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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 12 September 2012 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, Janet Bragg, Roger Davison, Tony Downing, Adam Hurst, Cate McDonald, Denise Reaney, Peter Rippon, Jackie Satur, Diana Stimely, Garry Weatherall and Joyce Wright.

Sheffield Local Involvement Network
Anne Ashby, 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, or you can ring on telephone no. 2734552. 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. Please see the Council's website or contact Democratic Services for further information.

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If you require any further information about this Scrutiny Committee, please contact Emily Standbrook, Scrutiny Policy Officer on 0114 27 35065 or email emily.standbrook@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
12 SEPTEMBER 2012

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

5. **Minutes of Previous Meeting**
   To approve the minutes of the meeting held on 18th July 2012.

6. **Appointment of Deputy Chair**
   To appoint a Deputy Chair for the municipal year 2012/13

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

8. **Joint Health and Wellbeing Strategy**
   Louisa Willoughby (Commissioning Officer, Sheffield City Council), Laurie Brennan (Policy Officer, Sheffield City Council) and Tim Furness (Sheffield PCT) to report

9. **Transforming Support for People with Dementia who live at Home: An Involvement Exercise**
   Julia Thompson (Strategic Commissioning Manager, NHS Sheffield) to report

10. **Child and Adolescent Mental Health Services (CAMHS) Update**
    In attendance for this item will be-

    Tim Furness (NHS Sheffield)
    Kate Laurance (NHS Sheffield)
    Dr. Steve Jones (Sheffield Children's Hospital NHS Foundation Trust)
    Shona Ashworth (Sheffield Children's Hospital NHS Foundation Trust)
    Jon Banwell (Sheffield City Council)

11. **Work Programme**
    Report of the Scrutiny Policy Officer

12. Dates of Future Meetings

To note that future meetings of the Scrutiny and Policy Development Committee are to be held on Wednesdays 17th October and 21st November 2012, and on 16th January, 20th March and 8th May 2013, all at 10.00 am in the Town Hall.

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

A new Standards regime was introduced on 1st July, 2012 by the Localism Act 2011. The new regime made changes to the way that your interests needed to be registered and declared. Prejudicial and personal interests no longer exist and they have been replaced by Disclosable Pecuniary Interests (DPIs).

The Act also required that provision is made for interests which are not Disclosable Pecuniary Interests and required the Council to introduce a new local Code of Conduct for Members. Provision has been made in the new Code for dealing with "personal" interests.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously, and has been published on the Council's website as a downloadable document at -http://councillors.sheffield.gov.uk/councillors/register-of-councillors-interests

If at all possible, you should try to identify any potential interest you may have before the meeting so that you and the person you ask for advice can fully consider all the circumstances before reaching a conclusion on what action you should take.

Further advice can be obtained from Lynne Bird, Director of Legal Services on 0114 2734018 or email **lynne.bird@sheffield.gov.uk**

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE

Meeting held Wednesday 18th July 2012

PRESENT: Councillors Mick Rooney (Chair), Garry Weatherall, Clive Skelton, Janet Bragg, Jackie Satur, Katie Condliffe, Sue Alston, Cate McDonald, Joyce Wright, Antony Downing and Adam Hurst.

Non-Council Members (LINK)
Anne Ashby and Helen Rowe

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1. **WELCOME AND HOUSEKEEPING ARRANGEMENTS**

1.1 The Chair welcomed attendees to the meeting and explained housekeeping and fire evacuation procedures.

2. **APOLOGIES FOR ABSENCE AND SUBSTITUTE MEMBERS**

2.1 There were no apologies for absence from Members of the Committee.

3. **VOTE OF THANKS**

3.1 The Chair extended his gratitude towards all former Members of the Committee from the Municipal Year 2011/12 for their hard work and success achieved throughout the year.

4. **DECLARATIONS OF INTEREST**

4.1 Councillor Katie Condliffe declared an interest as she worked for a private mental health care provider.

5. **MINUTES OF PREVIOUS MEETINGS**

5.1 The minutes of the meetings held on 16th and 30th April and 16th May 2012, were approved as a correct record, subject to an amendment in paragraph 8.3 of the minutes of the meeting held on 16th April 2012, to replace the word ‘morality’ with the word ‘mortality’.

6. **PUBLIC QUESTIONS AND PETITIONS**

6.1 **Public Questions**

1. Sylvia Parry asked whether it would be possible for Community Assemblies to commission a report upon care for elderly people in each Community Assembly area, for this report to then be considered by the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee as an item for the Work Programme,

and the Chair said that this would be considered.

2. With regard to Extra Care Housing, Sylvia Parry asked whether there was sufficient work taking place to ensure that joined up thinking was happening between each Community Assembly area, and in response Miranda Plowden, Director of Commissioning, stated that there were already several good news stories with regard to provision of new sheltered housing, for example at Stocksbridge with 50 new flats being built at Newton Grange, and she added that the model of care in each Community Assembly area was now that of virtual extra care and that members of the public would be consulted as part of the process.

3. With regard to a meeting to be held on 25th July 2012, at The Venue, Stocksbridge, at 7.00 pm, it was confirmed that Councillor Garry Weatherall would attend this, as it related to the new housing in the Stocksbridge Ward.

7. **HEALTH, WELLBEING AND CARE IN SHEFFIELD**

7.1 The Committee received presentations from key representatives of Health and Social Care organisations in the City to introduce Members to their organisations, and provide an overview of their priorities and challenges for 2012/13.

Communities Portfolio

7.2 Miranda Plowden, Director of Commissioning, reported to the Committee about the work of the Communities Portfolio. She provided an overview of the areas covered by the Communities Portfolio commenting that the work of the Portfolio was to make a contribution to the wellbeing of the people of Sheffield by working with individuals, families, households, communities and partner organisations. Work was underway to help to build safe, strong and active communities and to ensure that good quality housing and housing services were available for all. Work was also underway to ensure that people had access to the information they required in order to lead fulfilling lives and that they were able to be independent, healthy, safe and well.

7.3 Ms. Plowden provided an overview of the Care and Support Team, the Community Services Team, the Commissioning Team and the Business Strategy Unit, and detailed the work undertaken by each of these sections. She also detailed the development of the Fairness Commission, whose remit was to make a non-partisan strategic assessment of the nature, extent, causes and impact of inequalities in the City and to make recommendations for tackling them. She also spoke briefly about the proposed Government Welfare Reforms which could have potential impacts upon Housing Benefit, Council Tax support, Incapacity Benefit and other such taxes and credits. There was particular impact potentially for Communities' customers, vulnerable adults and families.

7.4 She went on to detail some milestones for the year ahead which included managing change in provision for extra care housing and dementia support, the rolling out of self directed support and re-ablement, the Active Ageing Strategy, the Right First Time initiative, and changes to the NHS which would affect all areas of the Portfolio. She added that a reduced budget was also a major challenge for the whole Portfolio.

7.5 Ms. Plowden spoke briefly about homelessness in the City, commenting that there was an increased level of homelessness, potentially due to the recession, but that there were no families in bed and breakfast accommodation at present, which was a positive thing for the City. However, greater preventative work needed doing to ensure that people did not become homeless in the first place.

7.6 Following on from the theme of prevention, Ms Plowden outlined a great number of initiatives which were being developed in order to make an impact on early intervention work to prevent people from needing to access services, and to ensure independence and quality of life. The Right First Time initiative was all about preventing long stays in hospital and preventing emergency admissions, by investing in early intervention work to reduce the number of people requiring long-term residential care.

7.7 Ms. Plowden outlined other reviews which would take place over the year, including the Lettings Policy Review, a review of Community Assemblies and Libraries, and a joint review with South Yorkshire Police regarding anti-social behaviour. There would also be the arrival of the Police and Crime Commissioner in April 2013. Ms. Plowden added that Asylum Support was now being delivered by the company G4S, and no longer was delivered in-house by Sheffield City Council. She added that there were ongoing concerns around the standards of some private rented housing across the City.

7.8 Ms. Plowden reported to Members that it was essential to 'future-proof' the City in order to improve the experience for a growing older population.

7.9 The Chair thanked Ms Plowden for her presentation, and answers were provided as follows to Members' questions:-

- It was noted that the Sheffield LINK had not been formally approached for involvement in the Dementia Care reform review, and it was agreed that Ms Plowden would pick this up.

- Members were concerned about how care contracts and quality of care would be monitored if care contracts were given out to independent providers through the personal budget scheme. In response, it was noted that each personal budget would be risk assessed before implementation, and that a list of recognised providers was provided for each person whilst designing their personal

budget. All personal care was also continually assessed for quality.

- It was noted that there were better links now taking place at Howden House First Point Reception with regard to homelessness and signposting for people suffering from mental health problems, as these two issues were often very closely linked.

- It was hoped that the Committee would have an input into the following reviews – Welfare Reforms, Housing Review and Anti-Social Behaviour Review.

Public Health

7.10 Jeremy Wight, Director of Public Health, then addressed the Scrutiny Committee regarding the new arrangements for Public Health in Sheffield. He reported on some of the key aims of the coalition Government, which were to empower local leadership, to strengthen health and wellbeing, support self esteem, increase confidence and personal responsibility, promote healthier behaviour and lifestyles and to change the environment to support healthier choices and protect the public from threats to their health.

7.11 Dr. Wight outlined the reforms which would see Public Health brought back under the responsibility of the Local Authority and he outlined Local Authority commissioning responsibilities, indicating which ones were mandated services. He reported that the new functions of Local Government would be to have a duty to improve the health of the population by commissioning services from a range of providers, working with a Clinical Commissioning Group to integrate care pathways, using the Health and Wellbeing Board to integrate commissioning approaches, providing population healthcare advice to the NHS, and ensuring that plans were in place to protect Public Health.

7.12 He added that local political leadership was critical in order to make this work. He went on to detail local leadership for health protection in that the Secretary of State would be responsible for health protection via a body called Public Health England. Public Health England would have three main functions - delivering services, leading for public health and supporting the public health workforce.

7.13 Dr. Wight then outlined the timeline for transfers from NHS to Local Authority and he commented that January 2012 had seen the local transition plan completed, and local area test arrangements for delivery of specific public health services would be in place by October 2012. The final legacy of handover documents was to be produced in January 2013. Local Authorities would then formally take on responsibilities by April 2013. Dr. Wight reported that in Sheffield there was a long history of joint working to build on already and that a hub and spoke model had been agreed, which would include the allocation of specific public health functions to various

City Council Portfolios. A number of NHS staff would also transfer over to Sheffield City Council.

7.14 He outlined the ring-fenced resources which would be transferred from the NHS to the Local Authority to ensure the effective deliverance of this work. Dr. Wight added that he saw many positives in the proposed changes, in that Sheffield City Council already had an influence over some key areas which directly impacted on health, such as Adult Social Care, Children and Young People's Services and Housing. He added that the Health and Wellbeing Board was already meeting in shadow form and that a budget of £28m would be transferred from the NHS to the Local Authority in order to continue the commissioning work.

7.15 With regard to Public Health England, it was noted that Duncan Selby had been appointed as Chief Executive, and that Mr. Selby was in the process of creating a structure which would ensure effective delivery of services, including specialist commissions, although full details of this were still be to confirmed. There would be a focus across all this work on reducing health inequalities. It was noted that relevant NHS staff would transfer to the Local Authority by April 2013.

7.16 Dr. Wight outlined a positive development, in that the boundaries of the Clinical Commissioning Group and Sheffield City Council were to be the same which would ensure that all Portfolios within the Council would assume some responsibility for Public Health.

7.17 Members felt that more work needed to take place with regard to GP referrals for people from deprived areas of the City, to ensure that health problems were identified earlier rather than later.

7.18 It was noted that Primary Care Trusts (PCTs) would no longer exist under the new arrangements, and that GPs would instead form a new Clinical Commissioning Group. The NHS Commissioning Board would have the same role as the PCT in that it would be a primary care and specialist care provider responsible for GPs.

7.19 Members asked how medical adverts and campaigns were commissioned, and Dr. Wight replied that most of these were commissioned nationally and that there was not enough money to commission such campaigns locally. With regard to vaccinations, it was noted that these programmes would not change, but that Sheffield City Council would be responsible for holding the NHS Commissioning Board to account to confirm that vaccinations and screening was taking place as agreed.

7.20 With regard to dental health, it was noted that all clinical dental services would be under the control of the Local Authority, as would programmes such as proposed fluoridation of water, for example.

7.21 Dr. Wight commented that he was not sure who the Health and Wellbeing

Board would be accountable to.

7.22 At Members' request, with regard to the Annual Health Report, Dr. Wight commented that it would be possible in future years to breakdown statistics by Community Assembly area.

Sheffield Children's Hospital Foundation Trust

7.23 John Reid, Director of Nursing and Clinical Operations, Sheffield Children's Hospital Foundation Trust, then addressed the Committee to report upon the progress and performance of the Children's Hospital during 2011/12. He outlined the five main aims of the Children's Hospital which were to provide healthcare for children of the highest quality in the UK, reshape healthcare in Sheffield, develop specialist services, expand specialist pathology and to be a national leader in research and education.

7.24 He commented that progress had been made against the main aims during 2011/12, but that there was still work to be done. He added that the Trust was responsible for all aspects of children's health, apart from GP services. The remit of the Children's Hospital did cover children and young people mental health services and school nurses. He commented that any surplus revenue to the Trust was ploughed straight back into capital build to expand and improve facilities at the Hospital. He reported that there had been successes in that there had been no cases of MRSA in the Hospital over the 2011/12 period. There had also been advancements in technology with regard to neurosciences, and the Children's Hospital was a national leader in the UK for the study of brittle bones.

7.25 There were ongoing issues around parents bringing children to the Children's Hospital Accident and Emergency (A&E) instead of taking them to a GP surgery, as parents felt that their children could be guaranteed to see a GP within four hours. This created 'peak times' before and after school, which were challenging to manage. Although it was beneficial for parents to have their children seen by a doctor at A&E, the doctor on shift did not have access to the history of the child's medical records as a GP would.

7.26 Mr. Reid commented there was now a new facility called Becton Lodge which dealt with children with complex needs and learning difficulties. This pioneering centre lead developments with behavioural problems with learning difficulties in children and dealt with these issues at an early stage. Sheffield was also leading in genetics work around the prediction of certain diseases in new born children.

