its teams were integrated with social care and education to obtain the best outcomes for families. This was carried out through joint child protection arrangements, shared public health priorities and good communication. He referred specifically to complaints which had been received during 2012/13, which had showed an increase from the previous year, with the most common grounds for complaint relating to a diagnosis or a treatment plan, or in relation to complications of treatment.

7.5 Members of the Committee and representatives of Sheffield LINk raised questions and the following responses were provided:-

- It had been accepted, as highlighted by a recent case, that communication between clinicians has not always been effective. In response to this, a Paediatric Early Warning Tool had been developed, which comprised a system of coloured bands to enable consistency in terms of the assessments of different types of care, as well as setting down time limits in terms of doctors' responses and the levels of seniority of doctors dealing with different types of care.

- It was agreed that complaints should be dealt with as a form of customer feedback. As mentioned earlier, the number of complaints received had increased in the last few years, with the majority relating to a diagnosis or treatment plan. Whilst both issues were considered to be subjective, it had been agreed that all complaints should be viewed as valid, and a number of such complaints had been seen to be justified. An increasing number of issues were dealt with by the Patient Advisory and Liaison Service (PALS), which aimed to resolve as many issues as possible, prior to them becoming formal complaints.

- Despite the recent news regarding the Leeds Cardiac Unit, the Trust did not have any concerns with regard to the ability and safety of surgeons at Leeds, and was currently the Trust's preferred partner in terms of cardiac surgery.

- There had been considerable adverse publicity regarding the events at the actions of the Mid Staffordshire NHS Trust, where a high number of patients

had died as a result of the alleged substandard care and staff failings. The mortality rate had been considerably higher than other hospitals of a similar size. Standardised mortality rates for children were heavily dependent on specialities at each hospital. The low numbers of children's deaths do not readily lend themselves to statistical interpretation and consequently, an independent investigation into each child death was conducted by the Child Death Overview Panel. The Trust does report standardised mortality figures for its intensive care unit and these were published on the PICANET website. The figures for the Trust were about average for the mix of specialities.

- The Trust has worked with GP and midwifery colleagues to improve their access to paediatric medical advice. A paediatrician is available each day to discuss cases and avoid unnecessary attendance at A&E.

- The Trust had worked with health visitors in order to integrate them into the workforce. There had always been tension regarding whether health visitors should concentrate on a universal service or prioritise care for those families of greatest need. The Trust was carrying out a 1200 family community satisfaction survey and it was hoped that this would help provide the Trust with evidence to support the best balance between these approaches.

- It was accepted that there was no reference to meningitis in the report. Mr Reid undertook to supply the Committee with data on meningitis diagnosis locally and nationally. The success rate for dealing with cases of meningitis depended predominantly on what stage it was identified.

- In terms of the car parking on Western Bank, the Trust had prioritised this for people attending A&E, as having an acutely ill child and therefore, an urgent need to seek clinical attention.

- In terms of equality and diversity issues, the Trust's Equality Scheme was published on its website on an annual basis. Any language needs were addressed by the operation of an interpretation service, which comprised both face to face interpretation and a telephone-based language line in the emergency admissions department. Research has shown that more BME families tended to attend the Hospital at similar times in the mornings and afternoons, and the Trust had attempted to address this by changing staff shift patterns and talking to NHS Sheffield regarding the out of hours GP based at the Hospital. Some BME communities used the A&E service differently from the general population and the Trust was working with commissioners to see how this could be modified. The results of the A&E Survey, which was targeted at families attending A&E, had been published on the Trust's website.

- It was accepted that the Trust had failed a target on the issue of providing relevant information for asthma sufferers leaving the hospital. This was a relatively small audit, but had resulted in changes to discharge arrangements to ensure that patients had all the relevant advice.

- In terms of the quality improvement priorities identified for 2013/14, specifically regarding the implementation of the Department of Health response to the Mid

Staffordshire NHS Trust Public Enquiry – 'Patients First and Foremost', the Trust would involve non-executive Board Members, as well as Governors and families in any inspection and oversight of the Trust's services.

- The number of 265 local clinical audits and service evaluations may appear high. The Trust carried out nationally commissioned audits and some Trust commissioned audits. These were to quantify poorly understood risks. Most audits were carried out by trainee health staff, as part of their educational program and relate to areas of interest for them personally.

- Although the Committee recognised that Quality Accounts had to be drafted in a standard format, the Trust would consider producing an easy-read version of the Quality Account that was more accessible to the public.

- There had been a number of issues regarding the planning applications required for the hospital redevelopment on the basis that the Hospital was situated within a Conservation Area. Having underground parking below the Out-patient Department was one way to get round the strict limitations regarding Conservation Area planning consent. There were also plans to provide car parking on the triangular piece of land next to the Octagon, as well as providing off-site parking, with a shuttle bus service between the Hospital, the nearest Supertram stop and the proposed Tapton area car park.

7.6 RESOLVED: That this Committee:-

(a) notes the contents of the report now submitted on the draft Quality Account 2012/13, together with the responses to the questions raised;

(b) thanks John Reid for attending the meeting and responding to the questions raised; and

(c) requests (i) the Policy Officer (Scrutiny) to liaise with John Reid, with the aim of arranging a visit by Members to the new Home from Home villas and other areas of new build at the Hospital and (ii) John Reid to provide details of the results of the asthma audit which would be repeated in terms of the provision of advice to child asthma sufferers, to this Committee.

