Public Document Pack

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 25 February 2015 at 10.00 am

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

The Press and Public are Welcome to Attend

Membership

Councillor Mick Rooney (Chair), Sue Alston (Deputy Chair), Jenny Armstrong, Olivia Blake, John Campbell, Katie Condliffe, Jillian Creasy, Qurban Hussain, Anne Murphy, Denise Reaney, Jackie Satur, Philip Wood and Joyce Wright

Healthwatch Sheffield
Helen Rowe and Alice Riddell (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
25 FEBRUARY 2015

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** Members to declare any interests they have in the business to be considered at the meeting	(Pages 1 - 4)
5.	**Minutes of Previous Meeting** To approve the minutes of the meeting of the Committee held on 17th December, 2014, and to note the attached Actions Update	(Pages 5 - 16)
6.	**Public Questions and Petitions** To receive any questions or petitions from members of the public	
7.	**Call-in of Leader's Decision Regarding the tender for the Reprovision of Day Services and Residential Short-Term Care Beds for People with Dementia** Report of Emily Standbrook-Shaw, Policy and Improvement Officer	(Pages 17 - 36)
8.	**Sheffield Teaching Hospitals Annual Quality Report 2014/15** Report of Sandi Carman, Head of Patient and Healthcare Governance, Sheffield Teaching Hospitals NHS Foundation Trust	(Pages 37 - 40)
9.	**Commissioners Working Together Programme Update** Report of Will Cleary-Gray, NHS Sheffield Clinical Commissioning Group	(Pages 41 - 46)
10.	**Adult Social Care Performance Update** Report of the Executive Director, Communities	(Pages 47 - 58)
11.	**Sheffield Health Inequalities Plan** Report of Dr Jeremy Wight, Director of Public Health	(Pages 59 - 76)

12. Care Act 2014 - Update
To receive a presentation by the Executive Director, Communities

13. Work Programme 2014/15 (Pages 77 - 84)
Report for Emily Standbrook-Shaw, Policy and Improvement Officer

14. Update on Developing a Social Model of Health (Pages 85 - 90)
Briefing Note for Information

15. Sheffield Adult Safeguarding Partnership - Business Plan Update (Pages 91 - 102)
Briefing Note for Information

16. Date of Next Meeting
The next meeting of the Committee will be held on Wednesday, 15th April, 2015, at 10.00 am, in the Town Hall

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 Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Interim 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 17 December 2014

PRESENT: Councillors Sue Alston (Deputy Chair), Jenny Armstrong, Olivia Blake, Katie Condliffe, Anne Murphy, Denise Reaney, Jackie Satur, Brian Webster, Joyce Wright, Pat Midgley (Substitute Member) and Geoff Smith (Substitute Member)

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from the Chair, Councillor Mick Rooney, and as a consequence, the position of Chair was taken by the Deputy Chair, Councillor Sue Alston.

1.2 Apologies for absence were also received from Councillor John Campbell, with Councillor Pat Midgley deputising, and Councillor Philip Wood, with Councillor Geoff Smith deputising.

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. PUBLIC QUESTIONS AND PETITIONS

4.1 In response to a public question regarding the decision-making process on closing Health Centres, the Chair, Councillor Sue Alston, indicated that NHS England had been asked to provide a written response to the questions raised on Primary Care. Joe Fowler, Director of Commissioning, added that discussions were taking place between the Clinical Commissioning Group (CCG) and NHS England about the future of Primary Care and that responsibilities for this might transfer to the CCG.

4.2 RESOLVED: That the Policy and Improvement Officer be asked to include this issue in Work Programme discussions.

5. PETITION - OPPOSING THE POTENTIAL PRIVATISATION OF THE LEARNING DISABILITY SERVICE

5.1 The Committee received a report of the Interim Executive Director, Communities, which summarised the Council's position regarding the petition, which had been received by the Committee on 23rd July 2014, the issues raised and Unison's Ethical Care Charter, a copy of which had been circulated, together with a consultation timeline summary.

5.2 In attendance for this item were Susan Highton, Lead Petitioner, Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living, Joe Fowler, Director of Commissioning, Richard Parrott, Commissioning Manager, Kate Anderson, Contracts Manager, and Anne Flanagan, Interim Head of Learning Disabilities Service.

5.3 Susan Highton addressed the meeting and emphasised that the consultation in 2010 was about moving from residential to supported living and that there had been no suggestion of a change of provider until the meeting which had taken place at St. Mary's Church, following which the consultation had begun. She went on to state that the Sheffield Health and Social Care NHS Foundation Trust (the Trust), had not been selected as the provider for the Handsworth and Cottam Road schemes, and that the new providers may not be able to absorb all the existing staff. She considered that users had no choice in the matter and that it was all about changing the service to another provider to save on costs and further commented on the lack of consultation.

5.4 In response, Joe Fowler, Director of Commissioning, stated that supported living was the preferred model nationally and that staff were constrained by the residential model, which made it difficult to provide flexibility. With regard to the Handsworth scheme, the same three providers would have been selected if price was ignored and, in relation to the Transfer of Undertakings Protection of Employment Regulations (TUPE), the individual organisations would have to decide on this. An outstanding issue was who would provide the care, with the focus being on transition so it was likely that many of the staff would be operating in the same setting. He added that the Council did not want to see an erosion of staffs' terms and conditions and wished to see the situation managed sensitively and appropriately. He emphasised that the Council had no contract with the housing providers and that this was between the Housing Associations and the Trust.

5.5 Richard Parrott, Commissioning Manager, made reference to the consultation event which had taken place at St. Mary's Church in January 2014, at which Trust staff and relatives/users had been present. He had checked that people understood that there was a possibility of a change in staff provider and accepted that residents and relatives may experience a period of uncertainty. In relation to the best way of communicating with relatives and users, the response had been that this was best done home by home.

5.6 Kate Anderson, Contracts Manager, indicated that a timescale had been set for each home and that relatives had been contacted, with drop-in sessions for relatives and users being held, and that an advocacy service was available if

required. Contact details had been provided for relatives not living locally and there had been telephone contacts to keep people informed, together with the production of a monthly newsletter. Each relative and user had worked through an assessment and support plan from scratch in situations where the provider was to be changed. The providers had been contacted and asked for their proposals on delivery and shortlists of three or four providers had been drawn up, with Deciding Together events being held subsequently. Attempts had been made to accommodate different provider choices and relatives and users of the Handsworth scheme had wanted a single provider. Work had been undertaken with relatives and users to ensure that people's best interests were served and that they were being kept up to date with regard to the transition.

5.7 The following responses were provided to public questions:-

- The proposal was to deregister nine homes and users with higher needs tended to be supported by the independent sector. For example, Handsworth was used to dealing with those with brain injuries. In situations where the provider changed, it was vital that the transition was managed sensitively. The aim was to achieve sustainable supported living and, if there was a change in provider, TUPE would almost certainly apply, with long term continuity being envisaged.

- The contracts would be for three/four years with a period of notice, so that they could be terminated if the support was unsatisfactory.

- The deregistration discussion had started in 2010 when the decision to consider supported living had been made.

- Officers did not take part in the decision-making meeting and Cloverleaf Advocacy was an independent organisation which could challenge officers and feed in the thoughts of relatives and users, and which was paid for by the Council. Funding for this was also provided by the Citizens' Advice Bureau and Healthwatch.

- Officers would be happy to come back to the Committee with a before and after report on the care of residents.

- The Council had lost 50% of its Government funding, so any change had to be affordable. As a consequence of the pooled Health Budget, funds had been put into a learning disability service with the aim of trying to do the right thing in terms of the financial constraints which had been imposed.

- Guidance had been supplied to all providers in an open, fair and transparent manner, with each home being looked at to ensure that needs could be met.

- National and local user studies had shown that supported living was the future for the Learning Disability Service.

- It was important to have a fair process and it should be noted that the Trust

offer had not been up to standard.

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

- It was recognised that carers needed to be well trained and appropriately paid and that there were concerns across the country about carers' terms and conditions. Sheffield was currently looking at best practice and should be moving towards payment of a living wage.

- Care Managers were not registered Social Workers but worked under Team Managers who were. They had been involved with users over a number of years and all had to go through a quality assurance process and appear before a Senior Manager Panel. All assessments and support plans were signed off at senior level by qualified people and there was accountability through the management structures.

- If relatives were not happy with an assessment, there would be an initial discussion and the process would be looked at again. It should be noted that support plans for individuals would have undergone extensive scrutiny. Clear instructions had been provided to the providers so that assessment and support plans were based on future requirements in order to provide a degree of flexibility.

- The tenancies at the homes would remain with the Housing Associations and would be subject to a service charge. In addition, users would get other benefits for their living expenses. Some of the schemes would be in the form of shared housing and an element would be included in the rent for upgrades and repairs.

- Ideally, it was hoped to pay carers a living wage before 2023, but it was estimated that this could cost £10/20m in pay over the care sector in Sheffield. It should also be borne in mind that the Council had had to make £240m in savings.

- There were no significant differences in quality between NHS homes and the independent sector.

- The payment of benefits, staff qualifications and continuity were all considered as part of the tendering process. Twenty-seven providers had been approached and these were all required to maintain training under the Care Quality Commission (CQC) regulations and demonstrate that they had a well trained workforce which met individual needs. Staff turnover rates were also examined and, with regard to benefits, if the system changed, this would affect everyone in supported living and would need to be looked at nationally.

- Users and their relatives were given the opportunity to ask the providers questions through the Deciding Together process.

- The service would be monitored through the Council's Contracts Service with visits being made to each home every two years. In addition, inspections would take place by the CQC, with the subsequent reports being published. Other aspects of monitoring included user feedback, open ways of reporting to either the Care Manager, Social Worker or to the Contracts Team, and it was important to ensure that the provider responded to any complaints. There was also the formal Council Complaints Procedure and it should be noted that the Contracts Team would continue their involvement with the transition over the next year, with the same officers being involved.

- Providers had been given individual's details and they then had to show how they would meet needs across the board.

- In relation to consultation, residents and staff had been informed as soon as the process had been decided on and this consultation had been kept up throughout the process.

- It was hoped that people didn't feel bullied as part of the Deciding Together process. At the Handsworth scheme, relatives were given the option to decide the day after their meeting, but they had already made their choice. However, further time was allowed and they were contacted by telephone to check that they were still happy with their decision. Work was now being undertaken with the relatives and providers. The decision period had also been extended at the Cottam Road scheme and where people were happy with the decision further confirmation was sought later.

- The telephone calls relating to the Handsworth scheme decision were made by a Contracts Officer and it was made clear that if people changed their mind then this would be taken account of. It was important to work to try and get a solution in these situations and, to this end, the decision was not announced to the providers for a further two weeks.

- Consideration would be given to the production of a Care Charter relating to supported living.

- Documentation was sent out to all providers on the Supported Living Framework and, for the Handsworth scheme, there were ten responses. If providers failed in answering one of three questions, they would fail in their bid, which was a CQC requirement. Successful providers would then proceed to the method statement stage, which would consider social value, a description of how they would deliver, a case study and price, and their scores in each of these elements would be aggregated. Four providers had got through to the Deciding Together process for the Handsworth scheme.

- There may be some differences in training between providers as some of them specialised but all had minimum standards to comply with. If necessary, a provider may put in additional training where required.

- There would be no reduction in the number of hours of support provided for

individuals under the new support plans and at the Handsworth scheme it was proposed to have 230 hours extra daytime support.

- No staff member should be paying out of their own pocket for such items as taking users out on visits.

5.9 In response to a comment from a key worker at the Handsworth scheme, it was pointed out that the original timescale for its deregistration was to have been 5th January 2015, but the process had taken longer. The Housing Association had not yet started the deregistration process and this took a period of ten weeks. It should also be noted that Lifeways had confirmed that the TUPE regulations would apply.

5.10 In summing up, Susan Highton commented on the consultation process and felt that meetings with interested parties should have taken place before any decisions were made. She added that Dimensions UK employed qualified staff and were in the process of increasing their pay to £7.00 per hour and that Lifeways had no staff who could deliver the Learning Disability Service and that the TUPE regulations would not apply. It was her opinion that the proposals for the Handsworth scheme were totally wrong and asked for further consultation.

5.11 RESOLVED: That the Committee:-

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

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

(c) welcomes the contribution of the members of the public attending the meeting;

(d) supports the move from residential to supported living;

(e) recognises that a well managed transition based around individual needs was essential for the successful implementation of this change;

(f) recognises the valuable role that Care Workers play in supporting people with learning disabilities across the City and supports the Council's ambition that they receive the living wage by 2023 at the latest; and

(g) requests that:-

(i) an update report on the first phase of transition be presented to the Committee at the earliest opportunity, such report to include comments from service users and their families, friends and the independent advocacy service;

(ii) the Cabinet Member for Health, Care and Independent Living and the Interim Executive Director, Communities, consider developing a voluntary code of good practice for supported living, similar to the one

already developed for homecare and that a progress report on this be presented to the Committee in six months' time;

(iii) the issues raised as part of this meeting be passed to the Cabinet Member for Health, Care and Independent Living and the Interim Executive Director, Communities, for information; and

(iv) the Director of Commissioning reports back to the Committee as soon as possible to provide assurance that the Council and Providers are communicating clearly and fully with staff about the transition process and timescales.

6. BETTER CARE FUND- UPDATE

6.1 The Committee received a joint report of the Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group (CCG), and the Director of Commissioning, Sheffield City Council, which provided an update on the Better Care Fund which had previously been presented to the Sheffield Health and Wellbeing Board. The report was presented by Joe Fowler, Director of Commissioning, Sheffield City Council, who explained that the Sheffield CCG and the Sheffield City Council had agreed to establish a pooled budget in 2015/16 to cover four key areas of work which were Keeping People Well in their Community, Independent Living Solutions, Active Support and Recovery and Long Term High Support.

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

- In relation to the Keeping People Well in their Community workstream, some pilot schemes in the City had revealed that some GPs had been helpful and facilitated links with the voluntary sector, whilst in some areas Support Workers had been put in place.

- Consideration was being given to using local partnerships to help deliver outcomes, whilst the Equipment and Adaptations Service was sourced nationally as it lent itself to bigger providers.

- Right First Time was being considered in relation to Active Support and Recovery and Citizens' Reference Groups were being used.

- Sheffield had escaped the increases in Accident and Emergency (A&E) admissions experienced in other areas, but information was going out in this regard. It should be noted that some A&E admissions were avoidable and there were cultural issues involved. Of those presenting to A&E, 37% were subsequently admitted to hospital.

- Of the £1m secured from the Transformation Challenge Award, £100,000 had been allocated for evaluation and £70/80,000 for community activities. The bulk of this funding would be spent on ground support, workers who

would work with local organisations and partnerships with the aim being to visit 9,000 people over a 12 month period.

- Vulnerable people had mainly been identified through GPs, but training had also been given to people such as bar staff and hairdressers. Support Workers had also assisted in the training of Housing+ officers.

6.3 RESOLVED: That the Committee:-

(a) thanks Joe Fowler for this contribution to the meeting; and

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

7. MINUTES OF PREVIOUS MEETING

7.1 The minutes of the meeting of the Committee held on 15th October 2014, were approved as a correct record and the contents of the attached Action Update were noted.

8. INPUT TO CARE QUALITY COMMISSION 2015 INSPECTION PROGRAMME

8.1 The Committee received a report of the Head of Elections, Equalities and Involvement which drew its attention to a request from the Care Quality Commission (CQC) for input into its Inspection Programme for 2015. The report was presented by the Policy and Improvement Officer who explained that the only publicly announced inspection affecting the Sheffield area would be of the Yorkshire Ambulance Service, but other unannounced inspections could take place of Adult Social Care Services, Dentists and NHS GP Practices.

8.2 RESOLVED: That the Committee:-

(a) notes the contents of the report and the attached letter;

(b) notes that Healthwatch were undertaking work in relation to the Yorkshire Ambulance Service and would provide input in this regard; and

(c) requests that the Policy and Improvement Officer:-

(i) circulates details of the Care Quality Commission's request to all Councillors, with any responses being sent to her for co-ordination; and

(ii) makes reference, in the response to the Care Quality Commission, to the concerns expressed by the Committee in relation to GP Practices having appropriate conversations with patients about End of Life Care.

9. WORK PROGRAMME 2014/15

9.1 The Committee received a copy of its Draft Work Programme 2014/15.

9.2 RESOLVED: That the Committee:-

(a) notes the Draft Work Programme; and

(b) notes the request by the Healthwatch representative for the Committee to be provided with a copy of the Mental Health Crisis Care Plan for Sheffield for information.

10. DATE OF NEXT MEETING

10.1 It was noted that the next meeting of the Committee will be held on Wednesday, 25th February 2015, at 10.00 am in the Town Hall.

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Healthier Communities & Adult Social Care Scrutiny Committee
Actions update for meeting on 25th February 2015

Action	Minutes	Update	RAG
Learning Disabilities Petition Update on first phase of transition to supported living to be presented to the Committee at the earliest opportunity	17th December 2014	Added to work programme	
Cabinet Member and Exec Director requested to develop a voluntary code of conduct for supported living, and an update on progress to be presented to the Committee within 6 months		Added to work programme	
Issues raised as part of the meeting to be passed to the Cabinet Member and Exec Director		Actioned 22/12/2014	
The Director of Commissioning report back to the Committee, providing assurance that the Council and Providers are communicating clearly and fully with staff about the transition process and timescales		As agreed at the Scrutiny Committee on the 17th December, immediate discussions were held with SHSC (the employer of the member of staff who attended and raised the issue regarding their employment at Handsworth ceasing on the 5th January 2015) regarding consultation and updates to staff regarding the slippage in the de-registration at the 1st Care Home (Handsworth). SHSC confirmed that they have held ongoing discussions with the staff team regarding the timescales and all staff were made aware that the service would be continuing as a residential home past the original timescale of January 2015. Further to this, discussions were held between SHSC and the chosen incoming provider and it has been agreed that TUPE will apply at Handsworth. In order to allow sufficient time to complete the consultations (both group and individual) for TUPE, the service will transfer and de-register to Supported Living on the 1st April 2015. Until this time the care and support continues to be delivered to the residents by SHSC.	