7.27 Mr. Reid went on to outline plans for future Hospital development, which would include increased parking, and the introduction of en-suite rooms for patients. At present, patients shared a ward with many other children and parents which was not conducive to a good night's sleep, whereas the new en en-suite single rooms would ensure that 75% of patients would be able

to have their own room, with facilities for a parent to sleep next to the bed. Two villas on nearby Northumberland Road had also been purchased by the hospital and would be fully refurbished by April 2013, in order to become a home from home for parents of children who were in the intensive care unit. This would provide a much better experience for parents to be near to their children whilst they were in the hospital.

7.28 It was likely that the new car park would be one which would charge for car parking. Mr Reid explained that the Children's Hospital was 'landlocked' in the sense that they could not build upwards due to planning restrictions, and around the area there were a great number of restrictions on building due to the nature of the Conservation Area which the hospital was located in, as well as neighbouring universities, parks and hospitals meaning that land and parking was at a premium. There would be increased underground parking for people with mobility issues to have priority parking directly underneath the Hospital.

7.29 Mr Reid acknowledged that there had previously been a gap in care for patients suffering from anorexia, and that at Becton Lodge there were 48 beds which were able to accommodate children suffering from such psychological and behavioural problems. The Sapphire Lodge at Becton was a specialist centre for the treatment of anorexia and had yielded very effective results so far.

7.30 It was noted that the construction would commence in 2013 and would hopefully be completed by 2015, and the disruption in the meantime would be managed very carefully.

Sheffield Local Involvement Network (LINK)

7.31 Helen Rowe, Vice Chair of Sheffield LINK, then provided Members with an overview of the role of LINK, with regard to the provision of healthcare services across the City. She outlined its statutory role, its membership and its governance arrangements. She commented that one of the statutory roles of LINK was to conduct 'enter and view' visits to various healthcare providers across the City, which could either be announced or unannounced. There had been 35 of these achieved since LINK had formed, with effective outcomes.

7.32 Ms. Rowe went on to comment that it was free to join LINK and there were currently 28 very active volunteers, who worked together to devise an annual work plan. These members represented LINK on various external bodies, committees and groups. LINK had been in operation for four years, and was responsible for a number of outreach activities across the City. Over the four year period, LINK had visited 280 groups, organisations and networks, as well as holding consultation and focus group events and cascading information regularly across the City via its newsletter. LINK also had its own dedicated website, Facebook page and had produced three annual reports, with a fourth due out in Summer 2012.

7.33 LINK had also achieved national and regional involvement in the LINK Advisory Group, the Health Watch Pathfinder Case Study, and with the Yorkshire Ambulance Service and the Care Quality Commission. Ms. Rowe outlined the new aim of the Government, which was to lead a transition, and not a stop start movement, towards the implementation of Health Watch, and Sheffield LINK was currently working in partnership with Sheffield City Council as a commissioner for Health Watch. LINK meetings would be held to inform the public about the NHS changes which included Health Watch. With regard to the development of local Health Watch it was essential to build upon LINK's good practice and continue the enter and view activity, project work and outreach work, whilst maintaining existing contacts, networks, policies and procedures. In practical terms, support would be required to conclude the work of LINK in 2013, as well as the handing over of key issues and priorities.

7.34 During the development of local Health Watch it would be essential to retain LINK volunteers who had the relevant skills, knowledge and experience, but also to attract new volunteers to be part of Health Watch, especially to involve all of Sheffield's communities. Potential challenges to Health Watch were the level of funding and the fact that there was such a huge agenda for change to work through. Health Watch would also be required to work effectively with the Health and Wellbeing Board and the Clinical Commissioning Group.

7.35 Ms. Rowe commented that LINK had achieved effective outreach work through the Housebound Library Service, but that there had been a failure to publicise the implementation of LINK when it first started four years ago.

7.36 It was noted that there would be a report from LINK to the Scrutiny Committee upon Care Homes in Sheffield for the Work Programme 2012/13. It was noted that LINK volunteers received regular training on conducting effective enter and view visits, report writing and other such issues.

Sheffield Health and Social Care Foundation Trust

7.37 Kevan Taylor, Chief Executive, Sheffield Health and Social Care Foundation Trust, then addressed the Committee to outline the work of the Trust, which was to provide best value, high quality, integrated health and social care services, which aspired to be nationally excellent and improve individuals' health and wellbeing. The aim was to be the first choice for service users, carers, staff and commissioners. He reported that the integrated health and social care services included primary care services, the Inclusive Access to Psychological Treatment (IAPT), treatment of long term conditions and substance misuse, learning disabilities, dementia and specialist mental health care. He outlined the challenges which faced the Trust which included financial restrictions, demographic changes, future of social care provision, acute mental health care and the scale and pace of

change. The ambition was to bring people in need of specialist services back into Sheffield, and to improve acute care through reconfiguration and an increased community orientation. There was also an aim to integrate primary and secondary mental health care, building on Community Health Team reconfiguration and IAPT, as well as promoting healthcare and reducing the stigma around certain issues.

7.38 Mr. Taylor emphasised the importance of the prevention agenda; for example anxiety and stress could be treated at an early stage before it became debilitating and prevented people from attending work. Mr. Taylor commented that there was an increasing population in the City, and that the population of Sheffield was now nearer to 600,000, with a large increase in the number of Eastern European citizens.

Clinical Commissioning Group (CCG)

7.39 Tim Moorhead, CCG Chair, and Ian Atkinson, Chief Operating Officer, Sheffield CCG, then addressed the Committee. Mr. Moorhead informed the Committee that the CCG was meeting in shadow form at present, taking over from the role of the PCT. The role of the CCG would be to improve health outcomes for patients, promote the NHS Constitution, improve the quality of health services, improve the quality of primary care with the National Commissioning Board, and commission all non-specialised care for patients to the value of £740 million. The CCG would also have a role as being answerable to the National Commissioning Board which would commission primary care and specialist services. The Local Authority would be responsible for health improvement services and public health. The vision of the Sheffield CCG was to improve patient experience and access to care, improve the quality and equality of healthcare in Sheffield, to work closely with Sheffield City Council to continue to reduce health inequalities across the City, and to ensure there was a sustainable, affordable healthcare system in place in Sheffield.

7.40 The CCG would comprise GPs from across the City, with these clinicians being placed at the heart of decision making, in order to ensure patient centred quality and outcomes. The CCG would build on clinical links to deliver improved services, engage with public on their contribution and produce a Healthy City Strategy.

7.41 Challenges faced by the CCG were austerity measures, managing financial risk in the system, ensuring clear communication, achieving effective practice engagement, working with other CCGs, and building refreshed City relationships. It was hoped that the CCG would make a difference through placing patients at the heart of all discussions and decisions, by working with practices in localities, by drawing upon the evidence of opportunities for improvement, by ensuring leadership by senior clinicians, collaborating with clinicians and patients, and strengthening relationships between all organisations and clinicians.

7.42 The CCG would have strong partnerships with Sheffield City Council, South Yorkshire Police, Sheffield Universities, Sheffield Foundation Trusts, Third Sector, other South Yorkshire CCGs and the National Commissioning Board.

7.43 The CCG was acting in shadow form currently in 2012/13, with delegated authority from the PCT Cluster for business planning, organisational development, and engagement and the Health and Wellbeing Board. From 2013, it would be authorised as a Statutory Body, and there were great opportunities and ambitions ahead for the CCG.

7.44 The CCG would be accountable to the National Commissioning Board and membership would consist of all 88 GP practices across the City. It was noted that the CCG would consist of four localities which were West, North, Central, and Hallam and South Central. Members requested that CCGs work closely with Community Assembly Chairs and Managers. It was thought that GPs were the best people to shape future provision of care services, as, over just one month, GP surgeries across the City could see up to 40% of Sheffield's population.

7.45 The Chair thanked all attendees for the updates given.

8. **WORK PROGRAMME**

8.1 The Scrutiny Policy Officer reported upon the Work Programme for the Municipal Year 2012/13, indicating that it would consider the following topics for inclusion (to be determined in conjunction with the Chair and Deputy Chair).

- Transforming support for people with dementia living at home
- Child and adolescent mental health services update
- Experience of care and support performance review
- Sheffield City Council Care Trust review
- End of life care
- Intermediate care
- Adult safeguarding
- Protocol for the scrutiny of health in Sheffield
- Quality accounts
- Sheffield Food Plan
- Diabetes in South Asian communities
- Paediatric cardiac surgery
- Personal budgets
- Welfare Reforms
- Care Homes Review from Sheffield LINK
- Clinical Commissioning Group and clinical outcomes
- Development of Right First Time and Health Watch

RESOLVED: That Members (a) note the contents of the above report for

inclusion in the Work Programme 2012/13, and (b) resolve to give this Committee's support to the Joint Yorkshire and Humber Regional Scrutiny Committee in considering the Review of Children's Congenital Cardiac Surgery with regard to opposing the closure of the Leeds Cardiac Surgery Unit.

9. **DATES OF FUTURE MEETINGS**

9.1 It was noted that future meetings of the Scrutiny and Policy Development Committee would be held on Wednesdays 12th September, 17th October and 21st November 2012, and on 16th January, 20th March and 8th May 2013, all at 10.00 am in the Town Hall.

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Report to the Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee
12th September 2012

Report of: **Richard Webb**
Executive Director, Communities
richard.webb@sheffield.gov.uk
0114 27 35167

Date: 12th September 2012

Sheffield's Draft Joint Health and Wellbeing Strategy (JHWS) 2013-18

The Joint Health and Wellbeing Strategy (JHWS) sets out Sheffield's aspirations to improve the long term health of people living in the city and improve the health, social care, public health, housing and children's services to support people to be healthier throughout their lives.

The JHWS is a new statutory responsibility under the Health and Social Care Act 2012 and Sheffield's Health and Wellbeing Board (and therefore individual partners that comprise the Board) will be responsible for putting the Strategy into action.

The Strategy's mission is to:
- Tackle the main reasons why people become ill or unwell and in doing so reduce health inequalities in the city
- Put people at the centre of services – services should be there to best meet the needs of people, not the organisations that provide them
- Value independence – stronger primary care, community-based services and community health interventions will help people remain independent and stay at or close to home
- Ensure that all services are high quality and value for money

The JHWS has five clear outcomes which the Health and Wellbeing Board (HWB) and partners will look to achieve over the coming years:

- **Outcome 1: Sheffield is a healthy and successful city**
  - *making health and wellbeing part of everything the city does, recognising that the city needs to be healthy to be successful and successful to be healthy*
- **Outcome 2: The health and wellbeing of people in Sheffield is improving all the time**
  - *focusing on specific aspects of children's and adults' health and social care and housing to improve health and wellbeing in Sheffield*

- **Outcome 3: Health inequalities are reducing**
  - *focusing on those people and communities who experience the poorest health and wellbeing*
- **Outcome 4: People can get health, social care, children's and housing services when they need them, and they're the sort of services they need and want**
  - *how people of all ages should experience health, social care, children's and housing services in Sheffield*
- **Outcome 5: The health and wellbeing system in Sheffield is affordable, innovative and delivers excellent value for money**
  - *how Sheffield's commissioners and service providers will deliver health, social care, children's and housing services*

Finally, the Strategy has **five 'work programmes'** through which the HWB will look to address specific health and wellbeing issues relating to employment; mental health and wellbeing; food and physical activity; early years and children; and supporting people to get health care and support at or as close to home as possible.

Having been approved as a draft by the HWB in July 2012, we have been consulting on the Strategy since 1st August 2012 and the HWB would value the views and contributions of Members of the Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee.

Under the Health and Social Care Act 2012, the Health Scrutiny Function will now be conferred on local authorities, rather than on Health Overview and Scrutiny Committees themselves. The scope of Scrutiny has been extended to include any private providers of certain NHS and public health services, as well as NHS Commissioners - and Scrutiny will be able to scrutinise the decisions and actions of the Health and Wellbeing Board.

It would therefore be valuable to consider firstly how the Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee can play a key role in achieving the outcomes set out in the JHWS. Secondly, as the JHWS focuses on the wider determinants of health, it is important to consider how *all of Sheffield's Scrutiny Committees* can use their responsibilities to focus on addressing health and wellbeing of the city through key areas such as housing, employment, transport and the physical environment.

Recommendations:

That the Committee:

- Considers the following questions:
  - **Are we focusing on the right outcomes?** – are the outcomes we've identified the right things for Sheffield?
  - **What do we need to do to achieve these outcomes?** – is the detail that we have set out under the outcomes focusing on the right issues? Is there anything missing?

- **How can the CCG and Council work differently to improve health and wellbeing in Sheffield?** – how can the Health & Wellbeing Board and partner organisations in the city make a difference to the health and wellbeing of local people?
    - **How do you think we can involve and engage effectively in improving health and wellbeing in Sheffield?** – how can we ensure that people are fully involved in shaping the health and wellbeing services the city provides and can choose the care that is right for them?
    - **What strategies and other work are you involved with, and what are the connections with the JHWS?** – how can we put health and wellbeing at the forefront of everything the city does?

- Considers what role Sheffield City Council's Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee can play with regards to the Strategy and within the city's new approach to health and wellbeing.

- Considers the wider role of Scrutiny within the Council in addressing the wider determinants of health in Sheffield.

Joint Health and Wellbeing Strategy

The **Joint Health and Wellbeing Strategy** is a **plan to improve Sheffield's health and wellbeing** which has been written by **Sheffield's Health and Wellbeing Board**. This Board is a group set up as part of the changes the Government are making to the NHS. It includes doctors, councillors and people who work for local charities.

The Health and Wellbeing Board's mission is to:

- Look carefully at why people become unwell and make sure everyone has the same chances in life
- Put the people of Sheffield at the heart of the services we offer
- Help you to live independently at home and in your community
- Give you good quality services and use our money well.

NHS Sheffield and Sheffield City Council, August 2012

You can read our strategy in full at **http://www.sheffield.gov.uk/healthwellbeingboard**

The Joint Health and Wellbeing Strategy will help us decide how to spend our money over the next few years so that the people of Sheffield are healthy and well. There are **five key outcomes in our plan**:

1: Sheffield is a healthy and successful city

What makes people healthy and well isn't just good health services. It's about things that happen in all areas of your life. We will work together with lots of different organisations to reduce poverty, give children a good start in life and do well in school, help people improve their skills and find satisfying jobs, make our communities safe and welcoming, and ensure the city has good housing, parks and public transport.

2: The health and wellbeing of people in Sheffield is improving all the time

Sheffield people are getting healthier and living longer. We want this to continue by tackling the causes of early death, helping people stop drinking, smoking and eating too much, and improving the things that make people ill, such as bad housing, poverty and stress.