8. SELF DIRECTED SUPPORT UPDATE

8.1 Eddie Sherwood, Director of Adult Social Care, submitted a report providing an update on the progress on the choice and control given to people receiving Adult Social Care, and providing an overview of how personalisation would continue to be implemented across Adult Social Care.

8.2 The report was supported by a presentation from Jeanette Thompson, Service Manager, Personalisation, and Jon Brenner, Programme Manager, and accompanied by Eddie Sherwood.

8.3 The presentation provided an explanation as to what self-directed support involved, details of what had been done in Sheffield, in terms of headlines, process

redesign and market development, what had been achieved in terms of choice and control, and what benefits had been achieved by individuals, as well as the impact the work had had on them. The presentation also provided information on how Sheffield compared to other local authorities, details of the on-going challenges and what the next steps for personalisation were in Sheffield.

8.4 Members of the Committee and representatives of Sheffield LINk raised questions and the following responses were provided:-

- Officers were trying to put all the various information together to make it as easy as possible for individuals to manage their personal health budgets. It was accepted that there was a need to make people fully aware of what their personal financial contribution would be, and there were systems in place to ensure that charges regarding Section117 were only made where relevant.

- If an individual's care needs changed, there was always scope to review their needs. The policy in terms of how this was done had recently been reviewed and if anyone's needs did change, this would automatically trigger a re-assessment.

- The individual's Support Plan would determine what training the Personal Assistant would require. Details of all Personal Assistants were maintained on a database, and they were regularly informed about relevant training courses, which were held at the Brockwood Training Centre. The Training Support Grant was used to pay for such training courses. Officers were presently looking at issues where the individuals had complex care needs.

- Some clients undertook all roles, such as payroll and tax. A number of organisations do exist that can help people with some or all of the functions they require. This is paid for from the person's personal budget. Most individuals paid the standard rate for their Personal Assistants. However, those with more complex requirements would pay more.

- In terms of Criminal Records Bureau (CRB) checks, if there was a child in the household, the Personal Assistant would be legally required to undertake a CRB check. Whilst there was no legal requirement if there were no children in the house, it was recommended that employers undertook such a check on prospective staff.

- In terms of direct payments, under the present arrangements, officers had a better idea of what individuals were spending their money on, therefore checks could be made as to how the money had been spent. If there was a capacity issue, the Council would identify groups or organisations which could organise this on behalf of the individual. Audits of the individual's bank accounts were undertaken every three months, as part of a check to find out how the money had been spent.

- Individuals were expected to find their own Personal Assistants. People need to work out what they wanted from an Assistant and that helped to inform where to start looking for one. This has always been the case and some

agencies do offer assistance with this process.

- If an individual did not want to receive direct payments, they should still get an equal opportunity in terms of choice and control as to whether they wanted a provider to sort things out for them.

- There was no age limit in terms of the Personal Assistants. It was entirely up to the individual as to who they wanted to act as their Assistant. Most individuals did not want carers visiting them in their homes, and considered that Personal Assistants gave them greater flexibility.

- Individuals were provided with advice on how to incorporate payments such as holiday cover/sickness into the payments. A spreadsheet/calculator has been developed to help with this process.

(NOTE: At this stage in the proceedings, the Chair left the meeting, and Councillor Roger Davison took the Chair for the remainder of the meeting.)

- Individuals would complete an assessment questionnaire in order to evaluate how much they were provided in terms of a personal budget. They would be awarded points in terms of how they responded to questions, relating to their care needs. People could be awarded a maximum of 100 points, although based on analysis of the questionnaire, very few people scored above 70 points. However, whenever people were able to demonstrate that they had additional care needs, officers would have to include this within the decision-making process.

- It was accepted that there could be delays in people receiving their payments if the information they had provided was not accurate. The Council was introducing an electronic scheme, which would hopefully speed the process up. Also, there was a more robust team of officers, who would assist to help speed up the process, including carrying out the audits.

- In terms of potential delays in getting individuals into the system following their initial assessment, officers had undertaken considerable work on this issue, which had included changing the structure of the Teams, which had resulted in more staff working on the initial assessments in order to speed up the process.

8.5 RESOLVED: That the Committee:-

(a) notes the information contained in the report now submitted, the information reported as part of the presentation and the responses to the questions raised;

(b) thanks Eddie Sherwood, Jeanette Thompson and Jon Brenner for attending the meeting and responding to the questions; and

(c) requests Eddie Sherwood to submit a further progress report on Self Directed Support and Personalisation, to a meeting of the Committee in approximately one year's time.

9. QUALITY ACCOUNT RESPONSES

9.1 It was agreed that the Policy Officer (Scrutiny) would circulate details of the Committee's responses to the Sheffield Health and Social Care NHS Foundation Trust Quality Account 2012/13 to Members of the Committee, for comment and approval, prior to submission.

10. WORK PROGRAMME AND CABINET FORWARD PLAN

10.1 The Committee received and noted a report of Policy Officer (Scrutiny), containing the Committee's draft Work Programme and the latest version of the Cabinet Forward Plan.

11. DATE OF NEXT MEETING

11.1 It was noted that the next meeting of the Committee would be held on Wednesday, 8th May 2013, at 10.00 am, in the Town Hall.

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