Mental Health Crisis Care Plans To receive an update on the Crisis Care plans for Sheffield. All areas are due to declare by the 31st December.	17th December	Sheffield is signed up to the Crisis Care Concordat, action plan in progress. Will be submitted once all partners have agreed to it.	
CQC Inspection Programme Request feedback from Members and pass to CQC	17th December 2014	Actioned 05/01/2015	
Child and Adolescent Mental Health Service (CAMHS) Working Group Report	10th April 2014	Scrutiny report to be used as part of evidence base to be presented to Health and Wellbeing Board, proposing changes to the way services are provided in Sheffield.	
Nutrition and Hydration Working Group 10.2 (b) formally share the reports with the trusts	23rd July 2014	STH Formal response received. Welcomed the report. Have included the recommendations re condiments and standardised food organisation have been included in their Hydration and Nutrition Assurance Toolkit which will be launched across the Trust in November. Offer open to any member wishing to be part of the Trust Nutritional Steering Group.	

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

25th February 2015

Subject: Call-in of decision to tender for the provision of day services and residential short term care beds for people with dementia

Author of Report: Emily Standbrook-Shaw, Policy & Improvement Officer
emily.standbrook-shaw@sheffield.gov.uk 0114 27 35065

Type of item:

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	**x**
Briefing paper for the Scrutiny Committee	
Other	

1. Background

1.1 On the 3th February 2015 the Leader of the Council gave approval to:

- The Interim Director of Commercial Services in consultation with the Director of Commissioning (Communities) to tender for the provision of dementia day services and residential short term care beds based on the existing specification and service volumes at Hurlfield View.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the Cabinet Member for Care and Independent Living to develop the community day support facilities in line with consultation and the dementia commissioning plan.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the interim Director of Commercial Services to award the contract for residential short term care beds and day services on a block for 3 years with a reduction in the day support element after 1 year and delegates authority to the Interim Directors of Legal and Governance and Commercial Services to take all necessary steps to negotiate and enter into the contract. The new contract will commence on the 1st August 2015.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the Cabinet Member for Care and Independent Living to take such steps as they deem appropriate to achieve the outcomes set out in this report.

The full report is attached as appendix A.

1.2 As per Part 4, section 16 of Sheffield City Council's Constitution, this decision has been called in, preventing implementation of the decision until it has been considered by this Scrutiny Committee.

1.3 The Call-In notice is attached at appendix B, stating that the reason for the call-in is that the "decision could have important and far-reaching consequences for service users, their families, the carers and for colleagues providing hospital services".

2 The Scrutiny Committee is being asked to:

2.1 As per the Scrutiny Procedure rules, scrutinise the decision and take one of the following courses of action:

(a) refer the decision back to the decision making body or individual for reconsideration in the light of recommendations from the Committee;

(b) request that the decision be deferred until the Scrutiny Committee has considered relevant issues and made recommendations to the Executive;

(c) take no action in relation to the called-in decision but consider whether issues arising from the call-in need to be fed back to the decision maker or added to the work programme of an existing Scrutiny Committee;

(d) if, but only if (having taken the advice of the Monitoring Officer and/or the Chief Finance Officer), the Committee determines that the decision is wholly or partly outside the Budget and Policy Framework, refer the matter, with any recommendations, to the Council after following the procedures in the Budget and Policy Framework Procedure Rules

(If a Scrutiny Committee decides on (a), (b) or (d) as its course of action, there is a continuing bar on implementing the decision).

2.2 The Scrutiny Procedure rules state that if a decision is referred back, it is referred back to the individual or body that made the decision. In this case the decision maker is the Leader of the Council.

Category of Report: OPEN

SHEFFIELD CITY COUNCIL

Executive Leader Report*

Report of:	Laraine Manley – Executive Director Communities
Report to:	Executive Leader
Date:	19th Dec 2014
Subject:	Tender for Reprovision of Day Services and Residential Short Term Care Beds for people with Dementia.
Author of Report:	Joe Fowler (Director of Commissioning)
Key Decision:	YES
Reason Key Decision:	Expenditure/savings over £500,000* Affects 2 or more wards*

Summary:

National and local dementia strategies suggest there is a need for a more modern approach to the way in which we support people with dementia which means changing the way services are designed and delivered to ensure they reflect a person's individual needs and aspirations.

The emerging best practice in daytime activities for people with dementia is towards locally based services, whilst recognising that depending on the level and complexity of an individual's needs; for some this support may be better provided in a centre based setting.

This is in line with the feedback from the city wide Dementia consultation and engagement exercise which took place in 2012. The responses indicated that people favoured more innovative solutions to day opportunities than the

traditional centre based model of day support and that there would be more opportunities to support a wider range of people's needs if there was a mixture of solutions based on community models.

These services are provided in 2 centres and based on the traditional model by means of collecting people by mini buses and bringing them in to the centre.

Currently a large proportion of the city council's commissioned support for people with dementia is provided by the Sheffield Health and Social Care Trust (SHSCT) The Trust provide day services and residential short term care beds at Hurlfield View however this agreement expires on the 31st March 2015. Although the agreement with this provider ends there is still a need to ensure that there remains adequate provision in services to support people with dementia both in the early stages and also those people with more complex needs. This is particularly important given that it is predicted that there will be a significant increase in the number of those with dementia living in the city.

In addition there is a requirement achieve best value from the available resources which means looking at ways to reduce the cost of provision whilst maintaining the quality and the overall service levels.

Over recent months colleagues in the City Council's Commercial services section have been engaged in discussions with the SHSCT about more affordable and suitable solutions for people with dementia and their carers' and requested SHSCT respond with a proposal which could deliver this. Unfortunately their latest proposal has indicated that they are unable to deliver the scale of the savings without a significant reduction to current service levels.

A review by Commissioners of comparative costs of provision provides evidence that the service could be provided at the same quality and at a reduced cost to the council but with no loss of service to the Council. In addition a recent soft market test undertaken by Commercial Services provides further evidence that there are a number of other independent sector providers who could provide the specified services at a reduced cost whilst still maintaining the levels of service required. Based on this and the response from SHSCT the advice from Commercial Services is to proceed to tender the service across the wider provider market.

It is therefore proposed that a re-tender exercise is under taken for the existing services provided at Hurlfield View for both residential short term care beds and day services. In order to stimulate the market it will offer a block payment for 3 years with an agreed reduction in the volume of day services element after year 1.

Due to the timescales it is proposed that the current contract with SHSCT be extended until the end of June 2015 to facilitate the tender. The tender for the re-provision of services for both residential short term care beds and day services is proposed on a block basis for 3 years with a reduction in the volume of the day services element based at Hurlfield after the first year.

This will also help facilitate the shift of investment towards a more community based approach and offers further potential to explore other solutions such as an innovation fund. Commissioners will work with users, their carers and other key stakeholders to develop these alternative plans and this is in line with what people told us would help them and their carers to continue to live well at home and independently.

It is proposed the new contract for services will commence on the 1st August 2015

This report summaries:

- The requirement for the provision of dementia residential short term care beds and dementia day care services in Sheffield and the benefits of the services in terms of the reducing the health and social care expenditure and the wider benefits to the health and social care economy
- The current provision of funded dementia care services in the City
- The current cost and utilisation of services provided by SHSCT
- The need to reconfigure the current investment to facilitate change
- The key recommendations for re-tendering the existing day services currently provided by the Sheffield Health and Social Care Trust
- The outline proposals for the future reconfiguration of services including a new model of community based day support for people with dementia.

Reasons for Recommendations:
(Reports should include a statement of the reasons for the decisions proposed)

The emerging best practice in daytime activities generally and specifically for people with dementia is towards locally based services, whilst still recognising that depending on the level and complexity of an individual's needs support may be better provided in a centre based setting.

Feedback from the 2012 consultation - people indicated that they would like more innovative solutions to day opportunities that did not follow the traditional model of day support. The SHSCT currently run 2 centres of day support both based on the traditional model of collecting people in buses to bring them to centre based day care. Early indications are that there would be more opportunities offering day support with a mixture of solutions based on community models.

There is a need to ensure that there is adequate provision in services that support people with dementia in the early stages and also for those people with more complex needs.

A review by Commissioners of comparative costs of provision provided evidence that the service might be provided at a reduced cost to the council but without compromise on quality or loss of capacity. This was based on financial and performance information supplied by the Trust and work on comparator costs through Laing and Buisson.

As the Council faces significant budgetary challenges over the coming years it also needs to diversify the service delivery market by looking at new and innovative approaches to deliver services to more people, achieve better outcomes and increase value for money where possible particularly if it is to meet the demographic demands.

Recommendations:

That approval is given to:

- The Interim Director of Commercial Services in consultation with the Director of Commissioning (Communities) to tender for the provision of dementia day services and residential short term care beds based on the existing specification and service volumes at Hurlfield View.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the Cabinet Member for Care and Independent Living to develop the community day support facilities in line with consultation and the dementia commissioning plan.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the interim Director of Commercial Services to award the contract for residential short term care beds and day services on a block for 3 years with a reduction in the day support element after 1 year and delegates authority to the Interim Directors of Legal and Governance and Commercial Services to take all necessary steps to negotiate and enter into the contract. The new contract will commence on the 1st August 2015.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the Cabinet Member for Care and Independent Living to take such steps as they deem appropriate to achieve the outcomes set out in this report.

Background Papers:

Category of Report: **OPEN / ~~CLOSED~~***

<u>If CLOSED add</u> 'Not for publication because it contains exempt information under Paragraph (insert relevant paragraph number) of Schedule 12A of the Local Government Act 1972 (as amended).'

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* Delete as appropriate

Statutory and Council Policy Checklist

Financial Implications
YES/~~NO~~ Cleared by: Karen Heskith
Legal Implications
YES/~~NO~~ Cleared by: Deborah Eaton
Equality of Opportunity Implications
YES/~~NO~~ Cleared by: Phil Reid
Tackling Health Inequalities Implications
~~YES~~/NO
Human Rights Implications
~~YES~~/NO
Environmental and Sustainability implications
YES/~~NO~~
Economic Impact
YES/~~NO~~
Community Safety Implications
~~YES~~/NO
Human Resources Implications
~~YES~~/NO
Property Implications
~~YES~~/NO
Area(s) Affected
ALL
Relevant Cabinet Portfolio Lead
Cllr Mary Lea
Relevant Scrutiny Committee
Health and Wellbeing
Is the item a matter which is reserved for approval by the City Council?
~~YES~~/NO
Press Release
YES/~~NO~~

REPORT TO THE EXECUTIVE LEADER

1. SUMMARY

National and local dementia strategies suggest there is a need for a more modern approach to the way in which we support people with dementia which means changing the way services are designed and delivered to ensure they reflect people's individual needs and aspirations.

The emerging best practice in daytime activities for people with dementia is towards locally based services, whilst recognising that depending on the level and complexity of an individual's needs for some this support may be better provided in a centre based setting.

This is in line with the feedback from the city wide Dementia consultation and engagement exercise which took place in 2012. The responses indicated that people favoured more innovative solutions to day opportunities than the traditional centre based model of day support and that there would be more opportunities to support a wider range of people's needs if there was a mixture of solutions based on community models.

These services are currently provided in 2 centres and based on the traditional model by means of collecting people by mini buses and bringing them in to the centre.

Currently a large proportion of the city council's commissioned support for people with dementia is provided by the Sheffield Health and Social Care Trust (SHSCT) The Trust provide day services and residential short term care beds at Hurlfield View, however this agreement expires on the 31st March 2015. Although the agreement with this provider ends, there is still a need to ensure that there remains adequate provision in services to support people with dementia both in the early stages, and also those people with more complex needs. This is particularly important given that it is predicted that there will be a significant increase in the number of those with dementia living in the city.

In addition there is a requirement achieve best value from the available resources which means looking at ways to reduce the cost of provision whilst maintaining the quality and the overall service levels.

Over recent months colleagues in the City Council's Commercial services section have been engaged in discussions with the SHSCT about more affordable and suitable solutions for people with dementia and their carers' and requested SHSCT respond with a proposal which could deliver this. Unfortunately their latest proposal has indicated that they are unable to deliver the scale of the savings without a significant reduction to current service levels.

A review by Commissioners of comparative costs of provision provides evidence that the service could be provided at the same quality and at a reduced cost to the council but with no loss of service to the Council. In addition, a recent soft market test undertaken by Commercial Services provided further evidence that

there are a number of other independent sector providers who could provide the specified services, at a reduced cost whilst still maintaining the levels of service required.
Based on this and the response from SHSCT, the advice from Commercial Services is to proceed to tender the service across the wider provider market.

It is therefore proposed that a re-tender exercise is under taken for the existing services provided at Hurlfield View for both residential short term care beds and day services. In order to stimulate the market it will offer a block payment for 3 years with an agreed reduction in the volume of day services element after year one.

Due to the timescales it is proposed that the current contract with SHSCT be extended until the end of June 2015 to facilitate the tender. The tender for the re-provision of services for both residential short term care beds and day services is proposed on a block basis for 3 years with a reduction in the volume of the day services element based at Hurlfield after the first year.

This will also help shift the investment accordingly towards a more community based approach and offers further potential to explore other solutions such as an innovation fund. Commissioners will work with users, their carers and other key stakeholders to develop these alternative plans. This is in line with what people informed us would help them and their carers to continue to live well at home and independently.

It is proposed the new contract for services will commence on the 1st August 2015

2 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE

These proposals will ensure that:

- There remains adequate provision in bed based support and day services to support people with dementia both in the early stages and also those people with more complex needs, both in the short term and if needs and demand increases.
- The proposed changes will be introduced over a period of 3 years, therefore there will be no radical changes over a short period and no reduction in the current volume or quality of the services provided.
- Provide a further opportunity for people with dementia and their carers to help shape the future design and delivery model of day support.
- The future approach to services is more aligned to communities and one which helps keep people independent safe and well.

3 OUTCOME AND SUSTAINABILITY

The proposals are:

- In line with the consultation and engagement undertaken to date.
- Meet with the key principals of both national and local strategies.

- In line with the principles of the Care Act
- Ensure there is no loss of service, but addresses the need to achieve best value from the available resources.
- Addresses the need to meet the demographic growth and demand for services in a more affordable way
- Offers security to communities of capacity building
- Develops dementia awareness amongst communities
  The proposal for the developing the day opportunities on a community level basis meets with the joint SCC/CCG dementia commissioning plan which was discussed and endorsed by Scrutiny in October 2014

4 REPORT

Background
(Including Legal, Financial and all other relevant implications (if any)

National and Local Challenges

National estimates suggest that there are 800,000 people living with dementia in the UK and by 2021 this number is expected to reach over 1 million (Alzheimers Society 2014).

By 2015 there will be 850,000 people with dementia in the UK, with numbers set to rise to over 1 million by 2025 (Alzheimers Society 2014)
The financial burden of dementia in the UK is significant and is expected to treble by 2040 and the latest estimates put the national costs of Dementia in the UK at over £26 billion a year. The greatest proportions of these costs are attributed to the care provided informally by an estimated 670,000 carers of people living with dementia in the UK. Unpaid carers supporting someone with dementia saves the economy £11 billion a year. (Alzheimers Society 2014).

The National Dementia Strategy (2009) and Prime Ministers Challenge on Dementia (2012) both highlight the need to ensure that people with dementia receive the right care and support at the right time to enable them to live independently at home for as long as possible.

In responding to the national requirements the City Council must also address a number of local challenges. There are currently and estimated 6,400 people living with dementia in the city, of which 4,000 have a formal diagnosis. The number of people living with dementia in Sheffield is expected to rise to over 7,300 by 2020 and 9,300 by 2030, with the biggest increase in people aged 85 and over.

The Sheffield Dementia Strategy and Commissioning Plan (2007) set out a number of key objectives building on the long history of the collaborative approach to the commissioning of dementia services in the City. A major consultation and involvement exercise was undertaken in 2012 by SCC, CCG and the Sheffield Health and Social Care Trust about the proposals for change to services that support people with dementia.

The outcome of these proposals informed an agreed plan for change. Since 2012 there has been good progress made in some areas including the reconfiguration of bed based emergency care and respite bed services provided under contract by the SHSCT. In addition the city council made a capital investment of £350k which provided the refurbishment of the day centre and created an additional 4 bed spaces to the building.

However, day support, information and advice services and other contracted dementia services have largely remained the same. These services are more variable in terms of the outcomes and benefits they deliver and do not consistently form part of the locally defined dementia care pathway, meaning that referrals are inconsistent and not always at the right time for individuals and the people who care for them.

With increasing focus within health and social care on the need to demonstrate value for money, quality and improved outcomes for people with dementia and their carers, continued commitment to a shared CCG and local authority approach to the commissioning and development of dementia services is essential. Dementia remains a key priority by both Sheffield City Council and the Sheffield Clinical Commissioning Group and a revised programme of work has been set out over the next 2 years.

Current Provision – Services Provided by SHSCT

Under the existing Section 75 partnership agreement SHSCT provide 20 residential short term care beds and 270 day care places per week at Hurlfield View. 230 of these places are offered at Hurlfield View over seven days with additional places from a satellite base at Stocksbridge.

The building and land is owned and managed by SCC and leased to SHSCT, 350k capital funding was recently invested to refurbish areas of the building and increase the bed space to 20 from 16.

Analysis of the demand and usage of the residential care beds shows that usage has remained consistent, largely due to the reconfiguration of the service provided by SHSCT in 2012 which resulted in the closure of two dementia resource centres and all services being relocated to one centre at Hurlfield View but also because of the lack of other available short term/respite care beds available across the independent sector for people with dementia.

Around 130 people use the 270, day care places available per week with many attending on multiple days. However, more than 35% of the places funded by the city council are taken up by full fee payers some of which, if they were assessed may not meet the city council's eligibility criteria. This means that the number of places commissioned by the city council are not being fully utilised. The full fee payers and others who choose to purchase additional support fund the cost of their own day care.

Feedback from some service users and carers suggests, that for younger people with dementia, or for those with more moderate needs, building based services

can be more limiting and frustrating and they tell us they often feel more isolated being away from others and their local community. This and the most recent data provided by SHSCT indicates that the current service design may not be the most appropriate way of meeting the wider general needs of people with dementia and their carers.

The proposals for a reduction in the volume of centre based day support over a period of time whist retaining sufficient places to meet needs will release resources for the development of more preventative community based support. This will broaden the offer to current and future service users to enable the outcomes people want to achieve rather than a service which does not necessarily meet the needs of many possible users. Meaning the services will still be available to full fee payers, but this must be in addition to the volumes and levels of the commissioned services.

The City Council also commissions a range of other services specifically for people with dementia including information and advice, peer support and other opportunities for informal carers to have a break. These services are currently provided by the voluntary sector and are not subject to this tender. However, they will be included and part of the scope for the future design and development for new community based and preventative services for people with dementia.