3: Health inequalities are reducing

We want to close the gap in how long people live between different parts of the city. This will include focussing our help on those people and communities who most need it, and supporting people to get support and treatment when they need it. This will help to make the whole of Sheffield healthier and more successful.

4: People can get health, social care, children's and housing services when they need them, and they're the sort of services they need and want

We want our services to meet the needs of all. We know people often want services to be closer to home, and want the choice to decide what is right for them.

5: The health and wellbeing system in Sheffield is affordable, innovative and delivers excellent value for money

Sheffield's population is growing as more people are being born and more people are living longer but public services have less money. We need to make sure we can provide good, local services with the money that we have.

In August 2012, we want to find out what you think about our plans. We need you to help us make Sheffield healthy and well.

To read more and to fill in an online questionnaire to tell us what you think, go to our website at www.sheffield.gov.uk/healthwellbeingboard.
You can also email us: healthandwellbeingboard@sheffield.gov.uk
or call us: 0114 205 7143.

A healthy Sheffield is a successful Sheffield

Sheffield's
Joint Health and Wellbeing Strategy
2013-18

CONSULTATION DRAFT

Foreword

Health and wellbeing matters to everyone. Being as healthy and well as we can be helps us to do the things we want to do and means that we can play an active role in our families, our communities and our city. Health and wellbeing is not just about being free from disease: it's about feeling physically, mentally and socially well and socially engaged.

Health in Sheffield has improved considerably over the last few decades but our city is still blighted by inequalities and so we need to take a new approach. We now have a new Health and Wellbeing Board for the city which is made up of GPs, Sheffield City Council and Sheffield Local Involvement Network (LINk). This is a big opportunity to stand up for Sheffield and start to make a real difference to the health and wellbeing of Sheffielders of all ages.

We now know that health and wellbeing can be affected by poverty, aspiration, education, employment and the physical environment as well as by individual genetics. Our mission therefore is to tackle the main reasons why people become ill or suffer health inequalities in the first place, as well as to work with and empower people to improve their health and wellbeing today.

In this Strategy, we have identified the five main things we need to do to make Sheffield a healthy, successful city. These five things can't be achieved by the NHS or the public services on their own. Everyone has a role in making Sheffield a healthier place to live, work, grow up and grow older.

After listening to what Sheffielders have told us, we've set out in this Strategy what we believe we need to do to improve health and wellbeing in the city. We'd like to hear what you think about it.

During August and September 2012, we'll be creating opportunities for you to comment on the Strategy and tell us whether you think we're focusing on the right things. There will be an online questionnaire so that you can give us your views and we'll be talking to community groups from across the city and through Sheffield LINk, trying to make sure that everyone has a chance to get their voice heard. We're also be setting up a 'free shop' on the Moor for a few days during August so that you can drop in and tell us what you think if you're around the city centre.

Everyone in Sheffield has a role in making our city a successful, healthier, better place to live and that is why your views and your involvement matter.

We look forward to hearing from you.

Dr. Tim Moorhead

Joint Chair

Sheffield Health & Wellbeing Board

Councillor Julie Dore

Joint Chair

Sheffield Health & Wellbeing Board

Section 1 Introduction

The establishment of Sheffield's Health and Wellbeing Board presents an unprecedented opportunity to transform health[1] and wellbeing in the city. The board brings together GPs who are responsible for commissioning £730m of health services every year and Sheffield City Council who are responsible for £1.5bn of local government services every year and who have influence over many other services in the city. This means that the board can: influence all of the things that affect people's health and wellbeing, not just health services; look at people's needs throughout their lives; empower individuals, families and communities to take control of their own health and wellbeing; join up services across health, local government and education; champion whole system solutions to stubborn problems; and use robust evidence to focus on what will make a difference to people's lives based on what works.

This is important because we know what helps people to be healthy and well throughout their lives and that isn't just good health services. It is much more about their experience in early life and developing life skills; how well they do at school and their educational attainment; whether they have a good job and how much they earn; and the quality of their house and the physical environment around where they live. This is why poor health and wellbeing is directly related to poverty and deprivation and why people who suffer from the worst health inequalities often experience the worst outcomes in all areas of their lives.

We know that people want to be independent during their lives and get on with the things that they want to do and that matter most to their families. Nobody *wants* to be unwell so when people do need help from services, they want to get better quickly, to have a say in the services they access and stay at home or as close to home as possible. And we know that if people need hospital or care services, they expect that these will be accessible, high quality, efficient and effective and that they will be treated with dignity and respect. It is also important that individuals are supported to develop skills to self-care and to make changes they want to make.

In fact, we know that what works for people also works best for the organisations that deliver services in Sheffield. If people are able to live well, to get on with their lives in the way they choose, stay at or close to home, and have access to efficient specialist treatment when they need it, the chances are that they will do better, be healthy and well for longer and the services they receive will cost less.

Our mission is to:

- Tackle the main reasons why people become ill or unwell and in doing so reduce health inequalities in the city
- Put people at the centre of services – services should be there to best meet the needs of people, not the organisations that provide them
- Value independence – stronger primary care, community-based services and community health interventions will help people remain independent and stay at or close to home
- Ensure that all services are high quality and value for money

This will require us to change the things we spend money on and use our influence to improve the things that have the biggest impact on health and wellbeing – poverty, housing, early years, community infrastructure; to shift services from hospital or residential care to the home or local community; to engage local communities through the voluntary sector in the planning and delivery

[1] Where we refer to 'health', we mean physical *and* mental health

of health interventions; and to ensure all services are effective. In short, we want to empower people to be healthier throughout their lives; to control their own health; provide more community-based services to help people stay at or close to home when they do need help; and improve people's experience of specialist services.

Section 2 Sheffield: opportunities to be healthy and successful

Sheffield has a reputation for being ambitious, innovative and resilient when times are tough. We can be a city of global significance where people and businesses are successful, where people feel included and where people enjoy the highest quality of life.

Sheffield's City Strategy has **five ambitions** to make Sheffield a great, globally significant city:

- **Distinctive** – a city which is recognised for its distinctive and authentic character and for what the city has to offer
- **Successful** – a city with a strong, internationally successful economy where people have access to good jobs and businesses have everything they need to grow
- **Inclusive** - a city where everyone has a chance to succeed and fulfil their potential, and where people feel welcomed, valued and can fully participate in the life of the city.
- **Vibrant** – a diverse, creative, innovative city which continues to be an international destination of choice
- **Sustainable** - a city where everyone plays their part to ensure that future generations can enjoy the city and its surrounding areas

To achieve these ambitions, it is important that we are a healthy city. This is because we know that health and wellbeing **affects** and is **affected by** all areas of life: better health and wellbeing often means people are able to learn, work, earn and be socially active; and unemployment, low educational attainment and isolation can damage people's health and wellbeing. We want people in Sheffield to be successful in everything they do but we know we have to address some of the underlying problems in the city to improve wellbeing and give everyone a chance to succeed.

Sheffield has much to be proud of and has the potential to be the city with the best health and wellbeing in the UK. We have got some real assets which set us apart from other cities and support Sheffielders to have healthy lives:

- Vibrant, diverse communities
- The Peak District and more green space than any other city in England
- World class sports, arts, culture and leisure facilities
- Improving education & lifelong learning services
- Attractive, desirable neighbourhoods
- Good range of housing
- Thriving local centres that provide everyday essentials close to home
- Good transport

Sheffield's economy is becoming an international centre for innovation in digital and advanced manufacturing. **We need a successful economy** to provide people with the good jobs, income, and skills which improve their quality of life but equally, the economy needs healthy, productive, well-trained employees to grow and be successful. Health and social care is the largest employment sector in the city. In Sheffield health and wellbeing go hand in hand with economic prosperity.

The city's population is growing and there are an increasing number of **children and young people** in Sheffield due to an increase in the birth rate and higher than average migration. This is a both a

major opportunity for the city's future with the prospect of more young, aspirational and skilled people contributing to our communities and economy; and it is also a challenge for us to ensure that Sheffield's young people get the best start in life and have the things they need to make the most of their talents. We also have an increasing number of children with complex needs and increasing rates of health inequalities for children which need to be addressed.

Sheffield is also **growing older:** over the last 10 years, the number of people aged over 85 has increased by 139%.[2] This is a triumph and we want to ensure that life expectancy carries on increasing but also ensure people spend more of their lives in good health. Most older people don't use health and care services, but as the number of people living longer increases there will be more people living longer with long-term conditions who do need help. We need to take steps now to improve wellbeing throughout people's lives and reduce the need for hospital and residential care because we will not be able to afford to support increasingly large numbers of people with long-term illnesses in the way we have done in the past.

Whilst people in Sheffield are living longer than ever before, **significant inequalities within the city** remain a major challenge. Inequalities persist between neighbourhoods and in the health of some groups who experience discrimination, social exclusion and the effects of social and economic deprivation. There is also a growing and significant threat to health from the way we live our lives today (eg. obesity, alcohol).

We are living through **difficult times** with rising unemployment, falling real incomes and increases in the costs of food, fuel and services. This will pose additional challenges to people's health and wellbeing. We need to recognise this and support people to weather the recession.

Like household budgets, the money available to public services and local councils is also reducing and the Government has introduced reforms to public services to reduce public spending. This means we need to take a new approach. We know that **we cannot carry on doing the things we have always done in the way we have always done them** and to tackle both the short and long term challenges facing Sheffield, we have to make changes now. Sheffield already spends too much money on the most intensive or 'acute' health and social care support which will become more and more unaffordable. We need to focus on promoting health and wellbeing throughout life to improve the chances of people retaining good health in later years; intervene early to stop problems getting worse; ensure our services focus on stability and recovery as well as value for money; and make the most of the assets in our communities.

The city's service **providers are an asset**: both the main statutory providers (Sheffield Teaching Hospitals, Sheffield Children's NHS Foundation Trust, Sheffield Health and Social Care Trust, Sheffield City Council) and crucially providers from across the private and voluntary community and faith sectors.

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[2] Sheffield First Partnership (2012) State of Sheffield 2012
https://www.sheffieldfirst.com/dms/sf/management/corporate-communications/documents/SFP/Key-Documents/Full-Report/State%20of%20Sheffield%20Full%20Report%20.pdf

Section 3 Guiding principles

These are the 10 things which will guide the new approach to health and wellbeing in Sheffield. This means that all the decisions we make about health services we pay for and deliver as a city will be shaped by the key principles below:

Valuing the people of Sheffield - we want the best for Sheffield and Sheffielders will be at the heart of everything we do. People will be able to make informed choices about their wellbeing, be supported to take charge of their lives and to share decisions about the services they access.

Fairness and tackling inequality - everyone should get a fair chance to succeed in Sheffield. Some people and families need extra help to reach their full potential, particularly when they face multiple challenges and layers of deprivation. Tackling inequality is crucial to increasing fairness and social cohesion, reducing health problems, and helping people to have independence and control over their lives. Fairness and tackling inequalities will underpin all that we do.

Health and wellbeing is everyone's responsibility - we cannot improve health and wellbeing through health services alone. We will make health and wellbeing a part of everything the city does. In short, health and wellbeing is everyone's job.

Evidence-based commissioning - we will use research expertise and national and local intelligence to ensure Sheffield's services are efficient, effective and meet the needs of people based on evidence of what works.

Partnership - we will work in partnership with communities and all public, private and voluntary, community and faith sector organisations to get the right services provided for the needs of people in Sheffield. We will join up health, social care, education, children's services, housing and other local government services to make a fundamental change to the city's health, wellbeing and quality of life.

Prevention and early intervention throughout life - we will stop problems occurring in the first place and respond efficiently to problems to get people back on their feet as quickly as possible. People don't want to have long periods of poor physical and mental health and therefore it is in everyone's best interests to tackle the root causes of ill-health. This will make Sheffield's health system sustainable and affordable for future generations.

Independence - we will help people maintain and improve their quality of life throughout their lives and increase individual and community resilience. Where people need support from health and social care services, those services will be tailored to individual needs and help people and their support networks to maintain or regain the greatest level of independence for their personal circumstances.

Breaking the cycle - we want to improve the life chances of each new generation by tackling the way in which poverty and inequality is passed through generations. We also want to stop the cycle of problems such as poverty, low aspirations, poor educational attainment, low incomes, unemployment, ill-health and in some cases, crime, alcohol and drug misuse which undermine the health and wellbeing of some people in Sheffield.

A health and wellbeing system designed and delivered with the people of Sheffield - we will uphold the principles and values set out in the NHS Constitution and will deliver health, social care, children's, housing and other services which are co-produced with service users and their carers to ensure that people get the right services for their needs.

Quality and innovation - we will ensure that the health, social care, children's and housing services provided in Sheffield are high quality and innovative in meeting the needs of service users. In particular, we will look to establish a 'Sheffield Standard' for care and ensure our workforce is highly skilled and flexible to meet the changing needs of service users in Sheffield. We will drive up quality and stimulate innovation in the health, social care and public health services providers in the city.

Section 4 How we will achieve our outcomes

We have identified **five things we want to achieve** (‘outcomes’) which the Health and Wellbeing Board will work on. Using its unique position, the board will: **influence people and organisations** to make better health decisions; separately and jointly **commission services** to improve health and wellbeing; and **give strategic leadership** to areas which will only improve if all partners on the board work together. We have used detailed evidence and intelligence to identify the five main things we need to do to achieve better health and wellbeing in Sheffield.

This is not a statement of everything we need to do for better health and wellbeing in Sheffield, nor is it intended to be. The Strategy is a statement of the most pressing priorities where there is a significant opportunity to improve outcomes for the city.

The Health and Wellbeing Board has three main ways in which it will achieve the objectives set out in this strategy. These are:

1. Influencing others

As part of the board, Sheffield City Council and the Clinical Commissioning Group (CCG)[3] are responsible for the budgets which pay for health services in the city, with the Council responsible for a wide range of services which impact on health and wellbeing. We work in partnership with other organisations and with local communities and will influence the actions of people and organisations to shape the decisions they make to improve health and wellbeing. This includes local people and families but also schools, the Police, Fire and Rescue, businesses and voluntary, community and faith organisations.

2. Commissioning services from providers

The Council and the CCG provide themselves or ‘commission’ (pay others to provide) health, social care and public health services, with the Council responsible for a wide range of services which impact on health and wellbeing. The services we provide or pay others to provide will help to achieve the five outcomes set out in this strategy and will apply the principles we have set out. The CCG’s commissioning plans will be formally considered by the Health and Wellbeing Board.