The CCG also commissions the city wide Dementia Rapid Response and Home Treatment Team (DRRHTT) and the Community Dementia Support Service (CDSS). CDSS is a small service which operates from Hurlfield View. Currently four of the residential care beds are allocated for use by the DRRHTT for use when the home situation has broken down and to prevent admission to hospital. The city council has discussed the proposals with the CCG and confirmed that the CDSS service can continue to operate from Hurlfield View and that the DRRHTT can still access the allocated residential beds.

Key Milestones/Timetable

Key dates to facilitate the tender are set out below.

Task	**Date**
ITT Drafting	1 – 31 Dec 2014
Procurement strategy submission	26 Jan 2015
Procurement strategy approval	6 Feb 2015
Publish ITT	9 Feb 2015
Closing date	8 Apr 2015
Evaluation	9 – 24 Apr 2015
Preferred bidder	27 Apr 2015
Contract approval	8 May 2015
Contract signature	29 May 2015
Mobilisation	1 Jun – 31 Jul 2015
Contract start	1 Aug 2015

COMMUNICATION

Service users, their carers and relatives will initially be advised by letter of the proposals to retender the service. Staff in the resource centre will be available to support individual users and carers and the commissioning team along with care and support colleagues will provide further opportunities to support or meet with users and carers if they wish to discuss the proposed changes.

Other stakeholders including other organisations who provide support and services to people with dementia will be advised of the proposals and kept informed of the key changes.

An outline of the Communication Plan is attached at **Appendix A**

Future Proposals - Future design of day support for people with Dementia.

There is a clear and accepted need to continue with the provision of residential short term care beds and some centre based dementia day services. Nonetheless scope to achieve further efficiencies which in turn will release resources to support a more innovative community based approach to day support.

The proposal is to reduce over time the volume of building based day support provided at Hurlfield View, this is reliant on building capacity in other areas and developing alternative support and services. To maximise use of the current available resources it is our intention to decommission the other commissioned services that support people with dementia (currently provided by the voluntary sector) to fund this new approach.

All current providers have been notified of the outline proposals and dialogue will be ongoing as part of the development and scope of the new proposals.

We will also be working closely with service users, their carers, and other people with dementia and other key stakeholders as part of the wider communication about our future plans. Commissioners will be supporting current providers and users in relation to the impact of decommissioning the services.

It is anticipated that the new arrangement for community based support and day opportunities will be in implemented during 2016.

5.0 FINANCIAL IMPLICATIONS

The annual investment in services with the SHSCT is currently £2.5m per annum. Efficiency savings have been identified by Commissioners against the current service volumes, based on a review of comprisable costs provided across the market.

In addition the council has a requirement to make year on year savings in line with its long term financial plan. The savings proposed below will not impact on

the current volume or level of support, and the proposals set out for the shift in investments will support a community based model of day support

The tender for the reprovision for both residential short term care beds and day services is proposed on a block basis for 3 years with a reduction in the volume of the day services element after year 1.

Below is an illustration of the maximum available resources available for the new contracts.

	Year 1 15/16 £000	**Year 2 16/17 £000**	**Year 3 17/18 £000**
Budget	2,464	2,264	1,864
3 month extension to SHSCT	821	-	-
Savings	200	400	200
Shift of Investment to fund development of alternative support	-	700	700
Totals available for new tender	**1,443**	**1,864**	**1,664**

The building and land is owned by Sheffield City Council. The costs set out above will include all costs associated with the management of the building. The terms of the lease will be set out in the tender documentation.

It is proposed that the new contract for services will commence on the 1st August 2015 which will also provide sufficient time to develop and consult on alternative plans.

To facilitate this a waiver of standing orders has been agreed for the extension of the contract with the SHSCT and the Trust will be asked to continue with the current arrangement until the end of June 2015, this will be based on current costs (proportionate to 3 months).

There is the risk that the investment will be insufficient to entice an alternative provider to take on existing NHS staff under TUPE; however, it is anticipated that by providing investment security on a block basis over a 3 year period this will mitigate the risk.

The procurement will also ensure that the provider will work with the city council to support the development of the community based facilities and therefore identify other potential efficiencies over the remaining term of the contract.

Commercial services will run the tender with the associated costs for this procurement taken against the savings in the first year.

6.0 EQUAL OPPORTUNITES IMPLICATIONS

In exercising any of its powers in this area, the Council needs to be mindful of the Public Sector Equality Duty contained in Section 149 of the Equality Act 2010, that is the duty to have due regard to the need to:-
(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
The protected characteristics in the Act include age and disability and the functions to which the PSED applies. In considering whether to tender the services the Executive Leader must take into account the effect on people with such protected characteristics and where the impact is negative the proposals to mitigate those effects.

Equal opportunities implications arising from this work were subject to a comprehensive Equality Impact Assessment which is included at **Appendix B**

7.0 LEGAL IMPLICATIONS

The Council's powers and duties to provide services for people with dementia currently flow from provisions in the National Assistance Act 1948 and the Mental Health Act 1983. From 1st April 2014 the powers and duties will flow from The Care Act 2014 and s.117 Mental Health Act 1983. In addition to these individuals there may be a small number of people who are not eligible for care and support because of their immigration status who the Council has a limited duty to assist to avoid a breach of their human rights.

The Care Act 2014 establishes national eligibility criteria for care. The Act will require the Council to assess the needs of anyone with a physical or mental health disorder who may be in need of support to identify what needs the person may have which impact on their ability to achieve specified outcomes and whether and to what extent this impacts on their wellbeing.

The Care Act 2014 also requires the Council to identify specific preventive services from which service users may benefit by preventing or delays their needs from progressing. This provision broadens the duty of the Council to provide some support, advice and assistance for those with dementia beyond support to those who meet the eligibility criteria.

s.5 The Care Act 2014 requires the Council to promote the efficient and effective market in services for meeting care and support needs with a view to ensuring that there is a variety of providers to choose from, a variety of high quality services to choose from. In performing that duty the Council must have regard to the current and likely future demand for such dementia services, the importance of ensuring the sustainability of the market for such services, foster continuous improvement in the quality, efficiency and effectiveness with which such services are provided and ensure the sufficiency of such services in Sheffield.

In arranging the provisions of services by other persons or organisations to meet eligible needs the Council must have regard to the importance of promoting the well-being of adults and carers in its area.
The proposed contracts outlined in this Report have a value in excess of the threshold for contracts for services (£172,514) in the Public Contracts

Regulations 2006 (the 'Regulations') and thus the procurement and contract award processes to be followed in relation to the proposed contracts will be subject to those Regulations. However, health services are Part B Services for the purposes of the Regulations and as such, only some of the requirements of the Regulations will apply.
The Council should also comply with the general EU Treaty principles such as non-discrimination, transparency and proportionality. This will require an open and fair procedure to be adopted.

The procurement process must also comply with the Council's
Contract Standing Orders and this should ensure the Council fulfils these legal obligations.

8.0 HUMAN RESOURCE IMPLICATIONS

It is recognised the proposed changes will cause some concerns for staff working for the service provider and across the wider service. In the event of this, the SHSCT will be expected to work with staff and Trade Unions and fully consult on any specific proposals that may affect them.

In the event a change in service provider it is likely that a transfer of undertaking will apply. This may mean that existing staff will be employed via TUPE regulations.

Bidders will be advised that It will be suggested to bidders that they consider the potential impact of TUPE and current providers will be required to share information as appropriate in accordance with their existing contracts and TUPE regulations.

Any TUPE transfer will be managed by the provider and will not represent any HR implications for the City Council.

9.0 ALTERNATIVE OPTIONS EXPLORED.

In making the recommendations a number of other options were explored.

Do nothing: This option is not favoured as this would not meet with the changing needs of those with dementia or meet with their wishes and desires as expressed in the consultation. From a City Council perspective this would not offer value for money.

Extend the contract with the current provider: SHSCT has indicated that they would be unable to continue with this contract at a more affordable price without

a significant reduction in the level of service. This option is not favoured and does not appear to provide the most effective way of providing these services and does not offer the opportunity to redesign services to meet needs more effectively.

Develop a new specification and tender for a new service: The expiry of the contract at the end of March 2015 does not give sufficient time to develop the new specification and undertake the necessary consultation with current users, carers and stakeholders about a new approach to community support for people with dementia.

10 REASONS FOR RECOMMENDATIONS

The emerging best practice in daytime activities generally and specifically for people with dementia is towards locally based services, whilst still recognising that depending on the level and complexity of an individual's needs support may be better provided in a centre based setting.

Feedback from the 2012 consultation - people indicated that they would like more innovative solutions to day opportunities that did not follow the traditional model of day support. The SHSCT currently run 2 centres of day support both based on the traditional model of collecting people in buses to bring them to centre based day care. Early indications are that there would be more opportunities offering day support with a mixture of solutions based on community models.

There is a need to ensure that there is adequate provision in services that support people with dementia in the early stages and also for those people with more complex needs.

A review by Commissioners of comparative costs of provision provided evidence that the service might be provided at a reduced cost to the council but without compromise on quality or loss of capacity. This was based on financial and performance information supplied by the Trust and work on comparator costs through Laing and Buisson.

As the Council faces significant budgetary challenges over the coming years it also needs to diversify the service delivery market by looking at new and innovative approaches to deliver services to more people, achieve better outcomes and increase value for money where possible particularly if it is to meet the demographic demands.

(Refer to circumstances where exemption is justified as explained in the Access to Information Procedure Rules in the Constitution and apply the public interest test. Further advice can be obtained from the Director of Legal Services).

11.0 RECOMMENDATIONS

That approval is given to:

- The Interim Director of Commercial Services in consultation with the Director of Commissioning (Communities) to tender for the provision of dementia day services and residential short term care beds based on the existing specification and service volumes at Hurlfield View.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the Cabinet Member for Care and Independent Living to develop the community day support facilities in line with consultation and the dementia commissioning plan.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the interim Director of Commercial Services to award the contract for residential short term care beds and day services on a block for 3 years with a reduction in the day support element after 1 year and delegates authority to the Interim Directors of Legal and Governance and Commercial Services to take all necessary steps to negotiate and enter into the contract. The new contract will commence on the 1st August 2015.

- Delegate authority to the Director of Commissioning (Communities) in consultation with the Cabinet Member for Care and Independent Living to take such steps as they deem appropriate to achieve the outcomes set out in this report.

Author: Sharon Marriott
Job Title: Commissioning Officer
Date: 19th December 2014

SHEFFIELD CITY COUNCIL

CALL-IN PROCESS FOR EXECUTIVE DECISIONS

I ..... Jillian Creasy ..... (Name of Member in Block Capitals)

under the provision of Standing Order A35, wish to call-in Item No. .....

relating to Tender for Reprovision of Day Services and Residential ~~Support~~ Short Term Care for People with Dementia
~~of the meeting of~~ ..... ~~(meeting title)~~

on 3rd Feb 2015 (Leaders' Decision) (date) for consideration by the

..... Health & Adult Social Care ..... Scrutiny Committee.

The relevant Scrutiny Committee will be indicated on the Checklist within the report relating to this matter.

Reason for Call-In

This decision could have important & far-reaching consequences for service users, their families, the carers and for colleagues providing hospital services.

Signed ..... Date ..... 4 Feb 2015

I have obtained the following signatures of the other Members who wish to call-in this item:-

	Name (in Block Capitals)	Signature
1.	SUSAN ALSTON	
2.	Brian Webster	
3.	SARAH JANE SMALLEY	
4.	ROBERT MURPHY	

(NOTE: Standing Order A35(1) requires five Members, including two from the appropriate Scrutiny Committee to 'call-in' an Executive decision for scrutiny. This can be done **up to 4 working days after the decision publication**.

The five signatures required for the call-in process must be submitted by the deadline date, but need not all be on one form.

COMPLETED FORMS TO BE RETURNED TO THE HEAD OF DEMOCRATIC SERVICES (ROOM G12, TOWN HALL), BY THE DEADLINE REFERRED TO ABOVE. THE REQUEST WILL BE LOGGED AND FORWARDED TO THE HEAD OF SCRUTINY FOR ACTION.

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 25th February 2015

Report of: Dr David Throssell
Medical Director
Sheffield Teaching Hospitals Foundation Trust

Subject: Quality Report 2014/15

Author of Report: Sandi Carman
Head of Patient and Healthcare Governance
Sandi.carman@sth.nhs.uk
0114 22 66489

Summary:
Foundation Trusts are required to produce an Annual Quality Report, which sits alongside the Annual Report.

The Quality Report has two key aims; to report on the quality of services delivered by Sheffield Teaching Hospitals in the year 2014/15 and to identify the Quality Report Objectives for 2015/16.

This update report is structured into the following sections

1. Introduction
2. Quality Improvement Priorities 2014/2015
3. Proposed Quality Improvement Priorities 2015/2016
4. Quality Report Production
5. Recommendation

This information is presented to the Scrutiny Committee to request their views and comments on the Quality Improvement Priorities for 2015/16.

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

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	**x**
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	**x**

The Scrutiny Committee is being asked to:
The Committee is asked to consider the proposals and provide views, comments and recommendations on the contents of this report and the proposed Quality Improvement Priorities for 2015/16.

Background Papers:

Monitor NHG Foundation Trust Annual Reporting Manual 2014/15
Quality Account: Reporting Requirements for 2013/14- Gateway Reference No. 00931 (awaiting 14/15 documentation)
Quality Account: Reporting Requirements for 2013/14- Gateway Reference No. 18690 (awaiting 14/15 documentation)
Monitor Detailed requirements for quality reports 2013/14 (not published for 14/15)
Quality Accounts: a guide for Local Involvement Networks
National Clinical Audits for Inclusion in Quality Accounts 2014/15

Category of Report: OPEN

Quality Report 2014/15 – Overview

1. Introduction

NHS organisations have a duty to provide patients with a service that delivers high quality care for all. The Quality Report seeks to provide the Board of Directors and key stakeholders with assurance that clinical quality is being monitored and assessed and that actions are being put in place when required.

The Quality Report details performance in Sheffield Teaching Hospitals NHS Foundation Trust using a range of information such as performance indicators, CQC reports, patient surveys and complaints. This report is presented to update the Scrutiny Committee on the production of the 2014/15 Quality Report, to provide feedback on the current progress with the 2014/15 improvement priorities and to seek views and comments on these priorities for next year.

2. Quality Improvement Priorities 2014/15

Sheffield Teaching Hospitals identified the following priorities to progress during 2014/15

1. Patient to know the name of their consultant and nurse responsible for their care

2. Improve complainant satisfaction with the complaints process

3. Review mortality rates at the weekend and bank holidays

4. Review the impact of waiting times on the patient experience

Progress on each of these measures will be presented to the Scrutiny Committee at the meeting of the 25th February 2015. It is important to note that full year end performance figures will not be available until mid-April 2015.

3. Quality Improvement Priorities 2015/16

The identification of Quality Improvement Priorities has been undertaken using a collaborative approach with staff, Healthwatch and Trust Governors.

1. To improve how complaints are managed and learned from within Sheffield Teaching Hospitals NHS Foundation Trust

2. To improve staff engagement by using the tools and principles of Listening into Action (LiA)

3. To improve the safety and quality of care provided by the Trust in ALL settings with the aim of reducing preventable harm

Further information on these suggested priorities will be provided during the presentation on the 25th February 2015.

4. Quality Report Production

The report will contain comprehensive information regarding a range of quality measures covering all aspects of the Trust; some of these are detailed in mandatory statements specified by Monitor. The mandated reporting

requirements should enable staff, patients and the Trust Commissioners to compare quality indicators across a number of provider Organisations

The full report is currently in draft format and will be reviewed by the Quality Report Steering Group and other key stakeholders Healthwatch and NHS Sheffield.

A copy of the draft version will be provided to the Scrutiny Committee early April when the majority of the year end data will become available.

5. Recommendation

The Committee is asked to provide views, comments and recommendations on the contents of this report and the proposed Quality Improvement Priorities for 2015/16.

Commissioners Working Together Programme Update

Sheffield Healthier Communities and Adult Social Care Overview and Scrutiny Committee Meeting

25th February 2015

1. Purpose

The purpose of this paper is to:

- Brief the Committee on the establishment of the Collaborative Partnership between NHS commissioners to lead a Transformational Change Programme across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield with a focus on hospital services.

2. Key messages

- Both health and care services face unprecedented challenges as a result of, aging population, rising demand, increasing expectations, clinical workforce challenges and budget constraints
- NHS organisations across the region have agreed to work together to make sure that hospital services continue to provide high quality services to our residents within the funding available
- Eight Clinical commissioning Groups and NHS England have established a collaborative partnership of commissioners under the auspices of *Working Together* to collectively plan and manage change to improve services
- A similar partnership has also been established comprising the seven acute hospital providers across the same geographical area.
- Both mechanisms for clinical engagement and engaging with patients and the public have been established via the Working Together Programme Clinical Reference Group and Patient and the Public Advisory Forum
- The programme is underpinned by strong clinical engagement and programme management approach
- The programme is also working with a range of stakeholders including the strategic clinical Networks and Clinical Senate
- The outcome of this work will lead to improvements in quality and sustainability of services and may result in changes to access to services

3. Background

The NHS is facing unprecedented challenges as a result of rising demand, due to an ageing population and the increasing burden of chronic diseases. At the same time there is an increasing expectation and need to improve the quality of our services in line with national standards. In addition, providers are approaching the fifth year of a seven-year austerity programme. Many of the straightforward savings have already been made, yet this challenge is unlikely to disappear after 2014/15 with cost pressures projected to grow

at around 4% a year up to 2021/22 and the predicted funding gap facing the NHS nationally is predicted to be in the region £30 billion. The current estimate for South Yorkshire alone is a £750 million gap over the next 5 years if services continue to be provided as they are currently which is not sustainable.

The NHS in England must therefore make sustained increases in productivity to avoid significant impact on services and a decline in the quality of care to patients. It is, however, unlikely that achieving significant levels of productivity gains and improvements will be possible unless there is a fundamental shift in the way NHS responds to these challenges. The scale and pace of this response will need to support and deliver fundamental changes to the way services are currently commissioned and delivered. The recently published NHS Five Year Forward View[1] sets out the case for change across the NHS with a radical rethink. There is also an acceptance that to achieve this scale of change will not be possible by organisations working in isolation at an individual level.

To start the debate on how this can be achieved, NHS England launched "A Call To Action" in July 2013; a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give everyone who works in or uses the NHS an opportunity for a say in its future.

Locally the Eight CCGs, NHS England and the seven Acute Trusts across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield agree they need to work together and take collective action on these challenges.