Where it is clear we can make a bigger impact together, we will jointly commission services.

3. Giving strategic leadership to work programmes where this is needed to deliver change

There are some areas where we know that we can only make a real difference by working together across the city to directly take charge of delivering plans to achieve better results. We have identified five areas or ‘work programmes’ where this applies. The five areas are set out below and are described in greater detail later in the strategy.

Work programme 1: Health and employment

Work programme 2: Building mental health, wellbeing and emotional resilience

Work programme 3: Food and physical activity for health and wellbeing

Work programme 4: A good start in life

Work programme 5: Supporting people at or closer to home

[3] Clinical Commissioning Groups – groups of GPs and healthcare professionals who will design and commission healthcare services in local areas across England from April 2013.

V 7.0

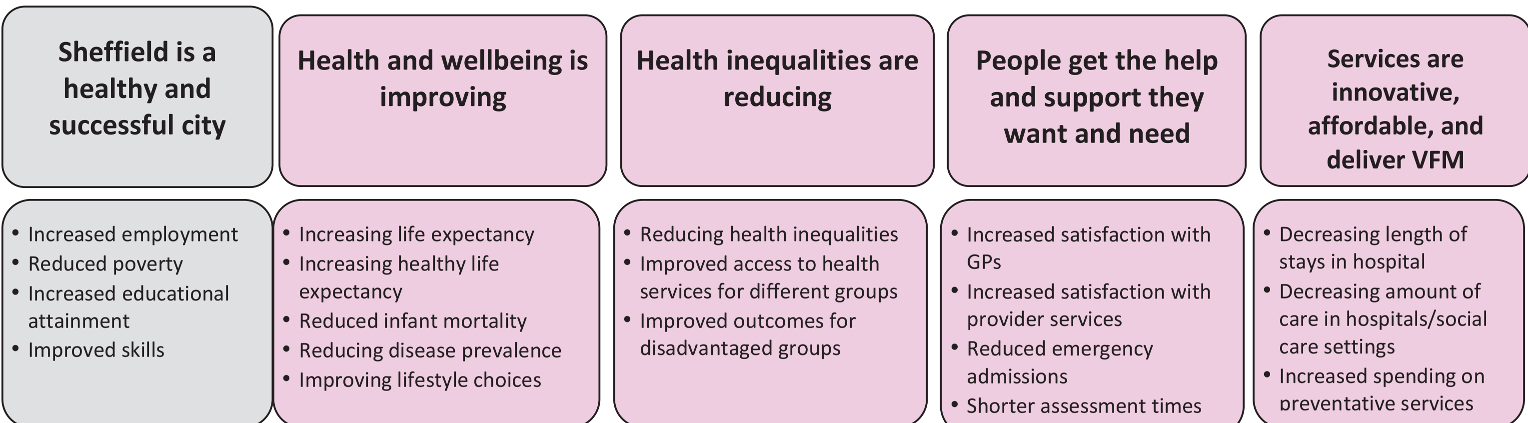
GOVERNANCE

Sheffield Health & Wellbeing Board

- Clinical Commissioning Group
- Sheffield City Council
- Healthwatch

MISSION

Mission: Tackle the main reasons why people become ill or unwell and in doing so, reduce health inequalities in the city;
Put people at the centre of services – services should be there to best meet the needs of people, not the organisations that provide them;
Value independence – stronger primary care & community-based services will help people to remain independent & stay at or close to home;
Ensure that all services are high quality and value for money



OUTCOMES	Sheffield is a healthy and successful city	Health and wellbeing is improving	Health inequalities are reducing	People get the help and support they want and need	Services are innovative, affordable, and deliver VFM
KEY MEASURES	• Increased employment • Reduced poverty • Increased educational attainment • Improved skills	• Increasing life expectancy • Increasing healthy life expectancy • Reduced infant mortality • Reducing disease prevalence • Improving lifestyle choices	• Reducing health inequalities • Improved access to health services for different groups • Improved outcomes for disadvantaged groups	• Increased satisfaction with GPs • Increased satisfaction with provider services • Reduced emergency admissions • Shorter assessment times	• Decreasing length of stays in hospital • Decreasing amount of care in hospitals/social care settings • Increased spending on preventative services

KEY WORK PROGRAMMES

- Health and employment
- Building mental health, wellbeing, & emotional resilience
- Food and physical activity for health and wellbeing
- A good start in life
- Supporting people at or closer to home

GUIDING PRINCIPLES

value people of Sheffield; fairness & tackling inequality; health and wellbeing is everyone's responsibility; evidence-based commissioning; partnership; prevention & early intervention throughout life; independence; breaking the cycle; a health & wellbeing system designed and delivered with the people of Sheffield; quality

Section 5 Promoting health and wellbeing in Sheffield: our five outcomes

This section sets out our key outcomes based on robust evidence which is contained in the Appendix.

Outcome 1: Sheffield is a healthy and successful city

Making health and wellbeing part of everything the city does, recognising that the city needs to be healthy to be successful and successful to be healthy.

What is the issue?

Health and wellbeing in Sheffield cannot be improved by health and care services acting alone. Absolute and relative poverty is at the root of poor health and wellbeing and there is good evidence to suggest that populations which experience lower levels of income inequality are less likely to be unhealthy than in those areas where there is a much larger gap between the best off and worst off in society.

The 'wider determinants' or 'root causes' of health such as educational attainment, housing, crime and fear of crime, and employment are all shaped by poverty and thus impact on health and wellbeing. These are all areas of significant challenge for Sheffield and are areas in which there are substantial inequalities between different communities and groups of people within the city. However, they are all areas which – to a greater or lesser degree – are within the influence of agencies that work in the city. Therefore, we are most likely to be successful in improving (and maintaining improvements in) health if we are able to improve people's overall quality of life and to reduce inequalities.

Health, social care and other services have a key part to play when problems arise (see Outcome 2), but **preventing problems** in the first place is what we mean by tackling the root causes of ill-health. This can only happen by making all agencies responsible for improving health and wellbeing. However, at the moment, good health is not designed into other services such as planning, transport, environment and food in a sufficiently systematic and integrated way. Therefore, this outcome is about ensuring that health and wellbeing is central to everything that the city does.

What do we want to achieve?

This outcome demonstrates the important role the Health and Wellbeing Board can play in making Sheffield a healthier city. We can only achieve this outcome through the partners on the board putting health and wellbeing at the core of the services they commission *and* influencing the way in which other partners and agencies deliver their own services, championing, challenging and advocating for change where it is needed.

This outcome is key to everything we want to achieve for the city and, over time, we would expect to see this become even more central to our thinking as we shift resources away from high cost acute hospital and care services and towards activities that promote good health and wellbeing for all ages and tackle the root causes of poverty and inequalities.

Over the lifetime of this plan, we want to **give every child the best start in life**. We know that good health and wellbeing throughout life is heavily influenced by a person's experience in the early years of life. This means focusing on poverty, financial inclusion, women's health, pre-natal and ante-natal support, promoting and supporting good parenting and providing excellent early years services to promote the good physical, mental and emotional development of every child in the city and ensure that when children start school they're ready to learn.

We want to enable all children, young people and adults to maximise their capabilities and have control over their lives and be able to contribute to the economy and to wider society by having **high levels of achievement and aspirations** about what they want to do in life.

A key component of good health and wellbeing is finding and maintaining **long term, meaningful and satisfying employment** – there is an important and often overlooked link between these two issues, and one that we wish to focus on during the lifetime of this Strategy. This also means taking steps to reduce unemployment, ensure there are good employment opportunities for all young people and support people who find themselves out of work to get a new job. Sheffield has built on the evidence from in Marmot Review[4] to set out the steps we need to take as a city to provide more and better opportunities for people to work and increase fairness in the labour market.[5] We see this as a vital part of improving population wellbeing and tackling the city's inequalities and we are committed to playing a lead role in the delivery of Sheffield's Health and Work plan.

Everybody in Sheffield should live in **welcoming, inclusive and safe communities** and have a **good standard of housing** that enables them to stay healthy and warm, and that meets their needs as they get older. Where people are unsafe in their homes or communities (e.g. as a result of harassment or domestic abuse), we will ensure they get appropriate support.

We want people to be able to **get around the city**, both through walking and cycling, and through good public transport services, and to connect people easily and cheaply to work and leisure opportunities. We know that lack of affordable transport can lead to social isolation and poor health outcomes.

And we want a city that has a **high quality built and green environment** which is designed to be and feel safe, supporting the improvement of everyone's wellbeing. Better health will be 'designed in' to Sheffield's physical environment, enabling people to have ready access to parks and green spaces, with good air quality, valuable shops and services in local centres, and opportunities for leisure and physical activity at all ages, which we know can have a dramatic positive effect on health and wellbeing.

Much of this work is already going on in the city. Numerous strategies already exist to improve Sheffield in each of these areas. Therefore, instead of replicating actions from a range of other strategies here, the role of the Health and Wellbeing Board will be to influence and hold those other partners and agencies to account, and to ensure that health and wellbeing considerations are built into each of these areas from the start.

Key things we want to do:

- Reduce poverty
- Improve parenting
- Increase educational attainment , skills and qualifications at all levels
- Increase Sheffield's economic productivity and support business growth
- Increase employment
- Increase income levels and financial security
- Promote health and wellbeing through the school curriculum, in the work place and in communities
- Improve access to good quality, affordable food
- Reduce crime and the fear of crime
- Improve mental wellbeing, resilience and reduce social isolation
- Improve the range, quality and affordability of housing
- Increase satisfaction with the local area/local environment
- Reduce air pollution
- Mitigate the impacts of climate change
- Improve transport
- Increase use of Sheffield's arts, culture and physical activity facilities
- Increase physical activity
- Increase social capital and strengthen community networks in Sheffield

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[4] Marmot, M (2010)

[5] Sheffield First (2012) *Sheffield's Employment Strategy*, https://www.sheffieldfirst.com/dms/sf/management/corporate-communications/documents/Economy/Strategy-FINAL/Employment%20Strategy.pdf

Outcome 2: The health and wellbeing of people in Sheffield is improving all the time

Focusing on specific aspects of children's and adults' health and social care and housing to improve health and wellbeing in Sheffield

What is the issue?

Health and wellbeing in Sheffield has improved in the past few decades and we have the highest male life expectancy and the third highest female life expectancy of the eight biggest cities outside London. People in all parts of the city are living longer, deaths from major illnesses, especially heart disease and cancer, have reduced markedly and there has been a reduction in the number of people, particularly children, killed or seriously injured on our roads.

By focusing on the root causes of ill-health in Outcome 1, we hope that we can have a major impact on the health and wellbeing of people for the long-term. However, this doesn't mean there aren't things we can do now to improve health and wellbeing where issues are having a negative impact on people's lives today. These include poverty, mental ill health, and poor quality housing which in turn play a part in obesity, smoking and alcohol consumption. These problems have led to a rise in chronic conditions such as heart disease, respiratory disease, cancer and strokes as well as to other health problems such as sexually transmitted infections and poorer health in children and young people.

As our focus on the wider determinants starts to make an impact on health and wellbeing, we anticipate that these problems will reduce.

What do we want to achieve?

Children

- A whole household approach, especially where parental wellbeing impacts on children's health
- Reduce child poverty
- Wholesale improvement of health and wellbeing for children, particularly those aged 0-4.
- All young people experience a positive transition from childhood to adulthood, including those with disabilities and mental health problems.
- Reverse the increase in obesity in children
- Improve the mental wellbeing of children

Adults / whole population

- Reduce poverty
- Improve physical and mental wellbeing of adults throughout their lives
- Reduce mental illness
- Improve women's health
- Reduce cancer mortality and increase cancer survival rates
- Reverse the increase in obesity in adults
- Every person has access to the sexual health information and services they need
- Reduce harmful levels of alcohol consumption
- Increase access to drug and alcohol treatment for those who require it
- Reduce smoking prevalence

Housing

- Improve the quality and range of the housing stock in the city to reduce the impact which poor housing has on the wellbeing of local people
- Increase the access to equipment and adaptations in the city to support people to live in their own home and be independent
- Ensure people have access to support and housing which is appropriate for their needs and maximises their wellbeing and life chances
- Identify and target Category 1 hazards in homes such as cold, damp and falls to reduce the major impact they have on people's wellbeing
- Improve the management of social and private rented housing through our relationships with landlords

Outcome 3: Health inequalities are reducing

Focusing on those people and communities who experience the poorest health and wellbeing

What is the issue?

Sheffield has stark inequalities between different groups of people and between different geographical communities. People in the most deprived parts of Sheffield still experience a greater burden of ill-health and early death, demonstrating that inequalities in health and wellbeing are linked with wider social, cultural and economic issues.

The life expectancy gap between the most and least deprived people for 2009-2011 is 8.7 years for men and 7.4 years for women. There are 29 neighbourhoods in the city (a quarter of the city's population) that are within the 20% most deprived in England. In Sheffield, some communities and groups experience a much poorer quality of life across all the wider determinants of ill-health. In particular, these groups include looked after children and children with learning difficulties and disabilities, some BME communities, migrant and asylum communities, homeless people, victims of domestic and sexual abuse and carers.

It remains the case that health inequalities are a blight on the city – it has been shown that more equal societies achieve better outcomes for everyone (not only the most deprived).

What do we want to achieve?

Children

- The health and wellbeing outcomes of children and young people who experience the worst outcomes (including children and young people of BME heritage and new arrivals, Looked After Children and those with learning disabilities) are increased to at least the city average
- Children with complex needs are supported through an integrated care package
- The reducing rate of teenage pregnancy in Sheffield continues to improve
- Young carers are valued, their contribution is recognised and they have access to a comprehensive package of support to address the inequalities they sometimes face

Adults / whole population

- Where the wellbeing of disadvantaged groups has improved, it continues to improve
- Target health interventions for BME population groups
- Increase health promotion and support better engagement of BME groups to improve health outcomes
- Safeguard the health and wellbeing of vulnerable new migrant communities, asylum seekers and refugees
- Support community development work with disadvantaged communities to enable them to tackle their priorities
- Deliver a comprehensive 'whole life' approach for people with learning disabilities and the most complex needs, tailored to the needs of individuals to maximise life outcomes and people's control over their lives
- People experiencing domestic abuse are identified, risk assessed and offered appropriate support wherever they present e.g. including health settings; develop a preventative approach to this issue
- Carers are valued, their contribution is recognised and they have access to a comprehensive package of support to address the inequalities they sometimes face

Housing

- Develop a complete supported accommodation pathway to ensure people get the appropriate support at the appropriate time to tackle the impact homelessness and crises have on local people
- Ensure Sheffield has robust homelessness prevention mechanisms to reduce the incidence of statutory homelessness

Outcome 4: People can get health, social care, children's and housing services when they need them, and they're the sort of services they need and want

How people of all ages should experience health, social care, children's and housing services in Sheffield

What is the issue?

In Sheffield, we spend too much money on high end or 'acute' health and social care services such as hospitals, special schools, out of city placements, and children's care homes. Levels of emergency hospital admissions and inappropriate attendances at A&E in Sheffield are significantly higher than the national average and we have longer times for social care assessments than the national average, with a high proportion of assessments taking longer than three months.

Too much reliance on high-end services often results in poorer wellbeing for people, leading to increased vulnerability and dependency on services. This applies at all stages of life: evidence shows that if children stay in residential care longer than six weeks, their chance of returning to the family is significantly reduced; older people with dementia face more chance of living in a care home following a stay in hospital, rather than returning to their own homes.

If we can redirect money from high-end services to those which tackle problems early on, we know that this will help people stay independent for longer, improve their long term health and wellbeing, and give them more control over their lives and the services they use.

The health, social care and housing system is complex and it can make it difficult for people to get the right support they need when they need it. This can result in problems getting worse and people's needs not being met effectively. Further, despite the increasing use of personal budgets, the health, social care, children's and housing system is still not good enough at putting power and control in the hands of the people and their support networks and supporting them with the information they need to make choices about the services that are right for them.

What do we want to achieve?

- Children and adults are able to manage their own care and support
- Children and adults can easily access the right range of services at the right time, feel they are in control of their own care and feel well supported when they need health, social care, children's and housing services.
- People have good quality information and support that helps them take control of their own health and wellbeing when accessing health, social care, children's and housing services.
- All health and wellbeing services promote resilience and opportunities to access community interventions to improve health and one to one support.
- All services promote recovery, independence and dignity
- Children and adults have a positive experience of the services they receive
- People know what choices are available to them locally, what they are entitled to and who to contact when they need support for their health and wellbeing.
- More services are provided at or closer to home
- Carers are valued and treated as equal partners
- Participation and strong community networks increase social contact and social support
- People, including those involved in decisions on health and wellbeing services, respect the dignity of the individual and make sure support is sensitive to individual circumstances
- Individuals and families are supported and treated with dignity and respect at the end of their lives with more people being supported to die in their own home.

Outcome 5: The health and wellbeing system in Sheffield is affordable, innovative and delivers excellent value for money

How Sheffield's commissioners and service providers will deliver health, social care, children's and housing services

What is the issue?

Over the next 10 to 20 years there will be a significant increase in the number of older people in Sheffield, alongside increasing numbers of children and working age adults with disabilities and complex needs. Whilst we are focused on maximising the number of healthy years of life people experience, we know that this population change is likely to increase demand on health, social care children's and housing resources.

With the city's population rising through birth rate and migration and people living longer, we know that there will be an increase in the number of people with disabilities, including the most complex disabilities, and illnesses such as dementia. The impact of the current economic crisis is likely to increase further the demands on health and wellbeing services, and exacerbate existing inequalities.

In the face of these challenges, we can't continue providing services in the way we've done in the past. Currently in Sheffield, we aren't good enough at keeping people out of hospital and helping them to get the services they need in or close to their home so that they can get on with their lives. Hospital stays are longer than the national average in Sheffield, more people are admitted to hospital in emergencies than on average, and we rely too much on hospital or residential care when we should be supporting people to get the care they need at home or close to where they live.

What do we want to achieve?

We will increase the amount of community-based health and social care services to reduce the need for the highest level of hospital and residential care. We will aim to support people to access services at home or in their local community so that people can carry on with their lives as far as is possible and we will strive to deliver the right services which prevent problems getting worse. The health and wellbeing system in Sheffield will help people maintain and regain independence, manage long-term conditions, promote stability and recovery and will provide services which meet the needs of individuals.

- Increase the health, social care, children's and housing services provided in or as close as possible to home
- Improve the quality and effectiveness of the health, social care, children's and housing services in Sheffield
- Reduce hospital and residential care admissions
- Prioritise prevention and early intervention for children and adults who need services
- Increase the focus on regaining/maintaining independence particularly for older people and people with long term conditions, including neurological conditions
- Deliver the 'Right First Time Programme' so that care and support is provided in the community and that hospital will *only* be used where the individual has a clear and acute health need
- Spend resources on the things which are best for people's long-term health and wellbeing, reducing long term dependency on services and providing the best value for money
- Ensure services offer continuity of care, shared decision making and a personalised approach to health and wellbeing
- Deliver responsive community services which are available when people need them
- Provide services in a timely fashion, improving on national waiting times.
- Improve co-ordination between services, reducing waste, duplication and simplifying processes such as assessment
- Ensure Sheffield's health, social care, children's and housing services are innovative and informed by evidence of what works

Section 6 Making a difference: how the Health and Wellbeing Board can help achieve the outcomes

The Health and Wellbeing Board has identified **five** '**work programmes**' which relate directly to critical issues within the outcomes. Work is already underway in all of these areas. Over the first year of the strategy, the Board will use research and local intelligence to identify specific issues or gaps within these five areas to understand where the Clinical Commissioning Group and Sheffield City Council can make a real difference by working together. Tackling inequalities will run across all five programmes.

Over the life of the Strategy the Board will identify further work programmes. These have been selected initially because they are fundamental to the delivery of the five outcomes.

Work programme 1: Health and Employment

Employment is important for improving health as being in work, job security and attaining 'better' jobs has a positive effect on the way people live and feel, and the choices they make with respect to their health. Being out of work has negative effects on an individual's health, reducing household incomes, increasing social isolation and increasing stress and depression. Most health risks associated with unemployment get worse over the time a person is out of work.

Mental health issues and musculoskeletal problems are the largest causes of workplace absence. Also developing a Long Term Condition can be a significant barrier to work. It is important to support those with these health problems to stay in work, thereby reducing the impact of their conditions and aiding recovery.

Sheffield has already identified these issues in the Employment Strategy and the board will play a lead role in delivering the city's Health and Work plan to address one of the major root causes of ill-health.

What do we want to achieve?

- Establish strong relationships between the Health and Wellbeing Board, CCG, the Council and employers in the city to increase the understanding of the important links between work and health
- Agree a health and work plan which is accountable to the Health and Wellbeing Board and Sheffield's Employment and Skills Taskforce, which will include:
  - Workplace Health - ensuring that business see value in and invest in the health of their workforce and healthy and safe workplace practices to prevent health conditions developing
  - Working with employers and supporting workers to manage health conditions in work, helping staff to return to work after periods of sickness, promoting prevention and early intervention to reduce long term sickness and wellbeing problems
  - Removing and managing health barriers to work - tackling the main health conditions which are causing worklessness and sickness in Sheffield (mental health and musculoskeletal conditions), preventing newly unemployed people becoming long term unemployed due to developing health conditions and giving workless people the choice and support they need to engage with work
- Work with other cities to ensure work-related health and welfare reforms don't create adverse health impacts

Work programme 2: Building mental health, wellbeing & emotional resilience

Mental well-being can positively affect almost every area of a person's life - education, employment, family and relationships. It can help people achieve their potential, realise their ambitions, cope with adversity, work productively and contribute to their community and society. Promoting mental well-being for all has multiple benefits. It improves health outcomes, life expectancy, productivity and educational and economic outcomes and reduces violence and crime. One-in-four people will experience mental illness at some point in their lives. Mental health problems are more common in the most deprived parts of Sheffield and in the current economic climate, problems such as anxiety and depression are expected to increase.

What do we want to achieve?

- Build mental and emotional resilience by jointly commissioning health, social care, children's housing and employment services
- Identify and support families who need the most help through the 'Successful Families' work
- Develop a positive transition into adulthood by targeting early intervention with young people and addressing the gaps in mental health services for young people
- Improve or maintain the wellbeing of younger and older people by tackling bereavement, loss, loneliness and isolation and recognise the health impacts of these
- Reduce stigma around mental illness and promote the '5 Ways to Wellbeing' in the city[6]
- Develop community resilience through social capital and the contribution of the third sector;
- Increase the support provided to people experiencing issues such as domestic abuse, drug and alcohol misuse.

Work programme 3: Food and physical activity for health and wellbeing

Food has a big impact on many parts of our lives. It gives us pleasure and connects us to our environment and our culture as well as giving us the energy to function. A nutritious and healthy diet can contribute to better wellbeing for people of all ages but we know that for many people in Sheffield, access to a healthy diet is a major problem. A lack of food or poor quality food reduces people's ability to go about their daily lives (eg. lack of energy, lack of concentration) but also undermines long-term health, contributing to conditions such as diabetes, heart disease and cancer.

Physical activity has a positive impact on physical and mental wellbeing, improving self-esteem and reducing stress. Although Sheffield has high quality sports facilities and open spaces, not everyone in the city is able to access or take advantage of these.

What do we want to achieve?

- Reduce the incidence and impact of poor diet, sedentary behaviours and excess weight on long term conditions (eg. type 2 diabetes, CVD, CHD, some cancers, liver disease)
- Reduce food poverty
- Gain a better understanding of the true scope and cost of obesity in Sheffield
- Support and promote healthy eating and physical activity throughout life
- Develop and use positive messages to promote healthy eating, physical activity and address low self-esteem, especially in young people

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[6] New Economics Foundation (2008) *Five Ways to Wellbeing*, http://neweconomics.org/sites/neweconomics.org/files/Five_Ways_to_Well-being_Evidence_1.pdf

- Ensure that positive choices relating to healthy eating and physical activity are easy, desirable and affordable for the people of Sheffield
- Maximise the use of the city's existing resources, including green spaces, sports facilities, food producers, retailers and public services to promote, support and enable healthy behaviours

Work programme 4: A good start in life

Evidence shows that the health and wellbeing of people throughout life is dramatically improved if their early years (0-4) are positive experiences. It can impact on health but also wider 'determinants' such as education and employment prospects. Poverty is a major factor which undermines people's early years which can influence things such as poor parenting, poor diet and obesity, low early years educational attainment, a high number of emergency hospital admissions and inappropriate attendances at A&E. The board believes it is critical that people in Sheffield get the best start in life to improve their chances of living a long, healthy life.

What do we want to achieve?

- A new approach to integrated practice in the early years, where public health, health care, early years education, child care and social care services work together to provide timely and streamlined help to families according to need
- Improved parenting and emotional well being support in the early years for all families and early identification and targeted evidence based support for those more at risk of developing poor quality parent infant relationships
- A significant reduction in the inappropriate use of unscheduled care, particularly in 0-5s, through system redesign and improving the confidence and skills within families and clinicians to prevent and manage common childhood conditions
- Improving care and support for children with complex needs, through integrated health, education and social care assessment and care planning, earlier identification of needs, meeting needs less intensively where possible within universal services, and bringing care closer to home

Work programme 5: Supporting people at or closer to home

Part of our mission is to reduce the dependency in Sheffield on high level or 'acute' hospital and residential care support. Not only is it expensive (and will become more so as more and more people live longer), it isn't what people tell us they want and doesn't always improve people's health and wellbeing in the longer term. It is estimated that about two-thirds of all healthcare resources are spent supporting people with Long Term Conditions. Supporting patients to self care can change people's attitudes and behaviours, improve quality of life, clinical outcomes and health service use including reducing avoidable hospital admissions.

Therefore, we want to make a real change in Sheffield to help people get the care and support they want at home or as close to their home as possible and support them to manage their conditions.. This will be better for individuals but also for families and for the organisations who deliver services. People growing older in Sheffield are naturally a focus in this work programme but it will apply to people of all ages who need health services, care and support in the city. We need to make sure that, as far as possible, people can get on with their lives and have the right support in place to help them live independently and happily in the place they feel most comfortable.

What do we want to achieve?

- Support people to remain independent at home by the development of better primary health, social care, children's and housing services linked to Right First Time;
- Move secondary care services to primary care settings where this adds value to patients and frees up money for reinvestment in prevention and early intervention
- Join-up housing, social care and health to help people can stay at home for longer, including increasing the use of assistive technology and adaptations
- Provide sufficient, suitable and affordable places to live by developing the housing supply and management to meet people's needs and invest in supported housing
- Enable people to stay at home by designing a new specification for home care

Section 7 How will we know that we're making progress?

The Health and Wellbeing Board will monitor progress in the delivery of the outcomes in the Joint Health and Wellbeing Strategy. Each one of the five outcomes has a set of measures or indicators which will tell us how we're doing in our efforts to improve health and wellbeing in Sheffield. We will publish our performance against all the measures to ensure that everyone can chart our progress towards the outcomes.

Where we have evidence that outcomes are not being achieved, the Health and Wellbeing Board will hold commissioners and providers to account. The Health Scrutiny Committee of Sheffield City Council will also be able to hold service providers to account and challenge them to improve.

It is also vital that, as the Health and Wellbeing Board, we regularly assess whether we are focusing, commissioning and delivering the right things. The Joint Strategic Needs Assessment has informed this strategy and will provide a regular overview of the health and wellbeing issues in Sheffield, highlighting where new health challenges occur and where health and wellbeing is either improving or worsening.

By April 2013 Sheffield Healthwatch will be established to replace LINk and act as the main channel into the Health and Wellbeing Board for Sheffield children, young people and adults to contribute their voice and influence. We also plan to engage with providers to ensure that the board's work is informed by best practice in service delivery.

Whilst we are confident that Sheffield's Joint Health and Wellbeing Strategy addresses the main health and wellbeing opportunities and challenges in Sheffield for the next 5 years, we intend to review the Strategy in 2013. This is because in April 2013, the Government's health reforms become law and Sheffield's Health and Wellbeing Board will be a statutory body. We will have had the opportunity to plan out the work programmes and any gaps and will be clearer about how we involve the public and service providers in the work of the board. We therefore propose to undertake a further consultation during the spring/summer and to agree a revised version of the Strategy by September 2013.

If you want to find out more, please get in touch:

healthandwellbeingboard@sheffield.gov.uk

Appendix 1: JHWS Evidence base

Outcome 1: Sheffield is a healthy and successful city

The increase in the city's population, which stood at 555,000 in 2010, is expected to continue and could rise to around 600,000 by 2020. Three factors combined to lead to this steady rise: more young adults living in the city as a result of more inward economic migration and a growing university student population; longer life expectancy which has seen a 24% increase in the number of people aged over 75 and more than a doubling of people aged over 85; and a continuing increase in the city's birth rate.