They have initiated a strategic programme of work to respond to significant challenges facing the delivery of services across a wide geographical area.

In February 2014 clinical priorities were recommended to CCG Governing Bodies to be taken forward as part of the Commissioner Working Together Programme and in April 2014 a partnership between the CCGs and NHSE was established – Commissioners Working Together.

The purpose of the Working Together Programme is to enable the participating commissioning organisations to commission transformational and sustainable changes to their services which would not have been possible on an individual commissioner basis.

The overarching aim of the Programme is to make demonstrable improvements to care which drive net benefits (either in quality and or financial terms) to the individual CCG areas and the region as a whole. Commissioners will work together and learn from each other to achieve the following benefits:

- Coherent and consistent service planning and commissioning across the patch, including alignment on quality and safety, ensuring that quality standards are met
- Provision of 'local' services in CCG communities

[1]NHS Five Year Forward View, October 2014

- Ensuring specialised services locally meet nationally specified critical mass and detailed service specifications, while understanding and proactively planning for wider-reaching impact
- Sharing limited resources and effort

A number of clinical services have been identified to be considered in the first phase of work though a process of prioritisation. These services were identified on the basis of there being challenges to the quality of provision on the basis of significant variation against commissioner standards, challenges in the current and future workforce and where there was evidence of realisable efficiency benefits taking a coordinated and collaborative approach.

The four key clinical priorities being taken forward by commissioners as part of the Commissioner Working Together programme are outlined below:

Summary of Phase One Work-streams

<table>
<tr><th>Work-stream</th><th>Focus</th><th>Problem</th><th>Desired Outcome</th></tr>
<tr><td rowspan="2">Children's Services</td><td>Paediatric Surgery and Anaesthesia</td><td>• Variation in compliance with National standards
• Shrinking workforce
• Unsustainable services</td><td rowspan="7">Compliant safe and sustainable services</td></tr>
<tr><td>Urgent care</td><td>• Sustainability
• Variability of services
• Lack of coordination</td></tr>
<tr><td rowspan="2">Cardiovascular Disease</td><td>Acute Cardiology</td><td>• Variation in compliance with National/locally agreed standards</td></tr>
<tr><td>Stroke</td><td>• Workforce sustainability issues
• Variation in outcomes and standards</td></tr>
<tr><td rowspan="3">Smaller specialties</td><td>Ophthalmology</td><td rowspan="3">• Unsustainable services
• Small patient numbers across multiple sites
• Heavy reliance on locum cover</td></tr>
<tr><td>OMFS</td></tr>
<tr><td>ENT</td></tr>
<tr><td>Out of Hospital (Urgent care)</td><td>Urgent care response
A+E
Scoping exercise against national Urgent Care Review</td><td>• Variation in Compliance with standards
• Workforce challenges
• Unsustainable services</td></tr>
</table>

4 Approach

A programme approach together with programme office has been established with an agreed governance framework within the established joint commissioning arrangements. It supports central engagement of CCG clinical commissioners and Area Team

commissioners, clinical communities and Patients and the Public across a patient population of approximately 2.2 million.

The programme has established a Clinical Reference Group which draws membership from across all partner commissioning organisation. It is led by a GP Clinical Commissioner and its main purpose is clinical assurance and ensuring that the work remains connected to supporting clinical objectives within each of the CCGs.

To ensure that patients and the public are supported and engaged in this work as early as possible, a Patient and Public Advisory Forum has been established. Its membership is drawn from each partner locality Healthwatch organisations. This enables the programme to start to share its work at a very early stage with patients and the public and offers an opportunity for advice on how to engage further at locality level.

The programme provided a regional stakeholder event in December 2014 to share more information about the work. The event was attended by a wide group of stakeholders and useful feedback was received which will help shape further stages of the programme.

Each clinical work-stream is being taken forward by a core leadership groups led by a Clinical Chair and CCG Accountable Officer and supported by clinical working groups. The clinical working groups have been establishing a consensus of understanding of the drivers for change and have established a programme of clinically focused events to confirm and challenge assumptions and start to develop clinical options for new way of delivering services which meeting standards set by commissioners and which are sustainable for the future.

Outline Summary of activities of Phase 1 – developing the case for change

Phase 1 – 2014/15			
Dates	**Activities**		**Outputs**
March – June	Scoping / Clinical Standards / Baselines	• Refining scope and case for change	Agreed Scope
			Agreed Clinical Standards
			Agreed Baselines
June – October	Issues Consensus	• Resilience meetings with Trusts • Confirm and Challenge Events	Shared understanding of Issues
October – December	Developing new clinical models	• Clinical Design Events	Development of Clinical Options
January - March	Consolidating outputs from Phase One		Strategic Case for Change

5. Potential impact 2015/16 and beyond

The work is at an early stage and the focus to date has concentrated on:

- Gaining clarity and developing an understanding of the of the problem by reviewing each service including assessing providers against core service standards
- Gaining consensus amongst clinical colleagues of the issues
- Identifying clinical models which could respond to key challenges facing the services
- Early engagement with key stakeholders on any potential change

The impact of any changes on patients is currently being worked through across the 4 clinical areas. The likely consideration for 2015/16 will be a result of the work from the Specialty Collaborative work-stream with a focus on Ophthalmology, Ear Nose and Throat out of hours and Oral Maxillofacial Services.

To achieve the improvement in quality and sustainability for patients in these three services patients may have to travel to a central clinical for out of hours services. The early indications are that the numbers of patient who are affected are very low across all of the smaller specialty services being reviewed in this first phase and there will be minimal impact on Sheffield residents.

6. Next steps

The next phase will focus on sharing the outputs of the work from the first phase and building on the high level clinical options to develop new service models. Engaging further with patients and the public and wider groups will be a key part of this next phase.

In addition to continuing the work started in the areas outlined in this paper Phase Two of Working Together will be underpinned by a wider strategic review of health and care across the Working Together Partnership. The outcome of that review will inform the development of commissioner's strategic plans and the response of providers to those plans.

6. Recommendation

The committee is asked to:

- Provide comments and receive further updates as the work progresses.

Will Cleary-Gray
Working Together Director
11February 2015

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
25th February 2015

Report of: Executive Director, Communities.

Subject: Adult Social Care Performance

Author of Report: Howard Middleton, Development Manager

Summary:

The attached powerpoint will be presented at the Scrutiny meeting on the 25th February, updating the Committee on adult social care performance.

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:
Consider and comment on adult social care performance.

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Adult social care performance

25 February 2015

Adult social care
The context

We provided adult social care services to over

13,000

people in 2013-14

Sheffield has the highest proportion of people over

65

compared to other big cities in England

We must make

£11.4m

worth of savings from Better Health & Wellbeing budgets in 2014-15

8,043 people's needs were assessed by our staff in 2013-14

We still want to keep improving… our vision is of

independent, safe and well communities

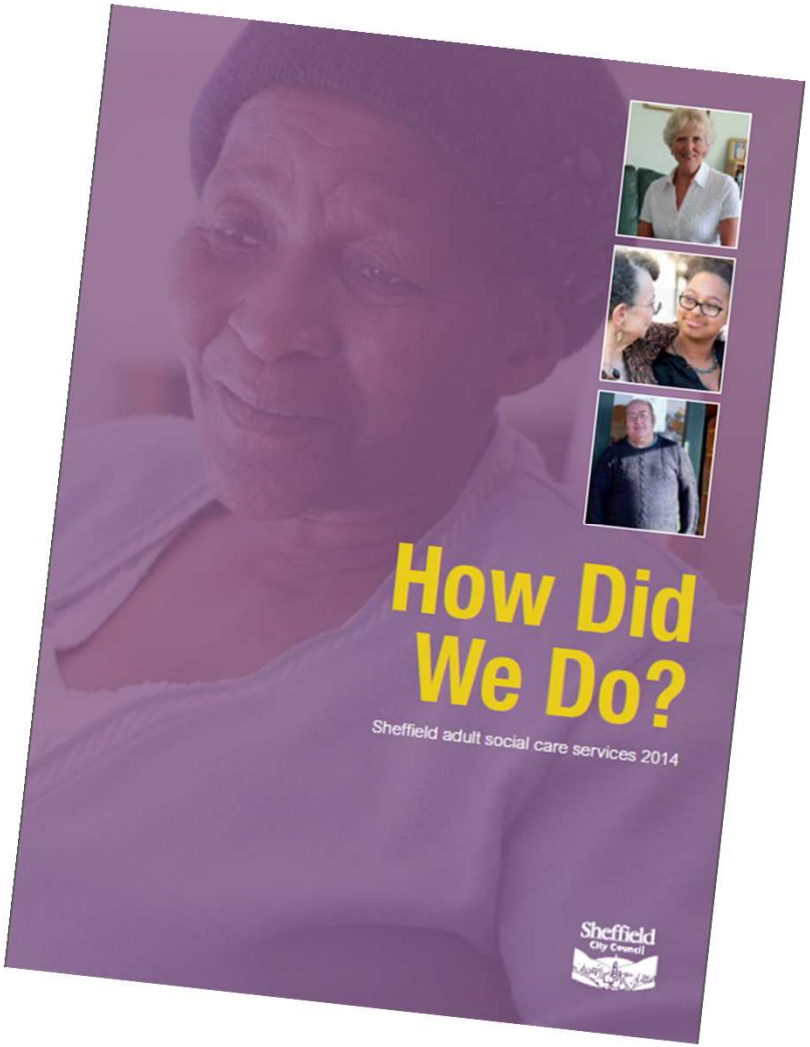
that are

treated with fairness and dignity

Adult social care
Our performance

- We work with the other 14 councils in the region to benchmark, support and challenge and to share good practice
- We benchmark on 18 indicators – in 2013-14 we improved on 11 of these from the previous year
- We rank in the region's top 3 on 4 indicators but in the bottom 3 on 7 indicators
- For more information on our performance, our annual report is here…

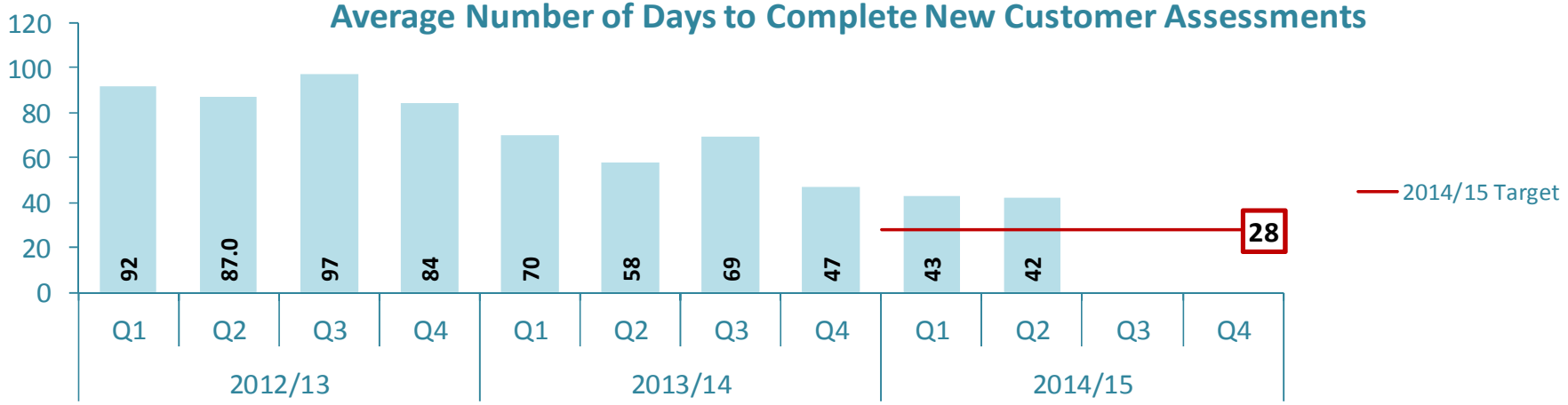
www.sheffield.gov.uk/caresupport/policy/local-account.html



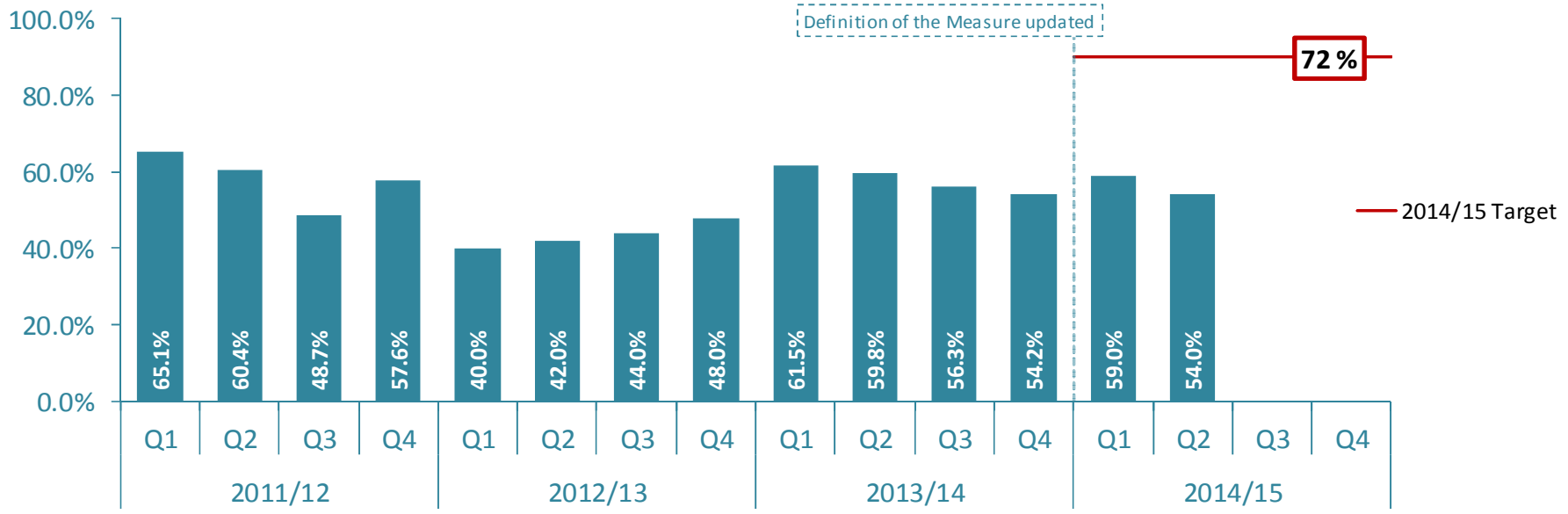
Adult social care
Assessment and review

Assessments were taking a long time to complete and there was a backlog of reviews. What we have done...

Average Number of Days to Complete New Customer Assessments

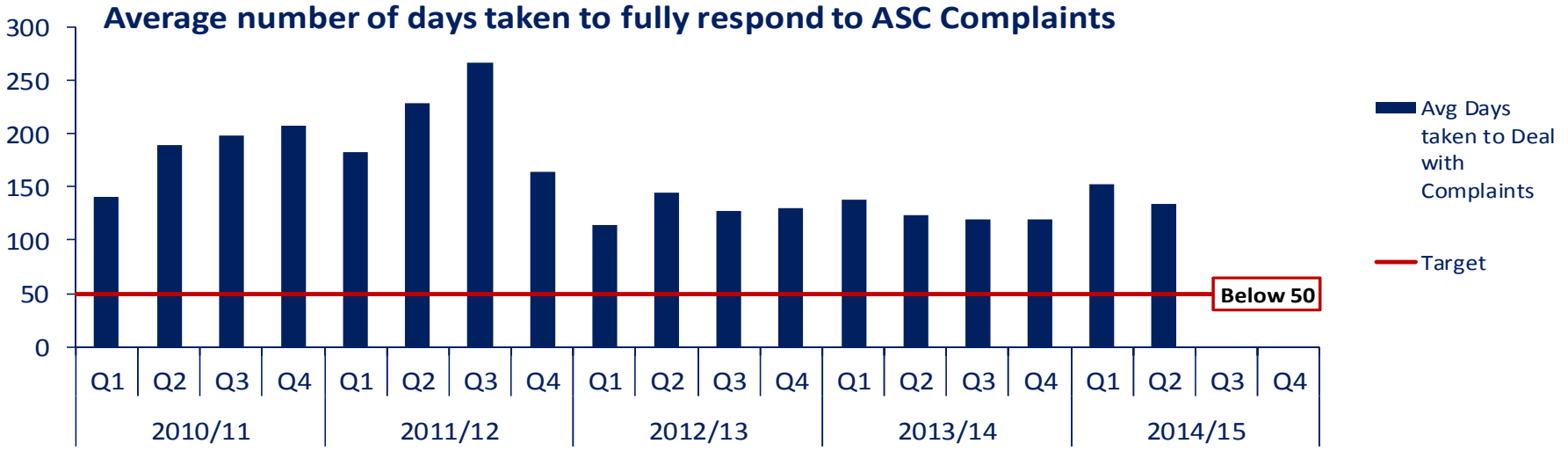


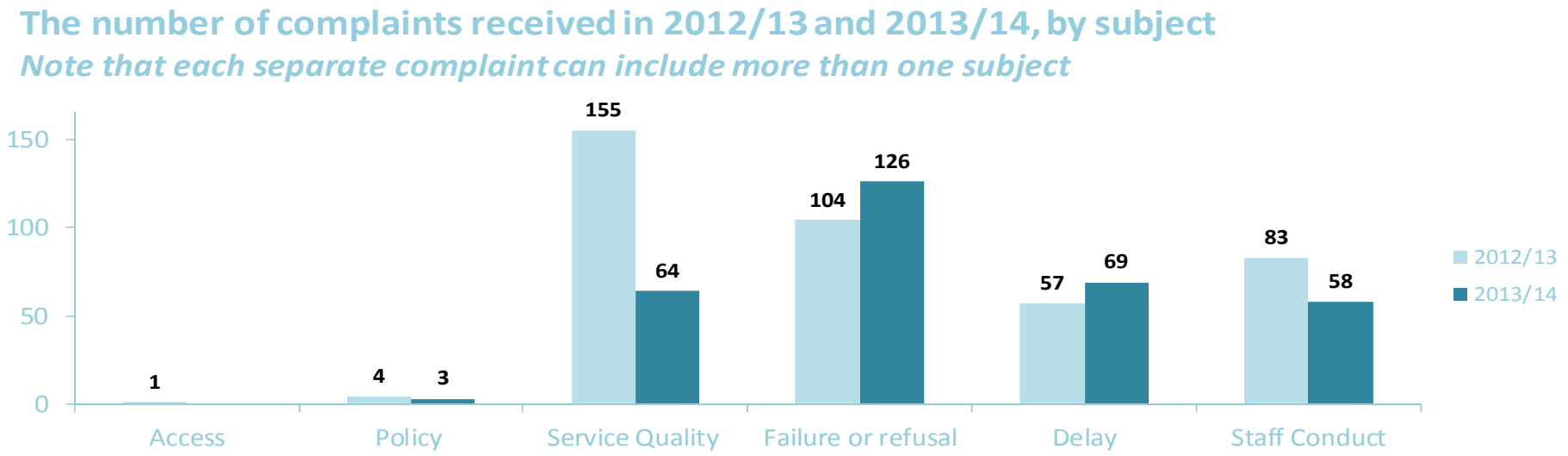
Adults Receiving a Review as a Proportion of Those receiving a Service



Adult social care
Complaints

We were taking a long time to respond to complaints. What we have done…





Adult social care
Safeguarding

Our safeguarding system had a backlog of cases. What we have done…

Safeguarding Adults Referral Process

Safeguarding Adults Alerts Received 2014/15 Q2

821

Alerts screened out as not meeting the Threshold

75%

Safeguarding Alert judged to exceed the threshold and the alert is continued onto a Strategy Meeting

25%

Safeguarding Adults Strategy Meetings Completed 2014/15 Q2

171

Allegation is assessed to be unfounded, unsubstanciated or inconclusive

71%

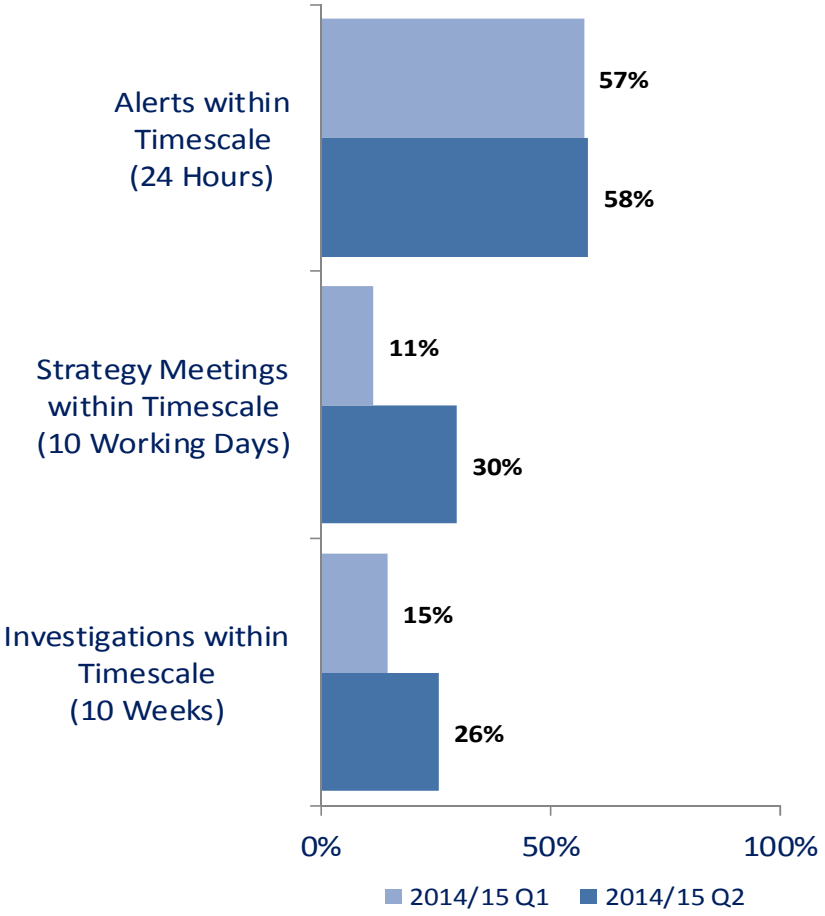
Strategy meeting concludes that abuse has taken place and an investigation is required to find the reasons behind this.

29%

Safeguarding Adults Investigation Completed 2014/15 Q2

64

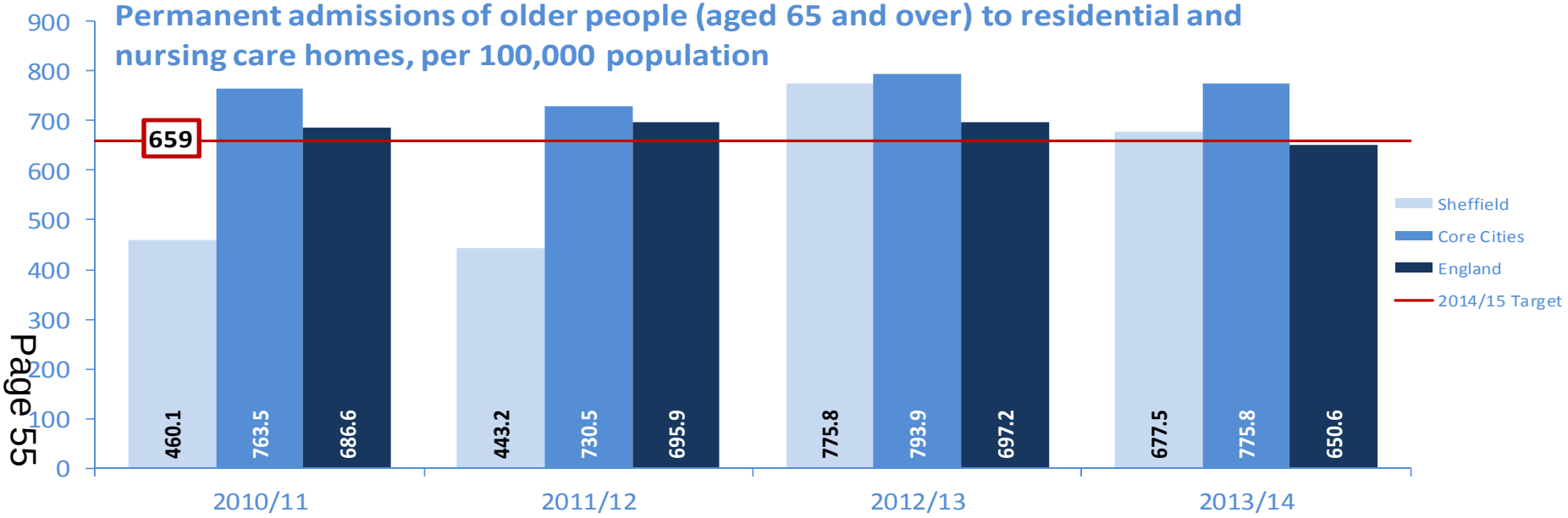
Proportion of Adults Safeguarding Stages completed within the timescales set by the Sheffield Adult Safeguarding Partnership

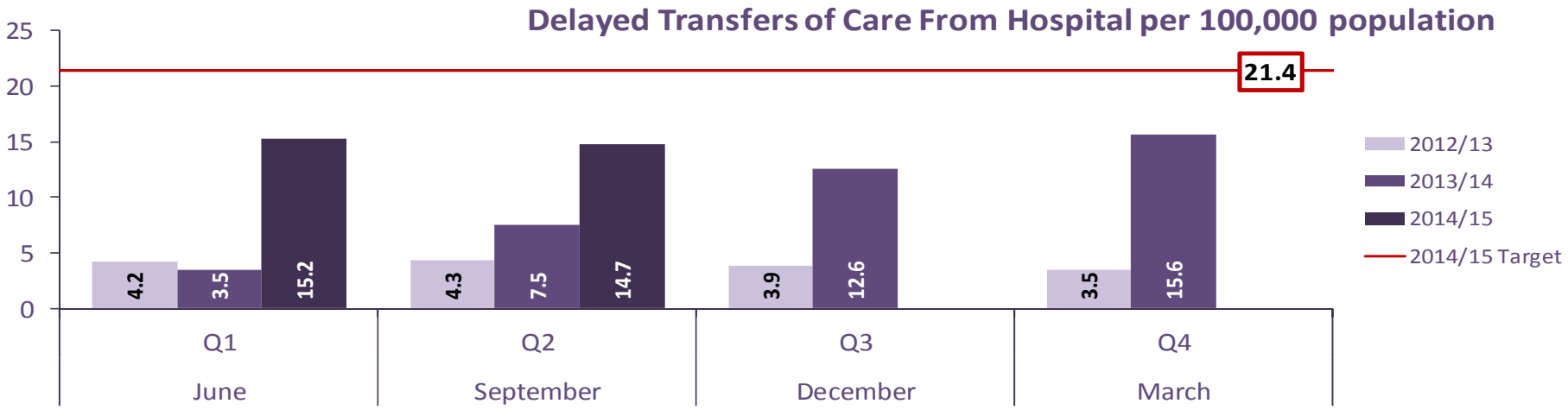


Adult social care

NHS policies and pathways

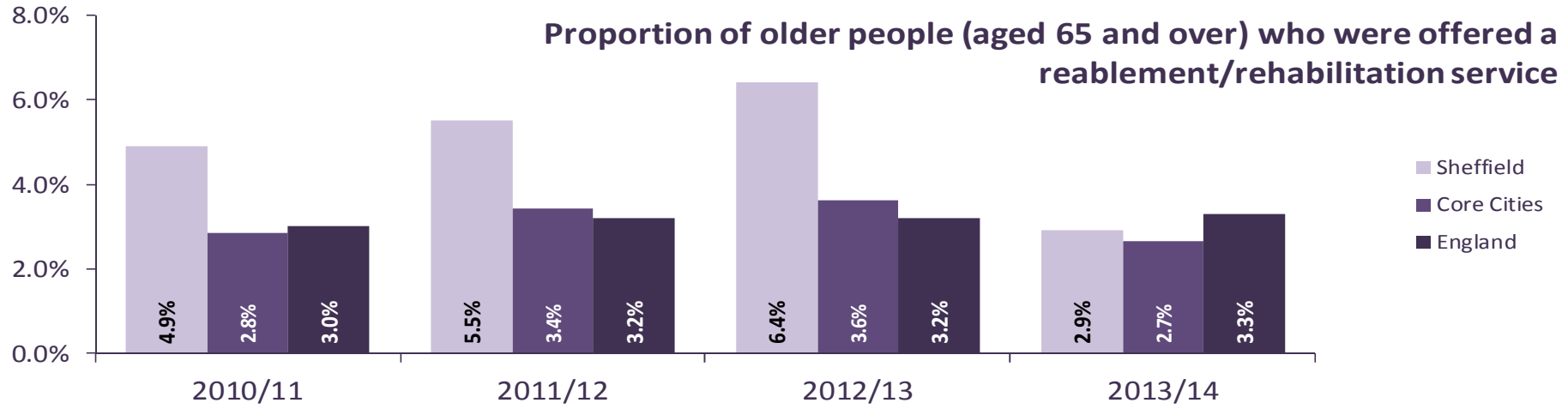
Permanent admissions to care homes were rising linked to changing care pathways and policies in the NHS, whilst delayed transfers of care seemed to be increasing.

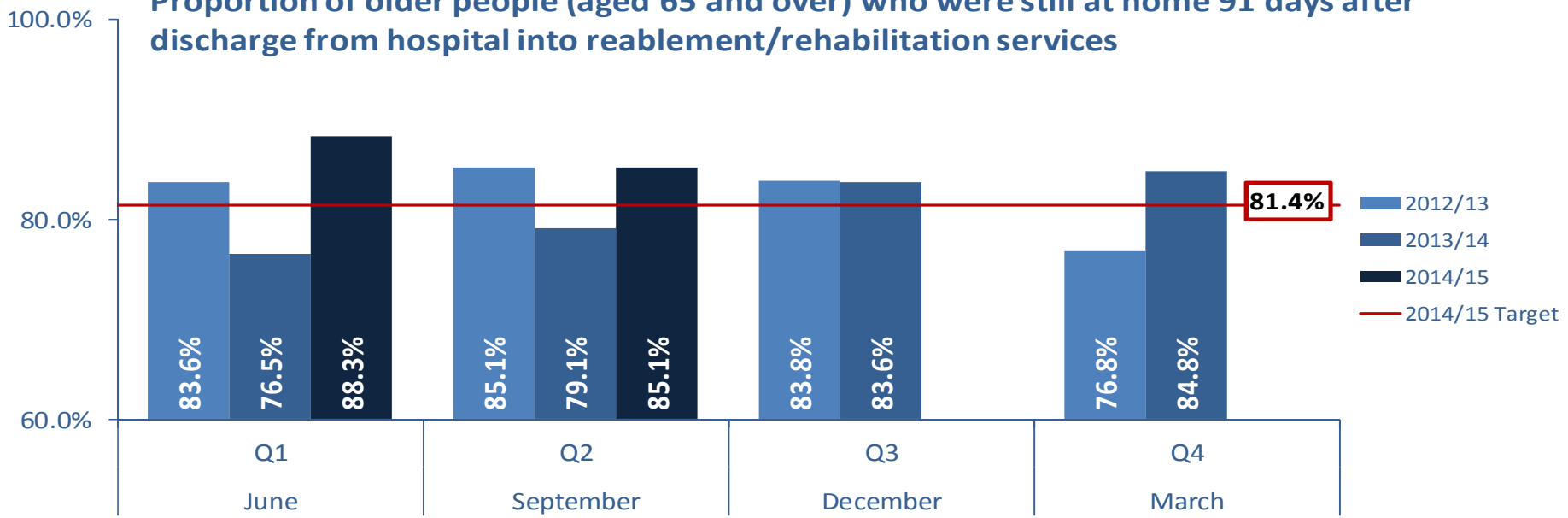




Adult social care
Reablement

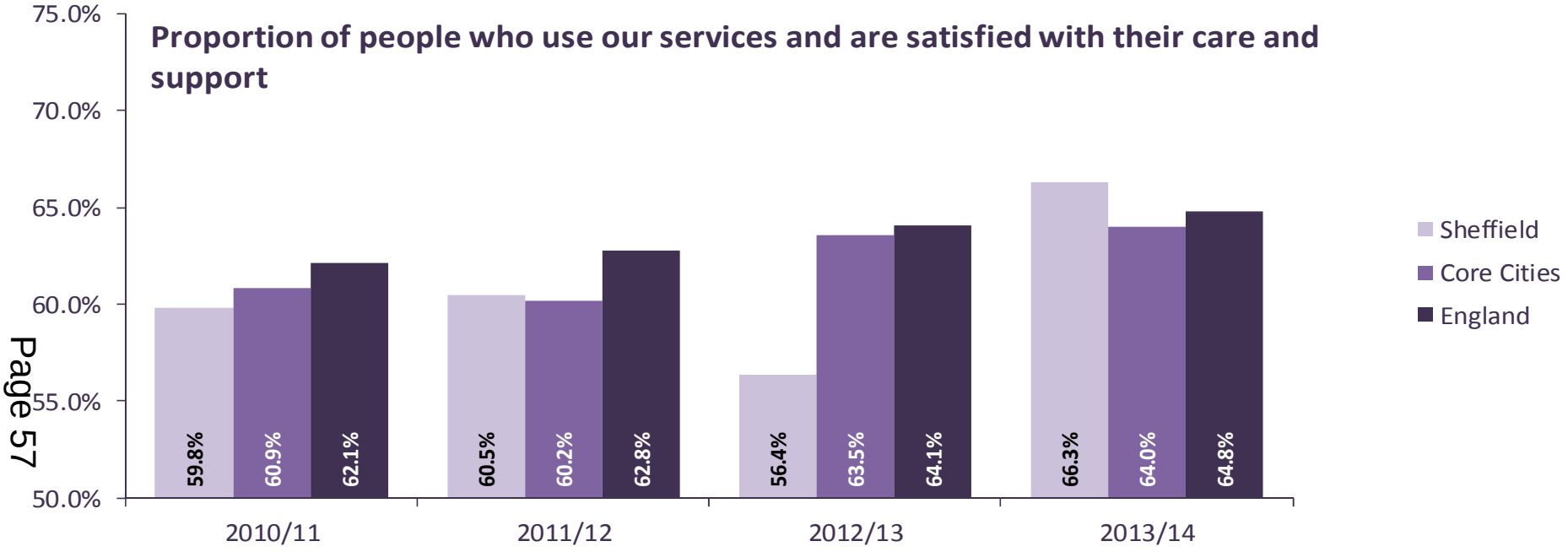
We needed to do more to ensure the effectiveness of reablement services. What we have done…

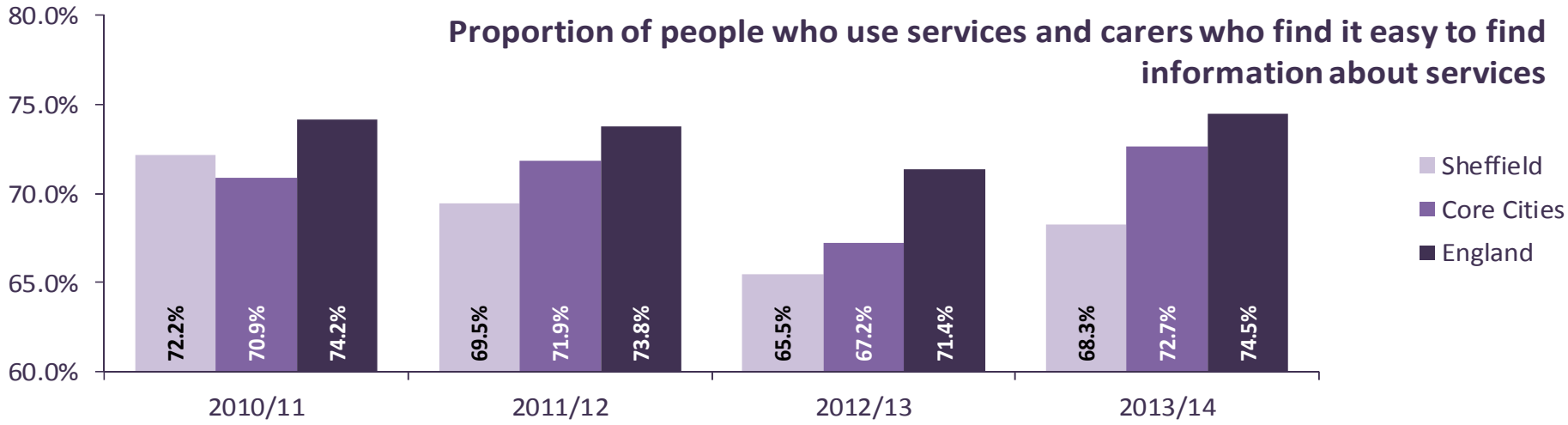




Adult social care
Other performance headlines

What the national survey of service users is telling us…





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Report to Health Scrutiny & Policy Development Committee
25th February 2015

Report of: Director of Public Health

Subject: Sheffield health inequalities plan

Author of Report: Dr Jeremy Wight, Director of Public Health, Sheffield City Council, Town Hall, Pinstone Street, Sheffield, S1 2HH
Tel: 0114 205 7462

Summary:
The Sheffield Health and Wellbeing Board has developed and approved a Health Wellbeing Strategy for the City. One of the specific outcomes in this strategy is that *health inequalities are reducing.* An action plan has been developed and was approved by the Health and Wellbeing Board in June 2014. It is now being implemented. Progress will be formally reviewed after 1 year.