Children and young people

Whilst children and young people growing up in Sheffield today are generally healthier than ever, between the 'best' and the 'worst' wards in the city we have:

- 2 fold difference in achievement at Early Years Foundation Stage;
- 4 fold difference in infant mortality rates;
- an 8 year gap in male and female life expectancy at birth

Sudden infant death rates are higher in Sheffield than nationally and concentrated in more deprived areas. Analysis of mothers who lose children to sudden infant death shows that 90% of the mothers smoke and 83% have social or mental health vulnerabilities.
Smoking during pregnancy is reducing but is still above the national rate and there is a seven fold difference at Community Assembly level in the proportion of women who are smoking 'at delivery'.
Breastfeeding rates are above the national average - currently 52.3% women are breastfeeding at 6-8 weeks compared to a national average of 45.2%, but again wide inequalities exist within the city.
Numbers of pregnant women with substance misuse issues has remained stable (c.60 per annum) despite an overall national decline in problematic substance misuse.

Partnership working is targeting pregnant women at risk of domestic abuse in order to offer early support and ensure, via the MARAC system, that agencies are aware of families with children under 1 where the risk of serious harm or homicide is high.

Around 40% of cases on the 'child protection register' have parental substance misuse as a significant contributory factor.

There is currently high use of children's emergency care with the highest <5yrs A and E attendance from the most deprived areas of the city. In 2010/2011 there were a total of 51,540 visits to Sheffield's Children's Hospital A&E department, of which 25,512 were under 5s.

Sheffield benchmarks very poorly against the national average and core city average for A&E attendances and emergency admissions for the under-fives e.g. emergency admissions rate (09/10) for respiratory conditions in 0-4 year olds in Sheffield is highest in England at 239.41 per 10,000 compared with Bristol (98.05) and nationally (115.26) (ChiMat 2009/10). Local data show that the highest use of A&E attendance in Sheffield is from the most deprived areas where rates are up to 50% above the city wide average

There has been some successful partnership working which has helped to slow the rise of childhood obesity but downstream the problem is still significant, which will impact health outcomes in later life and demand for hospital and primary healthcare services. Partnership working targeting those most at risk has been successful in reducing Sheffield teenage pregnancy rates which are now lower than ever, although still above the national rate

Multiagency prevention and early intervention services are succeeding in managing demand and improving the appropriate use of children's social care

There has also been a large increase in the number of children and young people with a learning disability since 2000, and in the last ten years the number of 10 to 20 year olds with a learning disability increased by 120%, although in the last five years the number increased by 38%, suggesting that the rate of increase may be slowing.

Data also indicates a significant increase in the number of people in Sheffield with severe or complex needs, and again particularly in younger age groups. The overall number of people with such needs rose by 17% between 1998 and 2008. However, the number of 15 to 19 year olds with severe or complex needs increased by 70% over the same time.

Education and skills

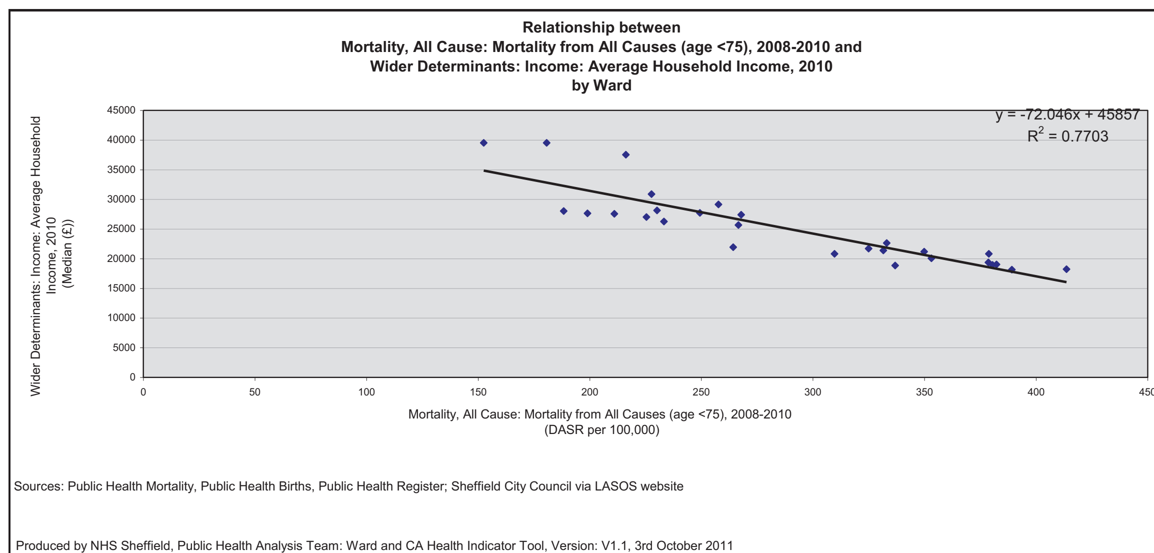
The proportion of the population with a degree level qualification (27.7%) also compares well with many other cities. Similarly, the educational profile of the city's population has seen the proportion of residents with no qualifications falling from 16.6% in 2008 to 12.4% in 2009, bringing Sheffield in line with the national average. Such wider education and early learning experiences provide a key link between individual aspirations and the city's demographic and socio-economic change. Educational attainment has been improving in the city at a similar rate to, or even faster than, nationally up to 2010. However, this rate of change is not as strong as other core cities recently and needs to accelerate.

Deprivation

Communities living in neighbourhoods in the north and east of the city are more likely to experience deprivation in respect to education, skills and training. Sheffield still has a higher number than the national average of 16-18 year olds not in education, employment or training (NEET). Sheffield has a geographical pattern of communities that experience differing levels of deprivation and affluence. Generally speaking, the most deprived communities are concentrated in the north and east of the city whilst the most affluent in the south and west. This pattern of affluence and deprivation has profound implications for inequalities within the city.

12% of households rely on benefits and 8% of older people are on some sort of state support. Around 24% of Sheffield's dependent children and 28% of the population over 60 years old live in households claiming Housing and/or Council Tax Benefit. There are 29 neighbourhoods in the city that are within the most 20% deprived within England, in total accounting for 28% of the city's population, whilst there are seven neighbourhoods in the 10% of least deprived locations in England.

Whilst social cohesion has to date remained positive in the city, the continuing financial and economic crisis is beginning to impact on the people who live in Sheffield. New housing completions have fallen by two thirds since 2007 and the number of affordable homes provided through developer contributions has also declined. Despite a previous decline, the number of people becoming homeless has increased in the past year. A key concern is the number of young people becoming homeless with almost half of priority homeless cases aged 16 to 24 years old. There is also a developing issue for the city where people live in asset rich but income poor households. Many older residents might be living in high value homes but unable to afford to adequately maintain them. Also, 19% of private households in the city experience fuel poverty compared to 13% in England as a whole.



Employment

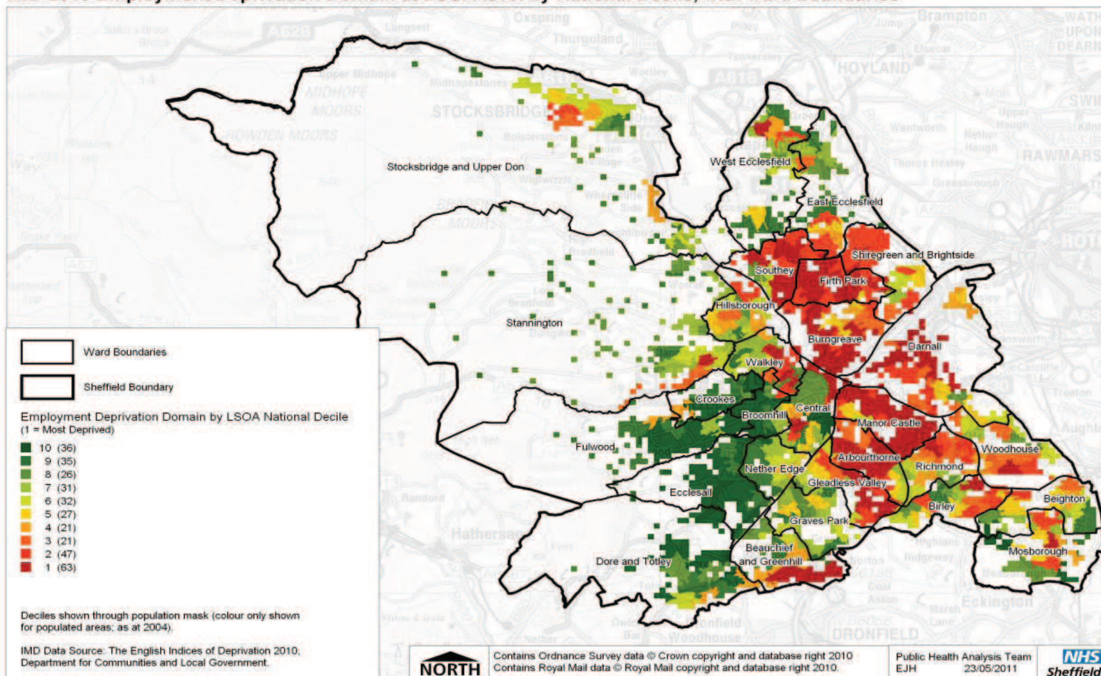
Sheffield has been transformed over the last 15 years. The city has successfully altered its economic path. New employment opportunities and businesses have been created and the city's image has been radically reshaped with a series of high profile investments which have led to improvements to how the city looks.

Around 240,000 people work in Sheffield in approximately 20,000 businesses, of which some 80% employ ten or less people. Just over 30% of people work part time. 11% of employees now work in manufacturing businesses, close to the national average. The majority of people work in services, with the 85% of workers in this sector also being close to the national average, but the highest in the wider City Region in which Sheffield plays an important role.

The number of people claiming unemployment benefits in Sheffield has doubled in less than three years since 2007 and the level of long-term unemployment has significantly increased both in the City Region and nationally. Youth unemployment has also increased but less than the England average. Key issues:

- In January 2012 there were over 48,000 people claiming out of work benefits in Sheffield. Of these: Over 18,000 were claiming Job Seekers Allowance
- 24,600 were claiming Incapacity Benefit or Employment Support Allowance
- 5,600 lone parents were claiming work-related income support
- 40% of employers view workers with mental health conditions as a significant risk.
- 42% of employers underestimate the prevalence of mental health in their workplace.
- It is the primary illness causing worklessness (approximately 11,000).
- 87% of people out of work due to mental health conditions have been out of work for more than 2 years, most for 5 years.
- Poor mental health can be self perpetuating, with the deterioration of skills and confidence often leading to further mental health problems.

IMD 2010 Employment Deprivation Domain at LSOA level by National Decile, with ward boundaries



More recent data shows growing stress for individuals in the labour market, now that around 23,500 people in Sheffield are unemployed and seeking work, and of these some 16,225 are currently claiming Jobseekers Allowance (JSA). The remainder either choose not to claim benefit or are not eligible due to being newly unemployed. There are also 30,700 people who are economically inactive or workless, including those who cannot work due to health problems or social circumstances such as being carers or single parents. 11,000 people in Sheffield claim Employment Support Allowance because of mental health conditions and 87% of these have been claiming for over two years. It is likely that these problems will be concentrated in those neighbourhoods of the city which were already experiencing employment and income deprivation.

Wellbeing

The general health of the city is improving. Compared with the other Core Cities, Sheffield has the longest overall life expectancy and the lowest levels of early deaths from cancer, heart disease and strokes. People in all parts of the city are living longer. Deaths from major illnesses, especially heart disease and cancer, have reduced markedly and there has been a reduction in the number of people, particularly children, killed or seriously injured on the roads. This means mortality rates for men have halved since 1975 and for women reduced by 40%. Life expectancy, at 81.8 years for women and 78.2 years for men, is only a little below the national average. Overall health in Sheffield continues to improve, including a narrowing of the gender gap but improvements in women's health have slowed over the last few years. This may be due in part to changing employment and lifestyles, since levels of smoking and drinking alcohol to excess have been increasing in young females.

Although the city is becoming healthier for most people, health inequalities across neighbourhoods remain and are in some cases widening, with particular individuals and groups remaining or increasingly vulnerable, in particular older people, the young and some women and some ethnic minority groups. People in the most deprived parts of Sheffield still experience poorer health and die earlier than people living in the rest of the city. This reflects the key issue that inequalities in health and wellbeing are intrinsically linked with wider social, cultural and economic conditions.

Compared with the national average and the Core Cities, Sheffield has high diabetes and obesity rates and low levels of healthy eating. Sheffield has the lowest level of physical activity in adults of the major cities. However, teenage pregnancy rates have been falling since 2004 and Sheffield now has the lowest teenage pregnancy rate of all Core Cities, close to the national average. More women are choosing to breastfeed their babies and give them the best possible health start in life – around 78% of new mothers in 2010 – although this does vary across the city from 40% to over 90% in some communities.

Ageing is a key component of overall wellbeing, and as stated earlier, it is likely that Sheffield will have many more older people in the future than it does now. More work needs to be done to understand how an ageing population will impact on the city and as the report states: “Without doubt our understanding and notion of wellbeing in later life is going through a re-assessment, and what constitutes ‘old age’ will continue to change, as will notions of ‘career’, ‘retirement’ and ‘independent living’.”