The Health Scrutiny and Policy Development Committee has requested a report on the health inequalities plan and progress to date in its implementation.

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	

The Scrutiny Committee is being asked to:
Comment on the action plan, consider progress against the identified actions, and consider any recommendations they may wish to make to the Health and Wellbeing Board.

Background Papers:

Sheffield Joint Strategic Needs Assessment –
https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/JSNA.html
Sheffield Health and Wellbeing Strategy –
https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/joint-health-and-wellbeing-strategy.html
Sheffield Health inequalities plan –
https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/tackling-health-inequalities.html

Category of Report: OPEN

Report of the Director of Public Health
Sheffield Health Inequalities Plan

1. Introduction/Context

1.1 Inequalities in health in Sheffield have been well documented for over a century. They are significant and persistent, in spite of much good work that has been done to address them. Their nature and extent are documented in the Joint Strategic Needs Assessment and elsewhere. The roots of health inequalities lie in the unequal nature of society, and they will persist as long as society remains unequal. But this does not mean that we cannot do anything about them.

1.2 The Fairness Commission considered health inequalities in detail and made a number of general recommendations as well as more specific ones relating to inequalities in the health system, mental health and wellbeing, and carers. The Joint Strategic Needs Assessment, as well as describing the health inequalities in the City, also made a number of recommendations. The Health and Wellbeing Board has identified addressing health inequalities as one of its priorities (the other being the integration of health and social care). It has approved a Health and Wellbeing Strategy that identifies five Outcomes which describe what it wishes to achieve for the people of Sheffield. One of these is that *health inequalities are reducing* and nine actions are identified in support of that. However there are also actions in support of another Outcome, *health and wellbeing is improving,* which will when implemented also have a significant impact on health inequalities.

1.3 The Health and Wellbeing Board approved the Health Inequalities Plan in June 2014. The plan describes how the actions contained in the strategy will be implemented. A report on progress in implementing the plan is due to be taken back to the Health and Wellbeing Board in June 2015.

1.4 The Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee requested a report on the health inequalities Plan,

including a report on progress in implementing it. This paper provides that report.

2. Main body of report, matters for consideration, etc

2.1 The Health and Wellbeing Strategy was developed during 2012 to 2013 by the Health and Wellbeing Board. The development included extensive consultation with partner agencies, health and social care provider organisations and members of the public. The strategy was formally approved in September 2013.

2.2 Outcome 3 of the strategy is that *health inequalities are reducing.* There are 9 actions that were identified to achieve that, as follows:

Action 3.1

Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.

Action 3.2

Agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community based organisations.

Action 3.3

Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined up city localities.

Action 3.4

Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.

Action 3.5

Ensure every child has the best possible start in life, including: focussed action, reducing infant mortality, improving parent/child atunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.

Action 3.6

Recognising that the City has growing numbers of new arrivals, including Roma, develop appropriate strategies to ensure families are appropriately accessing health, social care and education services.

Action 3.7

Commission disease specific interventions, including a programme to improve the physical health of the severely mental ill and those with a learning disability.

Action 3.8

Support quality and dignity champions to ensure services meet needs and provide support.

Action 3.9

Work to remove health barriers to employment through the health, disability and employment plan.

1.3 In addition to the above, there are a number of actions that appear under outcome 2 *Health and wellbeing is improving,* which will when implemented also have a significant impact on health inequalities. These are:

Action 2.1

Promote a citywide approach to emotional wellbeing and mental health, focussing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.

Action 2.4

Support the “More More” initiative to encourage people to be more physically active as part of their daily lives.

Action 2.5

Commission and implement an integrated approach to reducing levels of tobacco use through integrated work on: 1 – helping people to stop smoking, 2 – smoke free environment, 3 – smokefree children and young people, 4 – community based action on illegal tobacco, 5 – social marketing and communications to reduce smoking prevalence and de-normalise tobacco use, 6 – reduce smoking prevalence amongst pregnant women.

Action 2.6:

Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the ‘hidden harm’ to children living in households where adults abuse alcohol or drugs.

Action 2.8

Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.

1.4 A draft action plan was compiled which identified how the above actions would be implemented, who would be responsible for that and the appropriate timescales. This draft health inequalities plan was consulted on during the spring of 2014, and as a result of that consultation an additional action was identified as follows.

Action 3.10

To promote health literacy and earlier engagement with health services in disadvantaged communities.

1.5 The final approved version of the Health Inequalities Plan therefore contains 15 specific actions. A full copy of the plan can be found at https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/tackling-health-inequalities.html.

1.6 The actions identified have been chosen because they relate to causes of ill-health that are amenable to intervention, where relatively large numbers of people are affected, where a cause is unevenly distributed across society, and where the adverse health consequences are severe. It contains a range of actions, some of which will have an impact in the relatively short term, whilst others will impact only in the medium to longer term.

1.7 Each action has an identified lead officer, and is broken down into a number of specific tasks which will be necessary to deliver the action, with intended timescales and reporting arrangements.

1.8 The Health and Wellbeing Board approved the Health Inequalities Plan in June 2014, and requested an annual report on its implementation.

1.9 The current position with regard to the implementation of the plan is detailed in appendix 1.

3 What does this mean for the people of Sheffield?

3.1 Health inequalities are a matter of life and death. Although there are many different ways in which health inequalities can be measured, the best overall indicator is the slope index of inequality of life expectancy which indicates a life expectancy gap of just over 9 years for men and just under 7 years for women (2011-13 data).

3.2 There are however many different ways of describing health inequality. For example difference of infant mortality between different ethnic groups, or differences in life expectancy between people with learning disabilities or serious mental illness and those without. Implementation of this plan should help to reduce inequalities as measured in a range of different ways, as is detailed within the plan.

3.3 Health inequalities are at root a manifestation of socio-economic inequality. Health inequalities will continue as long as society remains unequal and if socio-economic inequalities widen, then the impact of this plan may simply be to stop health inequalities widening further.

4. Recommendation

4.1 The Scrutiny Committee is recommended to consider the plan, comment on its implementation, and consider any recommendations for the Health and Wellbeing Board.

Appendix 1: Update on Actions, February 2015

Action 3.1

Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.

Action to date

Communities of interest have been identified (see list below) and initial analysis undertaken covering availability of data about the health status of each group and, where data available, what this is telling us about the health disadvantage experienced. A number of community of interest health profiles (produced by Public Health England) and local Health Needs Assessments (HNAs) already exist and these are used where relevant.

Communities of Interest

- Homeless people
- People with serious mental ill health
- People with learning disabilities
- People with physical disabilities (includes sensory and cognitive impairments)
- Lesbian, Gay, Bisexual and Transgender
- Black and Minority Ethnic Communities (including migrants and asylum seekers and refugees)
- Carers

What are we planning to do next?

Recommendations to the H&WB Board about priorities for further data collection and analysis are currently being prepared. An implementation plan will be established when priorities agreed. This is likely to consist of a combination of health needs assessments and rapid reviews.

Action 3.2

Agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community based organisations.

Actions to date

Health Trainers Health trainers provide support to people to improve their health and wellbeing by increasing confidence and skill . They use a social prescribing model using with referrals from GP Practices. There are now Health Trainers in each of the Community Wellbeing Programme areas, including a City Centre based worker for vulnerable groups. Last year there were 1569 service users and 12,368 points of contact.

Community Health Champions. These volunteers are mainly recruited from disadvantaged communities and draw on their own local knowledge and life experience to undertake community interventions or provide one to one support to improve health wellbeing and social connectedness. CHCs work in areas of the City with the most need. Between 2009 and 2013, the total number of Health Champions was 400, supporting over 10,000 people.

Practice Champions Practice Champions is a recently established lottery funded initiative. It is delivered by VCF organisations particularly supporting GP Practices around appropriate use of NHS services and working with the practice on priority areas of work. There are 160 Practice Champions working with 4 GP Practices. The volunteers also enable links with other community interventions such as Social cafes.

Community Wellbeing Programme Current contracts are being extended for a year. The contracts will be changed to strengthen the work regarding building and supporting social capital as a way of improving health and wellbeing. Last year there were 21,258 Beneficiaries and 68,173 Points of Contact.

The CWP provides the framework for other public health interventions. A current example is the Eat and Heat Project – tacking fuel and food poverty. CWP providers are developing projects appropriate to their neighbourhood, working with other local organisations including food banks to identify vulnerable households and to support take up of available services.

Locality Working Public Health staff are working closely with the LAPs and the locality teams to achieve a joint neighbourhood approach engaging libraries and Housing Plus. The new CWP contract with VCF providers focuses on building social capital and asset based community development. Developing health and wellbeing networks is proving a successful approach for engaging local stakeholders

Developing Resilience Sheffield Executive Board has led an initiative to develop resilient communities. A task and finish group gathered evidence from a wide range of agencies working with communities. A report has been written describing a 'Fuzzy Framework' for building community resilience. A stakeholder workshop was held to take this forward and the feedback has been used to further develop the strategy. The Local Area Partnership Chairs have also been consulted about taking this forward.

Evaluation Reports from Sheffield and Leeds Universities and the data collected as part the national Health Trainer data base (DCRS) provide evidence of the success of the Sheffield Community Wellbeing, Health Trainer and Health Champions Programmes.

What are we planning to do next?

Health Trainers Working closely with primary care particularly supporting achievement of integrated Health and Social Care. The Public Health team is co-ordinating a multiagency bid to the Health Foundation. The proposal is to use HTs to empower people to take control over their own health, wellbeing and help them make healthier lifestyle choices.

Health Champions Currently agreeing a new contract with Sheffield Cubed to build on the success of this programme and to increase numbers of volunteers and give greater focus on social capital outcomes.

Practice Champions In order to sustain this work and work with more practices we are seeking funding for Practice Champions this as the funding ends in May 2015.

Community Wellbeing Programme A new Evaluation Framework is being developed with Sheffield and Sheffield Hallam University to measure social capital at individual, organisational and community level. It is anticipated that a new commissioning strategy will be developed as part of the wider work around the Integrated Health and Social Care Strategy.

Locality working A community development strategy is being developed

Developing resilience The resilience multi-agency working group are pulling together City approaches to building skills and capability into one City proposal/approach . They are also capturing stories of success in relation to the 'Fuzzy Framework'. The document will then be revised so it presents as a more challenging document. SEB members will then be asked to consider how they could support this document with a full SEB discussion in February.

Evaluation A report being written by Sheffield and Sheffield Hallam Universities

Action 3.3

Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined up city localities.

Actions to date

A Housing Delivery Investment Plan has been produced. The Air Quality Action Plan is being implemented but is due for a refresh.

What are we planning to do next?

Review of Air Quality Action Plan

Action 3.4

Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.

Actions to date

Actions to date have focused on understanding what the issues are in Sheffield, reviewing the evidence base of what works to improve access, and putting together a proposal for action based on this. This proposal has been discussed and approved by both the Council's H&WB Strategic Outcome Board and the CCG's Clinical Executive Team.

What are we planning to do next?

Our next step is to create project plans to implement the following actions:

- Ensure that increasing health literacy is an integral part of all community development commissioning and service delivery.
- Ensure that all city strategic and service plans that refer to service access address both demand issues (people's ability to recognise they need a service and can navigate the system) as well as supply issues (services are easy to use and accessible).
- Provide training and information on how the health care and social care system works to staff working directly with community members.
- Support services to understand which people or groups find their services difficult to access and what they need to do differently:
    - Support services to conduct 'did not attend' (DNA) audits: this will give specific service-level information about why some people or groups (for example, carers, BME groups, people with disabilities) find particular services difficult to access, and will tell services what they need to do differently.
    - Support the VCFS, Healthwatch and other volunteers to conduct audits of how much 'work' is involved in using services (for example transport, childcare, interpreters, time off work), then support services to make recommended changes.
    - Identify and implement specific actions from existing and proposed Health Equity Audits (current audits underway include access to primary care services for people with learning disabilities, and access to end of life care services for BME and other population groups).

Action 3.5

Ensure every child has the best possible start in life, including: focussed action, reducing infant mortality, improving parent/child atunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.

Action to date

A new *Best Start* strategy is under development and about to be consulted on. The City *Infant Mortality Strategy* is being implemented. A new contract for a service to address maternal smoking has been let (see action 2.5). Breast feeding peer support and doula programmes continue.

What are we planning to do next?

Consult on and implement the *Best Start* strategy.

Action 3.6

Recognising that the City has growing numbers of new arrivals, including Roma, develop appropriate strategies to ensure families are appropriately accessing health, social care and education services.

Actions to date

- Implemented a detailed strategic action plan that has brought together key services including health, housing, environment, schools, police, community and VCF to manage impact on Page Hall and develop a framework for supporting migration in the City to other communities.
- A matrix has been developed to track the cost of all interventions in the Page Hall, Fir Vale, Darnall areas.
- Selective licensing at Page Hall – all homeowners have either applied for a new licence or court action is pending for those that have refused to engage in legal process.
- A multi agency team has been established and additional resources have been deployed to tackle the immediate crisis which is selective licensing, waste/ environmental issues and supporting young people. Crime remains low but fear of crime and ASB remains high. Unprecedented demand for local health services remains a risk which is being managed within budgets available.
- Reviewed the Policing Plan for the Page Hall area.
- A new Cohesion Strategy (and family of related strategies) has been commissioned.
- A review of Grant Aid funding in the area has taken place to inform future years funding.
- Mapping community development activities in the area affected by new arrivals

What are we planning to do next?

Stakeholder engagement for the new cohesion strategy – A set of documents that explain how all new arrivals will be helped has been commissioned from Maxine Stavrianakos (H&NS - Head of Service), and it is hoped this will be completed by the end of the financial year. We will be involving all key stakeholders (including health) to shape the new strategy.
This work will also create a family of strategies that will feed into the *Cohesion Strategy – Asylum Strategy, New Arrivals & Migration Strategy etc***.**

The Asylum Strategy will use the 'asylum/immigrants journey' which has been mapped from when they first enter the UK through to the various agencies/ pathways, when they arrive in Sheffield and the support that is available to help them settle, integrate and seek access to work/access to services & support at a local level.
The *Cohesion Strategy* will be the route map that will inform the City's key strategies about how communities work and how we deliver services and support communities through direct Council delivery, working with Partners and VCF. The previous strategy did not reflect our ambitions and not well connected.
Aim also to incorporate education, employment, business issues. Need to develop employment opportunities in the local areas/neighbourhood planning.
Bidding is taking place to secure 'rogue landlord funding' from government (current funding ends 31.3.15).
A detailed short and medium term strategy has been developed for areas affected by rapid migration – Page Hall, Darnall, Burngreave and Grimesthorpe.
A bid that will seek some short term financial support for supporting key services including health, schools, community and housing has been submitted to CLG – outcome of meeting with ministers should be known by the end February.
Alongside this a long-term business case for the city affected by impact on migration in the above areas is being prepared working in partnership with Government Public Transformation team. This work should be completed by October 2015 and will include data mapping of resources, interventions and impact. A new Housing and Health Needs Assessment for Page Hall is underway to help inform the long term business case and will present a series of propositions to government in the autumn.

Action 3.7

Commission disease specific interventions, including a programme to improve the physical health of the severely mental ill and those with a learning disability.

This action overlaps with a number of others in the HIAP, most significantly action 2.8 'maintain a focus on CVD and cancer'. Over the past year the CCG has made significant progress with improving the physical health of people with serious mental illness and learning disability, which was the origin of this action in the HIAP. This work is continuing and is supported by recent national directives on achieving 'parity of esteem'. The CCG's current and future work on commissioning disease-specific interventions (all with a focus on reducing health inequalities) includes: reviewing and improving respiratory services; commissioning a liaison psychiatry service that will also enhance treatment and support for people with alcohol problems; and participating in a review of the City's TB services as part of the recently published national TB strategy.

Action 3.8

Support quality and dignity champions to ensure services meet needs and provide support.

Actions to Date
Healthwatch Sheffield have conducted a mapping exercise of existing dignity champions in the city. We have sent out a Survey Monkey questionnaire (223 by email, 14 by post) to all providers of care (domiciliary and care homes) in Sheffield, accompanied by a supporting letter from the Director of Public Health. Despite this we have only received four responses.

What are we planning to do next?
Conduct a literature search on the benefits of promoting the dignity agenda in terms of positive change for patients. Re-mailing of survey to providers of care, plus an extension of the survey to include health providers. Identify the benefits (or otherwise) of dignity champions, and areas where numbers are low across health and social care. Considerations of dignity will be incorporated into the forthcoming Enter and View schedule planned between February and May. A report on the final mapping, results from Enter and View and potential interviews with providers will be available in October 2015.

Action 3.9

Work to remove health barriers to employment through the health, disability and employment plan.

Action to date

- Produced a baseline study. https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/work-programmes/health-dis-employ.html
- Reviewed existing commissioned employment support across SCC and CCG on behalf of Member Working Group
- Incorporated findings into work with Public Sector Transformation Network, held multi agency session and initial action plan produced
- Currently seeking LEP support to develop increased opportunities across employers
- A £375k jointly funded pilot project between PH and JCP for ESA claimants has gone out to tender and contracts awarded.(SOAR, ZEST and MCDT were successful providers) Evaluation framework developed
- Resource secured to deliver Public Health England's Workplace Wellbeing Charter. Joint working with Rotherham, Barnsley and Doncaster

What are we planning to do next?
Working with Learning and Skills and Policy teams and CCG +JCP to develop new pathway from health system into employment system to increase

inclination and opportunity for employment for those with disabilities and health conditions. Also aiming to develop wider Employment Support Allowance (ESA) pilot as part of SCC Devolution Deal, using existing pilot as 'initial test'
Ensure supported employment commissioning activity is complementary and effective, and if not, secure re-alignment
Secure LEP collaboration and alignment of resources from their Economic and Social Inclusion commitments.
The contracts for the ESA pilot are about to be mobilised, and this work will be evaluated. Each contract(3 contracts) is seeking to work with around 140 ESA claimants and return 50 -60 back into employment during the contract (currently Work Programme providers can claim over £10,000 for returning those furthest from the labour market back into work for sustained periods)
Sign up 30 businesses across the City to the Workplace Wellbeing Charter in 2015/6

Action 3.10

To promote health literacy and earlier engagement with health services in disadvantaged communities.