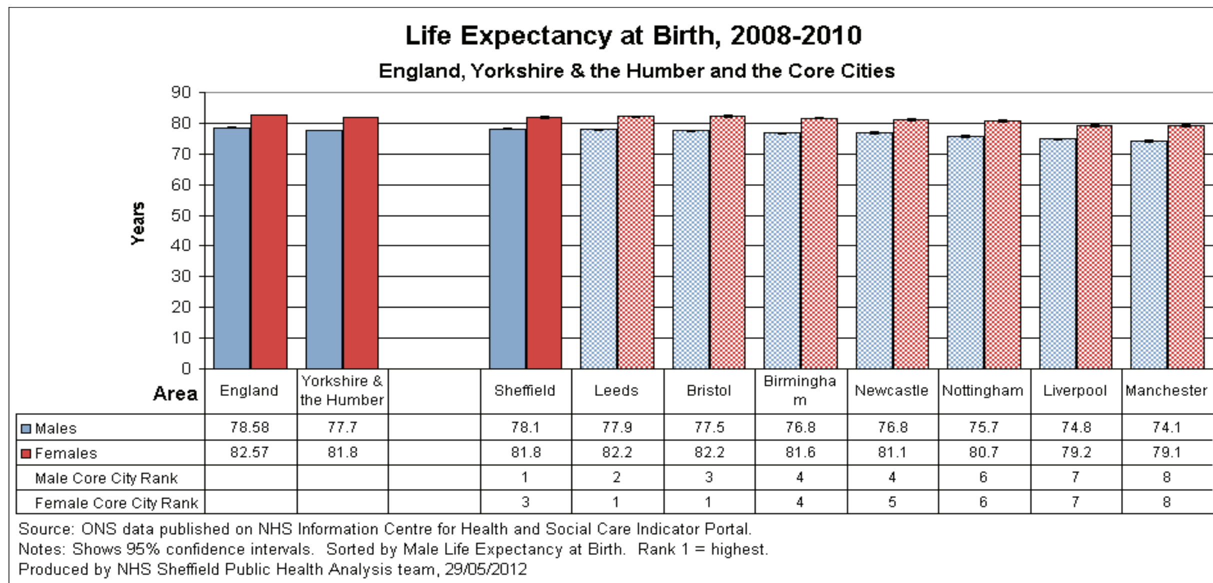
Currently around 9,000 older people (12% of all in city) receive support, and by 2025 it is estimated that there will be a 23% increase in people aged over 75 years living alone, and an increase of 21% in people over 65 years old unable to manage at least one self-care activity (such as washing or dressing) on their own.

The ‘health’ of a city not only refers to people but also to other measures such as its environment and its future sustainability. The Sustainable Cities Index published by Forum for the Future ranks the UK’s 20 biggest cities by tracking their progress on sustainability. Although the composite index placed Sheffield 7th overall in 2007 but 10th in 2010, the city has improved its overall environmental performance ranking from 10th in 2007 to 4th in 2010, and its overall quality of life ranking from 13th in 2007 to 5th in 2010.

Sheffield’s green space is recognised as a positive asset for the city and Sheffield’s scores in the index are also encouraging for air quality and the levels of household waste – as with all other cities the waste generated by the average person has been reduced. However the city scores poorly for recycling. The city benefits from an award winning City Centre District Heating Scheme, a low carbon energy source, which provides heating and hot water to over 140 buildings in the city centre. Getting around the city is changing with more people using Supertram and walking and cycling although bus travel is declining and motor vehicles are still used by most people to travel. In line with other cities, Sheffield needs to do more to tackle climate change. Carbon emissions from transport, industry, commerce and domestic activities, a more general indicator of sustainability, have declined in total in Sheffield over the period 2005 to 2009, from 3.8 million tonnes to 3.1 million tonnes. Sheffield has more micro-generation of electricity by households and small businesses from renewable resources than any other core city, mainly from solar production.

Outcome 2: The health and wellbeing of people in Sheffield is improving all the time

There have been major improvements in the health and wellbeing of people living in Sheffield over the past few decades. Sheffield has the highest male life expectancy and the third highest female life expectancy of the eight Core Cities. People in all parts of the city are living longer, deaths from major illnesses, especially heart disease and cancer, have reduced markedly and there has been a reduction in the number of people, particularly children, killed or seriously injured on the roads. Men's health, which has historically been worse than women's, has and continues to improve markedly. Consequently, mortality rates for men have halved since 1975 and for women reduced by 40%, and life expectancy, at 81.8 years for women and 78.1 years for men, is now only a little below the national average.



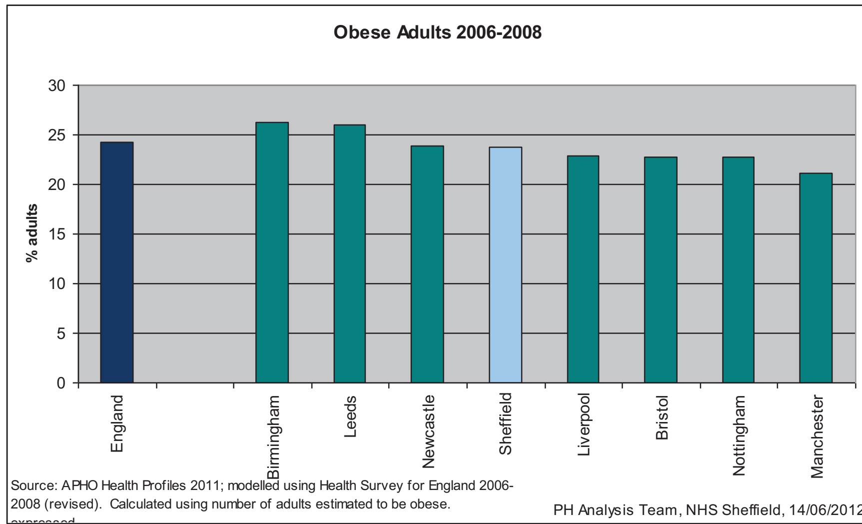
Area	England	Yorkshire & the Humber		Sheffield	Leeds	Bristol	Birmingham	Newcastle	Nottingham	Liverpool	Manchester
Males	78.58	77.7		78.1	77.9	77.5	76.8	76.8	75.7	74.8	74.1
Females	82.57	81.8		81.8	82.2	82.2	81.6	81.1	80.7	79.2	79.1
Male Core City Rank				1	2	3	4	4	6	7	8
Female Core City Rank				3	1	1	4	5	6	7	8

Source: ONS data published on NHS Information Centre for Health and Social Care Indicator Portal.
Notes: Shows 95% confidence intervals. Sorted by Male Life Expectancy at Birth. Rank 1 = highest.
Produced by NHS Sheffield Public Health Analysis team, 29/05/2012

However, we know that there is more still to do to ensure that the health and wellbeing of people in the city is improving all the time. There remain some stubborn areas of ill-health, including, for example, mental ill health and obesity. Some of these areas are caused or exacerbated by poor lifestyle choices.

Obesity and unhealthy diets

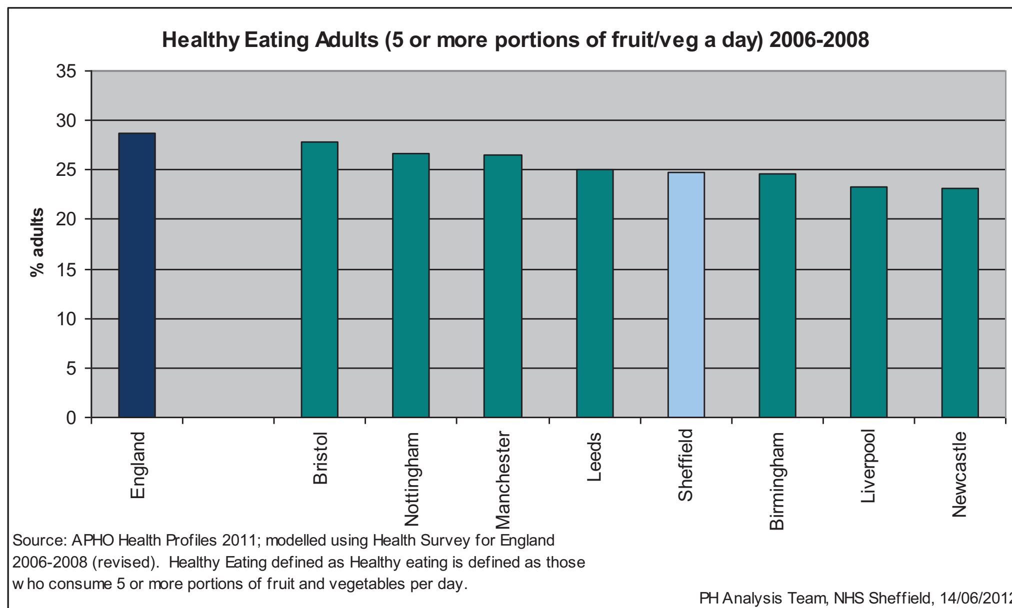
By 2015 it is estimated that obesity will cost Sheffield £165m per year. Obesity in children (aged 4-5) has been increasing in Sheffield, in contrast to national and regional trends.



Evidence shows that breastfeeding significantly increases a child's chances of being healthy throughout life, and the proportion of mothers initiating breastfeeding at delivery has increased from 70% in 2004 to 78% in 2010, but there are wide variations across the city with as few as 42% of mothers breastfeeding in some areas compared to over 90% in other parts of the city. In Sheffield, obesity in children remains a significant issue. In 2010-11, 34.4% of 10-11 year olds were classed as overweight or obese, and 22.8% of 4-5 year olds were overweight or obese.

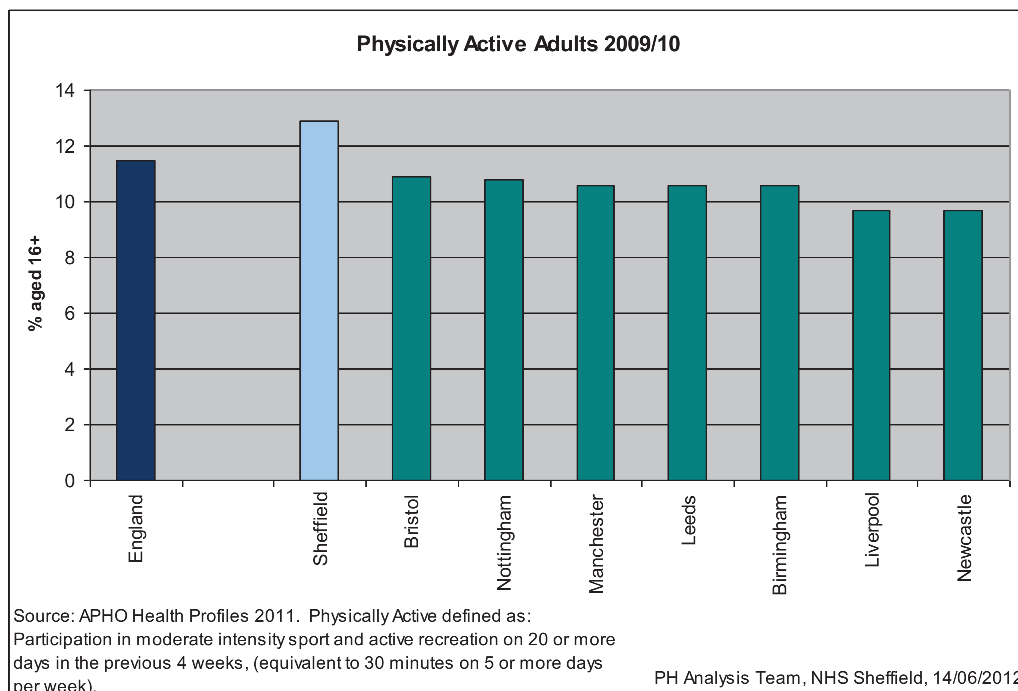
Obesity is estimated to be responsible for 58% of Type 2 Diabetes, 21% of heart disease, 10% of non-smoking related cancers and around 9,000 premature deaths per year in England (Foresight 2007).

The Department of Health estimates that nationally, 70,000 deaths a year could be prevented in the UK if people's diets complied with nutritional guidelines. This equates to approximately 580 deaths a year in Sheffield.



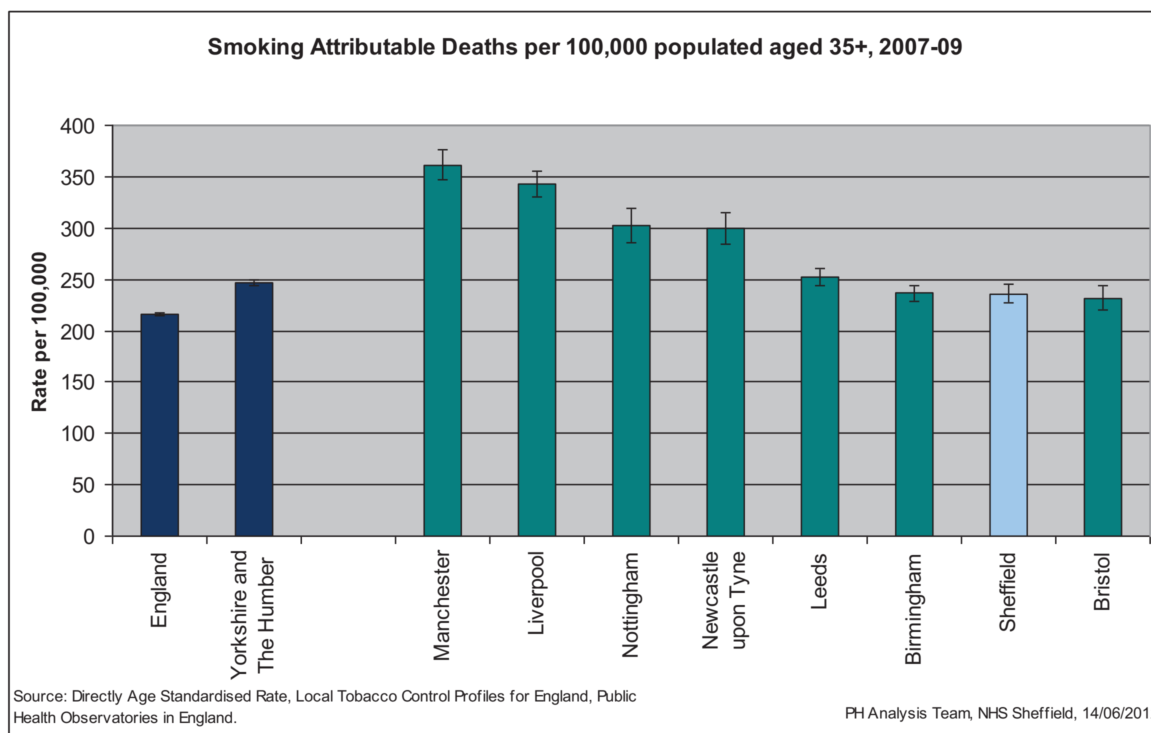
People's average daily intake of salt also has a negative impact of health and can lead to Cardio Vascular Disease. A 3g per day reduction in Sheffield would translate into approximately 162 fewer premature deaths per year in the city. Compared to the national average and the Core Cities, Sheffield has high diabetes and obesity rates and low levels of healthy eating.