Action to date

Health Literacy is important part of the plan to improve appropriate access to services. Research indicates that community-based peer support is likely to improve health literacy. This is particularly the case when peer supporters have something in common with the participants and get them involved in social networks; where there are opportunities to talk about their problems and get advice on how to manage from each other, and where participants are in control of identifying what they would like to do to address health and other issues.

Community programmes such as the CWP and the Health Trainer programme are able to help people understand factual health information. Health Trainers have been instrumental in improving health and wellbeing by setting and achieving goals as well as increasing health literacy in their clients. Clients have developed psychological and physical capabilities. As they experience success they become more motivated to change habits and routines and are more confident to try new things. Increased confidence in turn leads people to seek out opportunities independently and need less help from the Health Trainer.[1]

What are we planning to do next?

We will continue to work with local communities, community organisations and professionals working in those communities to increase health literacy by

[1] Janet Harris1, Tim Williams2, Oliver Hart3, Chris Hanson4, Gareth Johnstone5, Aziz Muthana5 and Chris Nield5 (2013) Using health trainers to promote self-management of chronic pain: can it work? British Journal of Pain 2014, Vol 8(1) 27– 33

increasing connections between and within communities and develop peer support.
There are opportunities to build on the success and integrate the programme with GP Personal Centred Care. We will further develop and extend the Community Wellbeing Programme, Health Champion, and Health Trainer model which embraces peer support so that disadvantaged areas have access to these services.
A health literacy and empowerment approach is central to self-management of health and learning from this approach will also inform the development of work to improve access to services. (See response to action 3.5)

Action 2.1

Promote a citywide approach to emotional wellbeing and mental health, focussing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.

Action 2.4

Support the “More More” initiative to encourage people to be more physically active as part of their daily lives.

Actions to date
A Move More Officer has been appointed and is now in post and being effective. A digital hub has been established as a ‘go to’ resource for information about physical activity in the City. An active Move More network has been established.

What are we planning to do next?
Further implementation of the ‘Move More’ Strategy. Discussion about Governance arrangements due at the Health and Wellbeing Board at end Feb.

Action 2.5

Commission and implement an integrated approach to reducing levels of tobacco use through integrated work on: 1 – helping people to stop smoking, 2 – smoke free environment, 3 – smokefree children and young people, 4 – community based action on illegal tobacco, 5 – social marketing and communications to reduce smoking prevalence and de-normalise tobacco use, 6 – reduce smoking prevalence amongst pregnant women.

Actions to date

A comprehensive programme of tobacco control to reduce smoking prevalence within Sheffield was launched on 1 April 2014. The three year programme is based on best evidence from the World Health Organisation, a comprehensive

consultation with key stakeholders and based on local health need. The programme comprises of six services, which together, in partnership aim to reduce smoking prevalence amongst adults, pregnant women and children (in line with the Public Health Outcome Framework indicator targets). The services are delivered by a range of private, public and VCF provider organisations. The providers are brought together on a quarterly basis in a 'Tobacco Control Hub' to share learning and develop a common tobacco control brand for the city. Performance is reviewed quarterly in contract monitoring meetings.

The newly commissioned tobacco control programme is as follows:

1) Smokefree Service, with prioritised action amongst population groups with the highest smoking prevalence, most addicted and need the most support to quit smoking, including residents living in the 20% most deprived areas of the city, certain BME groups and those with a diagnosed mental health condition.
   Unfortunately take up of this service has fallen off significantly in the last year, probably because would be quitters are increasingly using e-Cigarettes rather than accessing the service. This has led to a significant underspend against this budget in year.
2) Smokefree Spaces Service, to protect children under five and families from exposure to harmful tobacco smoke in homes and cars and help denormalise tobacco use within communities
3) Smokefree Children and Young People, to reduce smoking prevalence amongst young people by introducing a 'whole school approach to tobacco control' including Smokefree lessons and support for young people and staff who smoke.
4) Community development action for illegal tobacco, raising the harm caused within communities and how illegal tobacco encourages and actively enables young people to become 'hooked' on cigarettes, and remain smoking into adulthood.
5) A programme of marketing and communications for tobacco control, cross cutting all strands of the tobacco control programme. The provider is commissioned to deliver three campaigns each year. This service is delivered in partnership with Doncaster and Rotherham Councils.
6) A stop smoking relapse prevention service for pregnant women – to help women remain Smokefree post pregnancy (please note, this service launched January 1st 2015 after a successful open procurement process).

This programme sits alongside a number of pre-established tobacco control initiatives, the stop smoking service for pregnant women, delivered by STHFT Maternity Services and tobacco control enforcement action for illegal tobacco, provided by Sheffield City Council, Trading Standards.

What are we planning to do next?

The introduction of a comprehensive programme of tobacco control will ensure the city has comprehensive strategy in place to reduce smoking prevalence and the harm caused by tobacco across all communities in Sheffield.
An increase in the use of e-cigarettes has had a considerable impact on numbers accessing the Smokefree Services for support to quit. This is not a unique situation to Sheffield, instead is an issue being dealt with across the country. In Sheffield, at this stage, we are not considering stop smoking service as being non-viable because evidence clearly points to them providing the best overall success rates and we cannot let down those smokers who whose lives would be saved by them. However we are working locally with tobacco control partners to harness the potential health gain associated with e-cigarettes as a harm minimisation tool. Alongside which we are also working to improve service uptake by increasing marketing and communications whilst introducing 'new routes to quit', including telephone support, quitting online and a greater use of social media to make the service more accessible to smokers who want to quit.
At the same time there is an intention to carry forward £400K of PH Grant underspend to use in other areas of tobacco control to counteract the reduction in the number of smokers accessing support locally. This will likely include enhanced media work and increasing the level of resource for enforcement action across the City.

Action 2.6
Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.

Actions to date
Sheffield DACT has successfully implemented the Commissioning and Procurement Plan for community drug and alcohol services. The Cabinet approved the DACT's plan for three end to end services for Opiates, Non-Opiates and Alcohol in January 2014 and they were successfully awarded in July 2014. Services for Opiates and Non Opiates went live on 1st October 2014. A decision has been reached to delay the tender for Alcohol Services to allow opportunities for integrated commissioning with the CCG to be explored and a waiver has been secured to this end.
The Drug Interventions Programme (DIP) continues to provide an effective link between the criminal justice and substance misuse systems with 41% of referrals to structured treatment in Sheffield coming from the criminal justice system. DIP and other DACT interventions provide identification, assessment, harm reduction and engagement services into both drugs and alcohol services.
The Hidden Harm Service will continue to be resourced by DACT and a service level agreement has been agreed between Sheffield Safeguarding Children's Board and DACT and is now with Commercial Services.

What are we planning to do next?

There is an opportunity in that SHSC have won both contracts for Opiates and Non Opiates and are the incumbent provider for alcohol, therefore there is a single provider in the City at present. Any issues will be addressed in ongoing proactive contract and performance management.

Recent changes to provider organisations including the division of the Probation Service and the subsequent changes to delivery structures has led to a number of strategic reviews of integrated working with partner organisations, more effectively targeting a broader range of substance misusing offenders.

Action 2.8

Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.

Both the council and the CCG continue to have multiple strategies and programmes of work that aim to reduce levels of heart disease and cancer in people in Sheffield. This action in the HIAP overlaps with many other actions in the plan, including action 3.4 'improving access to services' and action 3.7 'commissioning disease specific interventions'. For example, the Council's strategies to reduce tobacco consumption, increase physical activity and improve diet in the Sheffield population will reduce illness and death from heart disease and cancer. The Council is also working with Sheffield Action for African-Caribbean Health (SAACH) to explore a strategy for engaging African-Caribbean men and their partners in an effective way around prostate cancer.

In the CCG, specific cardiovascular disease action is focused on stroke prevention in atrial fibrillation; improved detection and treatment of chronic heart failure; and improved detection and treatment of familial hypercholesterolaemia. For cancer, the CCG supported the Be Clear on Cancer campaigns on breast, lung, and bladder and kidney cancers.

Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
Draft Work Programme 2014-15

Chair: Cllr Mick Rooney **Vice Chair**: Cllr Sue Alston
Meeting day/ time: Wednesday, 10am-1pm
Please note: the Work Programme is a live document and so is subject to change.

Topic	Reasons for selecting topic	Contact	Date	Expected Outcomes
25th February 2015				
Tender for the reprovision of day services and residential short term care beds for people with dementia	The decision has been called in under part 4 section 16 of the constitution	Joe Fowler, Director of Commissioning (Communities)	Feb 15	Committee to consider decision and take action as per options available under the constitution.
Health Inequalities Action Plan	Request from 23 July meeting. Committee to be involved at early stage in any refresh of HIAP	Jeremy Wight, Director of Public Health.	Feb 2015	Committee to consider progress on action plan and make comments in advance of Health and Wellbeing Board's consideration of the action plan in March.
Care Act 2014	Progress update on implementation of the Act, including financial implications.	Luke Morton, Programme Manager.	Feb 2015	Gain understanding of Act and Sheffield City Council's response
Sheffield Teaching Hospitals NHS Foundation Trust –	The Committee is required to comment on the Quality Accounts of providers of	Sandi Carman, Head of Patient and Healthcare Governance.	Feb 2015	Committee comments will be published as part of final Quality Account

Annual Quality Account	health services in the City			
Performance Update	To consider current Sheffield City Council performance against key indicators	Jasper South, Head of Planning and Performance, Communities.	Feb 2015	(Committee to consider format and frequency of future performance updates)
Working Together Programme	Briefing on the Working Together Programme	Will Cleary-Gray, Programme Director, Working Together Programme	Feb 2015	Committee to consider issues and future involvement.
15th April 2015				
Sheffield Health and Social Care Trust – Annual Quality Account.	The Committee is required to comment on the Quality Accounts of providers of health services in the City	Jason Rowlands, Director of Planning and Performance, Sheffield Health and Social Care NHS Trust	April 2015	Committee comments will be published as part of final Quality Account.
Sheffield Children's Hospital, Annual Quality Account	The Committee is required to comment on the Quality Accounts of providers of health services in the City	John Reid, Director of Nursing and Clinical Operations, Sheffield Children's Hospital.	April 2015	Committee comments will be published as part of final Quality Account.
Sheffield Teaching Hospitals NHS Foundation Trust – Annual Quality Account	The Committee is required to comment on the Quality Accounts of providers of health services in the City	Sandi Carman, Head of Patient and Healthcare Governance.	April 2015	Committee comments will be published as part of final Quality Account

Right First Time Programme.	Minutes from 17th September 2014: the committee requests a progress report on the Right First Time Programme. including details of patient feedback, and the communication and informatics workstreams.	Kevan Taylor Sheffield Health & Social Care Foundation Trust	Apr-15	
Dementia Strategy Update	Minutes from the meeting on 15th October request an update on the dementia strategy in 6 months, to include information on prevention.	Sarah Burt, Senior Commissioning Manager, NHS Sheffield CCG.	Apr 2015	
NHS 5 Year Forward View – NHS Sheffield CCG response	Update on Sheffield's response to the NHS 5 Year Forward view.	Tim Furness, NHS Sheffield CCG	Apr 2015	
Update on the transition from residential to supported living in the learning disability service (minutes 17/12/14)	To receive an update on how the transition has gone, to include comments from service users, families and the independent advocacy service	Joe Fowler, Director of Commissioning	Apr 2015	

Date TBC				
Update on the development of a voluntary code of conduct for supported living (minutes 17/12/14)	To receive a progress report on developing the code.	Joe Fowler, Director of Commissioning	June 2015	
Alternatives to A&E Services in Sheffield	Understand what the alternatives to A&E in Sheffield are and how they are being promoted.			
End of Life Care – access to services.	Update on the work and action plan undertaken by Public Health to identify whether certain groups and communities have difficulty in accessing services.	Marianna Hargreaves, NHS Sheffield CCG	June 2015	
A Guide to Health Scrutiny in Sheffield	Presenting the final draft health protocol for approval by the Scrutiny Committee.	Cllr Mick Rooney, Chair	tbc	
Transitions within the CAMHS service	There was a recommendation in the CAMHS Working Group Report to include this topic on the work programme for 2014-15.	Anthony Hughes (CYPF), Tim Furness (CCG), Steve Jones (SCH)	tbc	

Commissioning Primary Care	Minutes from 17th July 2013 the Scrutiny Committee identifies the need for discussions with the National Commissioning Board's Local Area Board regarding GP practices in the City, including the numbers, location and skill mix." Public Question – 17th Dec 2014 re NHS England's approach to commissioning GP Services.	tbc	tbc	
SHSCFT - how patients with specific needs are supported when they are admitted to adult acute care at the Teaching Hospitals	The governors have asked if Scrutiny could look into how patients with specific needs are supported when they are admitted to adult acute care at the Teaching Hospitals. They have identified people with dementia, significant mental health issues, learning disabilities, deafness and blindness. They are particularly interested in how a person's level of need is firstly identified and then how the Trust assures itself that this need has been met	Sam Stoddart Membership Manager	tbc	

Sheffield Adult Safeguarding Partnership	15th January 2014 6.4 (c.) (iiii) Susan Fiennes shares details of any steps taken to improve safeguarding procedures, in the light of the Winterbourne Care Home case, with Members of this Committee when available	Sue Fiennes, Simon Richards	June 2015	
Briefing Papers				
Sheffield Adult Safeguarding Partnership - Annual Report 2012/13	Minutes from15th January 2014, the Committee requests that the Sheffield Adult Safeguarding Partnership (iii) provide a progress report to the Committee on a quarterly basis.	Simon Richards, Head of Quality & Safeguarding & Sue Fiennes, Independent Chair	(April 2014) July, Oct 2014, Feb 2015	
Update Report on developing a Social Model of Health/ Health Communities Review	Minutes from 19th March 2014, That the Committee:- 8.4 (c) "requests that a written update report on progress with the Social Model of Public Health/Healthy Communities Review be included on the agenda for each future meeting of the Committee"	Chris Nield, Consultant in Public Health.	(April 2014) July, Oct, Dec 2014, Feb & April 2015	
Task & Finish Work				

CAMHS Working Group	Report finalised and response received. Awaiting Submission to Health and Wellbeing Board	Emily Standbrook-Shaw, Policy and Improvement Officer		
Nutrition & Hydration Working Group	Report finalised, awaiting response from Trusts	Emily Standbrook-Shaw, Policy and Improvement Officer	Oct 14	
Joint Health Overview and Scrutiny Committee – Cardiac Services	Work ongoing, meetings arranged throughout October and November to hear evidence.	Led by Leeds City Council		A JHOSC response to the consultation on Congenital Cardiac Services was submitted in December 2014.

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Report to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
February 2015

Report of: Dr. Jeremy Wight (Director of Public Health)

Subject: Update Report on Developing a Social Model of Health / Healthy Communities Programme Review

Author of Report: Chris Nield (Consultant Public Health)

Summary:

Following the 'call in' of the Developing the Social Model of Public Health report and the attendance of the Head of Health Improvement and Councillor Mary Lea at the extraordinary meeting on 5/11/2013, the meeting requested a follow up report be provided to include an implementation plan, targets for the work and how outcomes will be measured. A report was submitted in March 2014.

The March Committee requested that a further report be given at their meeting in July 2014. A written report was presented to the Committee meeting on 23 July 2014.

This is a follow-up report to update the Committee on the current progress and implementation of the Social Model of Public Health and the review of the Healthy Communities 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	**X**
Briefing paper for the Scrutiny Committee	**X**
Other	

The Scrutiny Committee is being asked to:
The Committee is asked to consider the proposals and provide views, comments and recommendations.

Background Papers:

Cabinet report October 2013 Developing a Social Model of Public Health

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Healthier Communities Programme and Developing the Social Capital Commissioning Strategy Report (July 2014)

Category of Report: OPEN

Report of the Director of Public Health

Progress Report on Developing the Social Model of Health

1. Introduction/Context

The report presented to the July meeting provided a summary of progress with implementation of the Social Model of Health and provided further information, in particular;

i. The Healthy Communities Programme is now the Community Wellbeing Programme
ii. Clarified the aim of the Community Wellbeing Programme (CWP) and new emphasis on Social Capital
iii. Endorsed social capital as a way of working in sustaining and providing interventions which improve health and wellbeing
iv. Explain how effectiveness of the programme will be measured through developing a Evaluation Framework with a university partner
v. Reported on the discussions with Commercial Service and the procurement procedure with new contract expected to commence April 2015
vi. Acknowledged the need to create flexibility within new contracts to align investment with the model emerging from Integrated Health and Social Care (IHSC) Strategy including the Keeping People Well at Home work stream.

Committee members were keen to ensure that the procurement process was open to a range of providers and barriers for small providers were addressed.

Since July 2014 there have been a number of factors that have impacted on the procurement of the new CWP Commissioning Strategy and implementation of the Social Model of Health.

2. Developments since July 2014

2.1 Further discussion took place with Commercial Services, including how to open up the procurement process to all providers, including small organisations. Plans were put in place to include information workshops for potential providers and to encourage joint applications. It was proposed that the specification should recognise the local knowledge and experience held by community organisations.

2.2 The new Cabinet Member for Public Health resulted in further discussion about implementation of the review and new commissioning strategy.

2.3 It was recognised that there was a need for further investment in community development to build the necessary infrastructure in some of the neighbourhoods which form part of the CWP. As an interim measure, existing larger Providers would be asked to consider how they can support community infrastructure in the relevant neighbourhoods.

2.4 In September 2014, the procurement timetable was amended following a query from Commercial Services. The original Cabinet Report (October 2013) did not include appropriate delegated responsibilities. Further guidance from Democratic Services, Legal and Governance advised that a new report would need to go to cabinet for approval of the required delegated responsibilities to proceed with procurement of the new commissioning strategy.

2.5 The Integrated Health and Social Care agenda was moving forward with clear recognition the CWP - Health Trainers, Health Champions and the neighbourhood based programmes - were essential ingredients to this model and associated work streams including Keeping People Well at Home.

2.6 Developing a community based preventative model, community engagement, identifying and using local assets are key principles of the proposed Commissioning Strategies. The commissioning strategies concerned cover the CWP the Area Based Programmes, Health Trainers and Health Champions. The funding for these programmes is now part of the Integrated Health and Social Care pooled budget

2.7 The CWP offers a distinct approach in working with priority neighbourhoods with the poorest health outcomes. This is a community based approach working with local groups to develop skills and knowledge which should complement and enhance the individual focus of the adult social care.

2.8 In order for a new report to be submitted to the Cabinet a draft report was prepared for EMT in October. Further questions were raised including measuring the impact, value for money, consideration of budget reductions and links with overarching Integrated Health and Social Care Strategy.

2.9 There was a growing concern from CWP Providers around the length of their current work programmes and implications for staff employed by Providers.

3. Current Situation

3.1 EMT decided that the CWP will be commissioned as part of the overall IHSC Commissioning Strategy. In order for this to happen it is proposed that a 12 month extension with contract variations is put in place for existing Providers (April 2015-March 2016).

3.2 In order to make more resource available from the ring fenced Public Health Grant to support the wider Council budget, a 5% reduction is proposed for the CWP and the Community Health Champions. The Health Trainers budget was protected as the funding is provided by the CCG.

3.3 Discussion have taken place with all the CWP current Providers to discuss the Equality Impact Assessment of the proposed 5% cut, the 12 months extension and contract variation requirement to develop and sustain social capital as a way of improving health and wellbeing.

3.4 Providers have supported the proposal for a CWP Providers Hub and the first meeting will take place before the end of March.

3.5 Work is continuing on the new Evaluation Framework in conjunction with Sheffield University and Sheffield Hallam University. Over the next 12 months we will work with Providers to co-design and develop the evaluation framework. This approach to evaluation will ensure that organisations have the capacity and skills to routinely monitor activities and outcomes and standard approaches to collecting activity are in place. A robust evaluation framework as part of the new Commissioning Strategy will provide a strong evidence base for progressing and further developing this work in future years.

3.6 There will also be opportunity for the new evaluation tools to be used in other SCC projects and programmes

4. Community Wellbeing Programme and the Integrated Health and Social Care Agenda

4.1 The Community Wellbeing Programme will be one of the stands of work in the wider IHSC Commissioning Strategy. This values the contribution that the CWP can make in achieving the overall outcomes. It has a particular role in developing social capital at individual, organisational and community level.

4.2 The Community wellbeing strand in the roll out of the IHSC model needs to maintain a clear and distinct focus on developing the Social Model of Health, the social capital approach to improving health and wellbeing and challenging health inequalities

5 What does this mean for the people of Sheffield?

5.1 The aim of the Social Model of Health implementation is to ensure maximum health impact of Public Health investment and contribute to a reduction of health inequalities. This model reflects the Members views that Public Health is affected by factors beyond individual behaviours and seeks to better integrate this community based public health work into existing City-wide support infrastructure.

5.2 A 12 month extension of existing contracts will ensure continuity of community based health interventions working within neighbourhood with the poorest health outcomes.

5.3 Developing the new Commissioning Strategy as part of the IHSC strategy will ensure a joined-up approach in developing asset based community development and achieving shared outcomes.

6. Recommendation

6.1 The Committee is asked to consider the progress in the implementation update of the review of the Community Wellbeing Programme

6.2 Recognise the distinct strand of work that will be delivered through the CWP as part of the IHSC Commissioning Strategy

6.3 Provide views and comments.

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
25th February 2015

Briefing Paper of: Sheffield Adult Safeguarding Partnership

Subject: Business Plan Update

Author of Report: Simon Richards, Head of Quality and Safeguarding

Summary:
As requested, a quarterly update on the Adult Safeguarding Business Plan is submitted to the Committee.

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:
Consider the update and request further information if required.

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SASP 2014-15 Business Plan: Update Jan-15

Introduction

Each year, SASP Executive Board develops and agrees a business plan setting strategic direction and key outcomes, and connecting these to the council's vision and wider objectives, and matters of national strategy. Members are sufficiently senior in their organisations to influence, lead and support the implementation of the Business Plan and its further development.

Vision Statement

People of Sheffield are able to live a life free from avoidable harm, in communities that

- *do not tolerate abuse,*
- *work together to prevent abuse occurring*
- *know what to do when abuse happens'*

Core objectives and outcomes for 2014-15:

1. Implement an effective Performance Framework and use data and information to improve safety and practice quality
2. Improve the Quality of safeguarding practice, ensuring consistent standards across the partnership
3. Respond to improvement drivers (local and national) ensuring learning is embedded in practice, strengthening of risk mitigation and to ensure partnership working is effective
4. Deliver the Equalities Action
5. Promote public awareness of safeguarding being everyone's business

Key	**G/C**	completed
	G	Performing well / No concern - No further action needed
	A	Slightly off track / Minor concern - Active management needed
	R	Significantly Off track / Major concern - Escalation needed

Key Outcome 1: Implement an effective Performance Framework and use data and information to improve safety and practice quality			
step	What we will do	Update: Jan-15	RAG
1.1	Interrogate data and information presented to interpret apparent inconsistencies and trend	Quarterly report draws together routine statistical data to develop an over view of trend and evidence what's really happening. Data confirms there has been no significant change over the past 20 months in the characteristics of individuals at risk of abuse or nature of abuse. . Performance around timescales and the backlog of open overdue cases remain a concern: Interim Head of Care and Support has put in place a range of initiatives to strengthen leadership message, improve accountability and efficiency. Benchmarking data is reported in the SASP Annual Report using national statistical data to place Sheffield. Performance Indicators Task and Finish group meetings: Acceptance that some alerts do not meet threshold, benefit of reporting is that concerns are logged and visible. Narrative to support and explain data will be developed via Operational Board. Exception reporting, by agreement, back to Executive Board from 2015-16. **Completed**	G
1.2	Seek additional information to verify and explain when things are starting to go wrong so that we can act promptly to safeguard people	Partners have been asked to look ahead and share local intelligence to help predict emerging areas of risk and opportunity. 'Horizon scanning' allows us to consider priorities already identified in the 2014-15 Business Plan, and strengthen our ability to respond to the future challenges that we are likely to face. South Yorkshire Police (SYP) presented a draft Information Sharing Agreement to Sep-14 Operational Board: its purpose is to agree a formal information exchange between SYP and social care services, to assist working together to protect adults at risk, and provide a framework for action. The agreement aims to adopt a partnership approach to ensure policies and practice of agencies assist collaboration. The agreement includes Barnsley, Rotherham, Doncaster and Sheffield social services. Prevent / Channel strategy brief presented to Jun-14 Operational Board.	G

		Outcomes from Board Development event held Dec-14, includes key issues to address and develop in 3 year Strategic Plan Trading Standards have drafted a paper setting out a range of interventions to be implemented in 2015-16, and will be reported to the Operational Board for approval (date not yet agreed)	
1.3	Accepting there is no single system that allows us to easily report and analyse concerns that do not meet the Safeguarding threshold, share local intelligence to describe activity, themes and trends. Use this to help predict emerging areas of risk and opportunity	We know our local demographic continues to change, and use of face-to-face and telephone interpreting services 2013-14 (SCC contract) is a helpful source of intelligence to help target and direct support to vulnerable groups. This will inform our Equalities Action Plan, to promote awareness and access to information. Independent Chair of Adult Safeguarding presented a recommendation to Sep-14 Operational Board, seeking support to report ongoing initiatives and campaigns taking place across partner organisations that influence and perhaps go beyond key priorities of the 2014-15 SASP Business Plan. It was agreed quarterly updates will be reported into Operational Board, commencing Nov-14. Issues of concern, to be escalated by agreement to the Executive Board to facilitate a co-ordinated response. Commissioned services continue to develop risk framework – update report presented to Nov-14 Executive Board **Note: Amber status recognises there is no single system to collate concerns**	A
1.4	Ensure safeguarding workers have access to appropriate legal and professional advice to support risk management We monitor and report: • Use of Mental Capacity Act, analyse usage and identify areas for concern • Case advice response times, analyse usage and identify areas for concern	In line with national developments, Sheffield is experiencing an unprecedented rise in the number of DOL referrals from hospital and residential settings: The Supreme Court (Cheshire/West case) has clarified that a far greater number of people require an assessment and this has a significant additional extra cost. A briefing was presented to Jun-14 Operational Board. Operational Task Group established, including CCG, Legal Services and Director of Care and Support (SCC) to manage operational risk and provide governance assurance to SASP. Note: SASP Executive Boards role is to assure risks are mitigated as much as possible. SASP approved 50K additional funding (2014-15 only) to support additional cost pressures.	A

	• Deprivation of Liberty (DOL) These measures will feature as components of the performance, provide assurance that workers know where to access advice, and help identify 'cold' spots	Operational Board will oversee DOL action plan – report due Feb-15. **Note: Amber status illustrates demand/capacity.**	
Key Outcome 2: Improve the Quality of safeguarding practice, ensuring consistent standards across the partnership			
step	What we will do	Update: Jan-15	RAG
2.1	Quality assure Safeguarding process stages - Alerts, Strategy, Investigations via planned audits	Independent Chairs to seek more face-to-face feedback from service users about feeling safer, and the safeguarding process: this approach helps to embed the principles of Making Safeguarding Personal and improve outcomes for the service user. Promote Risk approach to balance the wishes of the person, in the most practical way. A temporary additional Safeguarding Development manager has been appointed to undertake quality assurance audits into decision making throughout the safeguarding pathway. An over view of themes is being collated, and will be used to improve performance: initial findings include 'inappropriate' alerts are made, and we accept some tolerance as evidence we are meeting the expectation of CQC. Key areas of development to focus on outcomes for service users, and promoting effective interface of a range of support services. Report and recommendations via Operational Board	A
2.2	Continue to link all sources of intelligence to inform Risk management in safeguarding	South Yorkshire Police have appointed a Safeguarding lead. Simon Richards attended Housing Services Managers meeting Jul-14 to champion and raise profile of Safeguarding: about 42,000 council properties are managed. ASB intelligence will improve identification of hotspots and possible links to safeguarding concerns. CE working with Safer Neighbourhoods manager to evaluate PRAM data. With the support of SCC and SYP increase the number of registered Sheffield Safe Places and make sure these are based in areas where people need them the most: demonstrate that partially hidden and under reported issue of crime and harassment targeting disabled	G

		people is effectively addressed. Safeguarding Adults at Risk Audit Tool implemented in Jun/July. A review of the relationship between VAP and PRAM panels and their interface is progressing. Associate Designated Nurse Safeguarding Adults is leading work to share public health data mapping, to help reveal hotspots. . New learning from SCR is embedded into training and development materials. The Jay Report raised public awareness of Child Sexual Exploitation – Sheffield response is currently being managed. SASP business plan approved resources to undertake research work into reducing the risk of 18-25 year old: impact on Sheffield CSE Service has contributed to this work being delayed.	
2.3	How good is safeguarding in care homes and how can it improve	Service contracts promote core values of independence, safeguard people's dignity & respect. Recent changes to the way serious incidents are reported and monitored will improve the screening of complaints. SCC Head of Strategic Commissioning and Partnership (Communities) presented to the Nov-14 Executive Board. A review of Quality in Care Boards has been completed and confirmed KPIs were sufficient. SF advised routine reporting of actions arising from the review will be via SASP Operational Board. A temporary part time resource works from the Adult Safeguarding Office to embed understanding and use of the Mental Capacity Act and DOL, and to promote care that is compliant with the legislation and the least restrictive. Evaluation to date indicates that the training and follow up is supporting changes in practice, however a number of care providers have not yet engaged in the initiative.	G

Key Outcome 3: Respond to improvement drivers (local and national) ensuring learning is embedded in practice, strengthening of risk mitigation and to ensure partnership working is effective

step	What we will do:	Update: Jan-15	RAG
3.1	Seek and receive assurance that outcomes relevant to Adult Safeguarding are progressed in a timely and effective manner • Winterbourne View • Francis Report • Cheshire/West	A verbal update from Kevin Clifford (NHS Sheffield CCG) about local implications of the Winterbourne View reports was given to the June-14 Exec Board. Assurance was given about governance arrangements SF updated Nov-14 SAB.: a recent national report suggests that sufficient progress has not been made. SF suggested a formal report be submitted to the Executive Board, The Supreme Court ruling has significantly reduced the threshold for DOLS and for the first time brought individuals in supported living accommodation into the scope of the legislation and people who are in receipt of 24 hour home care packages. It does not impact on people eligible for or subject to detention under the Mental Health Act. The Board reiterated this is a national issue and are awaiting a more structured national response. In the meantime all agencies must • minimise the likelihood of having to apply for DOLS • what can be done in practise to reduce the number of people who need DOLS. Best Interest Assessor resource released from NHS Sheffield for an interim period, building capacity to respond to the pressures in the short/medium term and to examine how longer term solutions can be developed effectively.	G
3.2	Ensure SASP is able to implement Care Act 2014	A briefing was presented to Jun-14 Exec Board, Implementation Project Team established, and public consultation closed on 9 July. Work is progressing and actions include: • Local implementation project • Initial review of guidance is positive – more detailed work to follow • Respond to consultation on draft guidance SR and CE completed initial RAG matrix testing readiness. Nov-14 SASP agreed Board members to nominate attendees. Priorities should be to scope the work needed and identify how best to manage it going forward.	G

Key Outcome 4: Deliver the Equalities Action Plan and continue SASP commitment to 'Manifesto for Change' in			
step	What we will do:	Update: Jan-15	RAG
4.1	Encourage, guide and monitor progress of Safe In Sheffield project to reduce disability related harassment and abuse of vulnerable adults	Heeley City Farm commissioned to continue work into 2014-15. The Scheme aims to support people with learning disabilities who may be lost, ill or frightened and to provide a temporary refuge where they can get help. There are currently about 100 registered places. Staff or volunteers who offer a safe place are given disability awareness training and are advised how to spot those suffering from hate crime or prejudice. All the venues are approved by police SHSCT register indicates there are about 3800 people with Learning Disabilities in Sheffield, and about 1700 have a care package. Sheffield Safe Places is now recognised regionally as a great example of this type • provides an increased support network of 3rd party reporting points, in public places, despite austerity measures • SASP commitment and endorsement helps evidence public authorities are progressing and meeting their Equality objectives in respect of safeguarding and disability-related harassment • Sheffield Hallam University show case event in Jan-15	G
4.2	Improve our understanding of the circumstances and motivations of perpetrators, and embed learning in training front line staff and partners in how to recognise and treat disability-related harassment	Safe In Sheffield action plan includes the production of Case Studies and use as part of publicity and training, to engage and empower volunteers. SCC Head of Neighbourhood Intervention and Tenant Support to consider how to support this scheme further, and utilise existing networks of housing providers and forums. This will improve the interface between agencies to identify and resolve persistent cases of anti-social behaviour and harassment, taking into account the vulnerability of the victim	G
4.3	Review of existing data to produce a	Continuation of developmental work started in 2013/14 to gain a better understanding of the	

	map analysis for Safeguarding in Sheffield, and build on analysis to construct a model against which levels of types of Safeguarding activity and outcomes can be effectively assessed	level of abuse across Sheffield will continue. First drafts produced; need to develop into postcode (occurrence and headcount) to protect confidentiality. Information from South Yorkshire Police (ASB reports) and safeguarding alerts used to identify geographical area to establish new Safe Places, and where these were needed the most.	A
4.4	Implement actions from the Equalities Workshop to improve access to services, and engagement with Adult Safeguarding across all communities in Sheffield	Enquiries by midwifes and health staff to identify incidents of domestic violence with regards to any additional vulnerabilities staff consider whether domestic abuse or safeguarding referral is required North Primary Care Locality has commissioned a piece of work aimed at support GP practices manage patients with Learning Disabilities and want to share the findings practices in the city. Please see attached documentation that highlights where practices can make reasonable changes to their systems and process in order to support this patient cohort. Work in progress with Public Health consultants to map incidence of abuse across Sheffield to inform targeted work SASP 2015-18 Strategic Plan to include updated equalities plan, progress reports to Operational Board.	A
Key Outcome 5: Promote public awareness of safeguarding being everyone's business			
step	What we will do:	Update: Jan-15	
5.1	Run a campaign to improve awareness and confidence as Safeguarding being an effective way to protect people at risk	Safe in Sheffield Scheme promoted during Learning Disabilities Week Jun-14, and includes actions to establish and develop effective relationships with Sheffield Community Council for Church Care (SCCCC), Dementia Alliance and other support groups SASP Exec Board endorsed the decision by SCC to engage with the Making Safeguarding Personal agenda (led by LGA). Representatives from Sheffield attended a workshop in York (29 Sept) to better understand the key principles of shifting safeguarding a process, to a	G

		commitment to improving outcomes alongside people, to developing a real understanding of what people wish to achieve. key issues to consider are: • How we engage practitioners in changing their responses to safeguarding • Balancing risk with the views of the person • Mental capacity issues and duress • Ensure advocates are available to people in safeguarding • How we will engage customers and customer groups to empower them to take on this role Cath Erine to produce action plan, and report via Operational Board.	
5.2	Target campaigns	Safe In Sheffield Scheme extended and promoted to engage key Mental Health (under 65) Adult Dementia and Brain Injuries service providers to help expand the support of this scheme, and improve the response to vulnerable adults. Outcomes from Customer Forum meeting held in Aug-14 include the routine reporting back from Operational Board, and that a standing item 'Customer Board Feedback' is included in the Operational Board agenda. SASP agreed to support a scoping exercise into how young adults at risk of sexual exploitation are supported: work commissioned, but impact of Jay Report on Sheffield CSE Service has unavoidably delayed this specific action. SASP to ensure learning and key messages from SCR and DHR are highlighted, and internal training updated. Action Plans routinely reported to Operational Board, lack of engagement or progress will be escalated to Exec Board for resolution. A total of 21,544 Home Safety Checks were carried out across South Yorkshire in 2012-13, 17,384 were for those considered to be most vulnerable e.g. households where the occupants are very young or elderly, are disabled have mobility problems and/or lifestyle increases the risk of fire. 4,182 referrals for the latter came from our partners and our Vulnerable Persons Advocate continues to deliver Fire Safety talks and presentations to professionals and service user groups e.g. Falls Prevention Group.	G