Lack of exercise



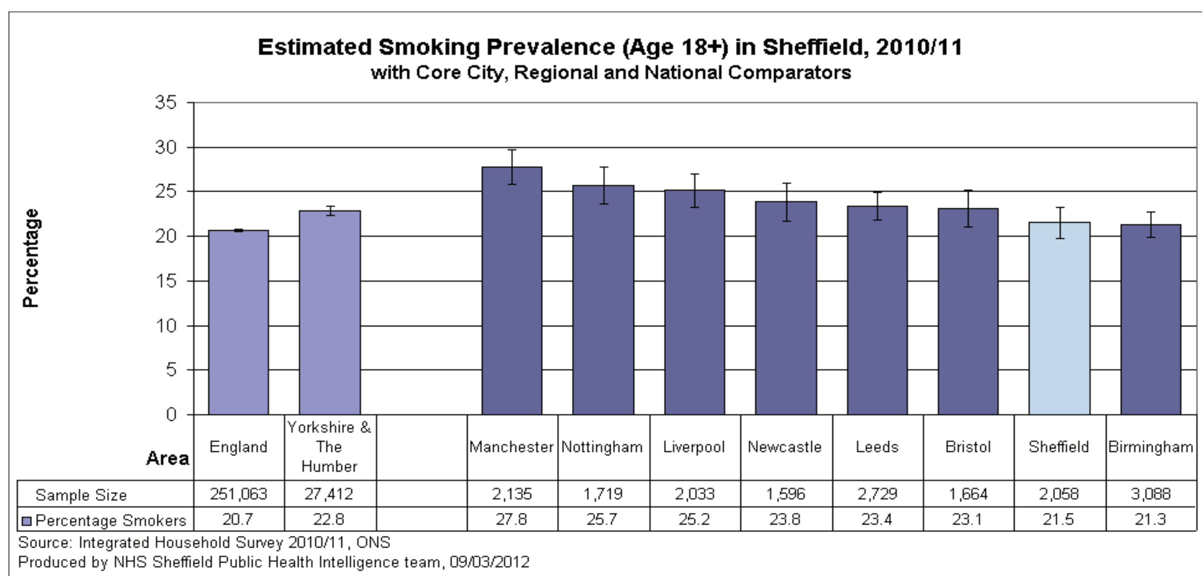
Smoking

Smoking related illness account for nearly 1,000 deaths and costs society up to £137m every year in Sheffield alone.



Sheffield smoking prevalence in persons aged 18+ is 21.5% (2010/11), similar to that in Yorkshire and the Humber (22.8%) and England (20.7%), and putting Sheffield within the 2nd highest quarter of local

authorities across England. Sheffield has the second lowest smoking prevalence rate in persons aged 18+ (2010/11) among the Core Cities (range 21.3% - 27.8%).

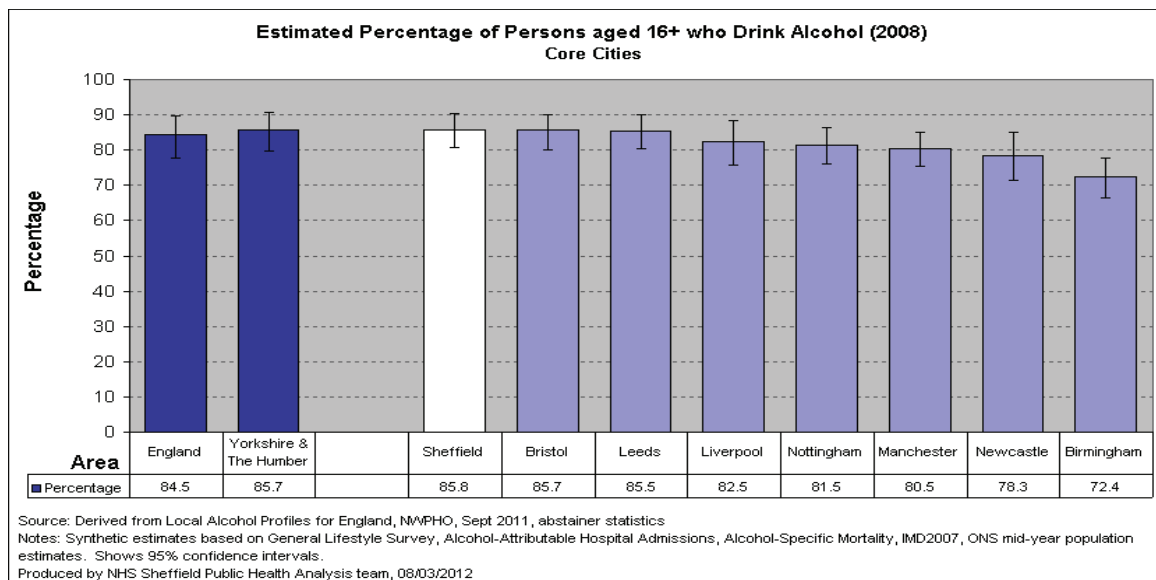


Area	England	Yorkshire & The Humber		Manchester	Nottingham	Liverpool	Newcastle	Leeds	Bristol	Sheffield	Birmingham
Sample Size	251,063	27,412		2,135	1,719	2,033	1,596	2,729	1,664	2,058	3,088
Percentage Smokers	20.7	22.8		27.8	25.7	25.2	23.8	23.4	23.1	21.5	21.3

In 2009/10, the estimated smoking prevalence in routine and manual workers (32.7%) was statistically significantly higher than that in the population as a whole (23.4%). Data for 2010/11 are not yet available for routine and manual groups.

Alcohol

Sheffield has the highest estimated proportion of people aged over 16 who drink alcohol of all the Core Cities, with an estimated 51,000 'high risk' drinkers.[7] 6,500 people are admitted to hospital each year due to alcohol-attributable conditions.

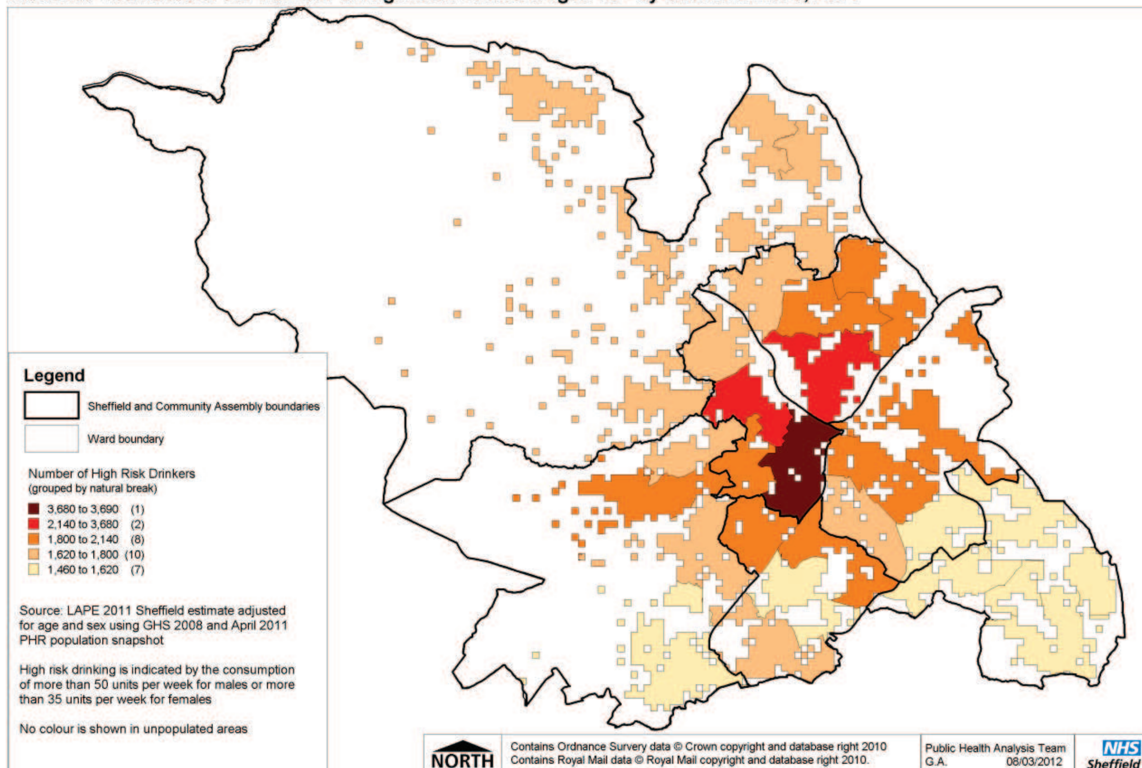


Area	England	Yorkshire & The Humber		Sheffield	Bristol	Leeds	Liverpool	Nottingham	Manchester	Newcastle	Birmingham
Percentage	84.5	85.7		85.8	85.7	85.5	82.5	81.5	80.5	78.3	72.4

[7] 'High risk drinkers' – with an average weekly alcohol consumption of more than 50 units for men or 35 units for women

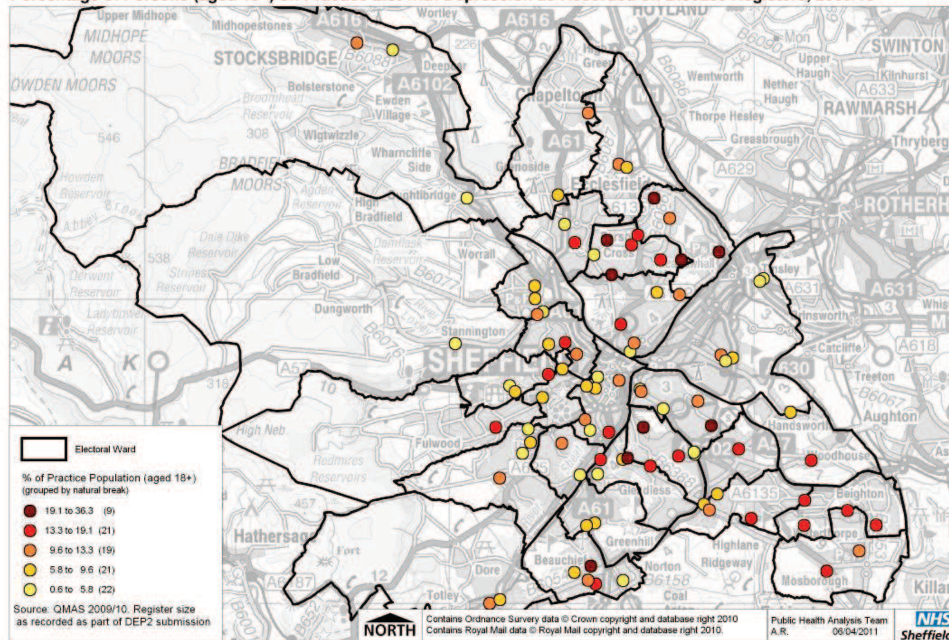
This has led to a rise in chronic conditions such as heart disease, respiratory disease, cancer and strokes as well as to other health problems such as sexually transmitted infections and poorer health in children and young people.

High risk drinking is defined as a usual consumption of more than 50 units of alcohol per week for men or more than 35 units per week for women. The map shows the estimated number of adults aged 16+ who are high risk drinkers by Sheffield ward, 2011 (LAPE 2011 Sheffield estimate adjusted for age and sex using GHS 2008 and April 2011 PHR population snapshot).



Mental health and wellbeing

Promoting mental health and wellbeing for everyone has multiple benefits. It improves health outcomes, life expectancy, productivity and educational and economic outcomes and reduces violence and crime. The impact of the recession means that the need for resilience is needed now more than ever to prevent health and wellbeing outcomes sliding backwards.



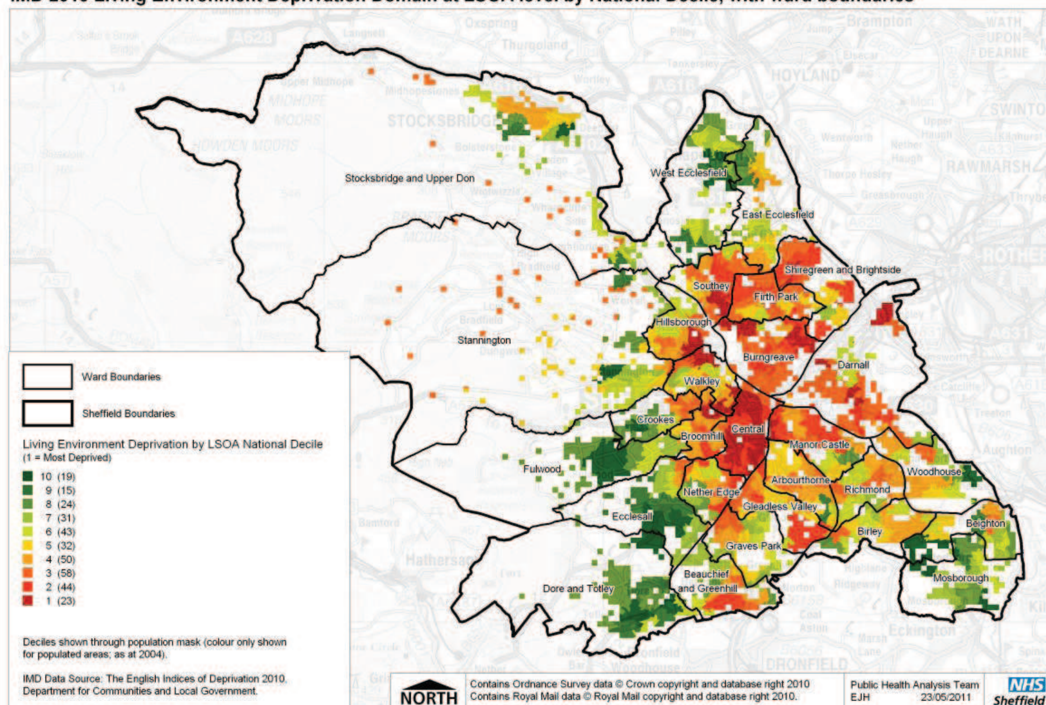
- Mental health needs and problems have a range of causes, and generally, mental ill health is very common, 1 in 4 people will experience a mental health problem at some point in their life, and very expensive for society, £105 billion in 2010 for the economy in England.
- Feeling good and functioning well influence physical health, affecting people's behaviour around smoking, exercise, healthy eating, sex, and alcohol and drug use.
- People with mental health problems have higher rates of physical illness and die earlier than the general population, largely from treatable conditions. People with long term physical health conditions often have undiagnosed mental health problems. The interaction between physical and mental health problems drives the cost of treatment up.
- There is a strong evidence base supporting the focus on work with children and young people. Half of people with lifetime mental health problems first experience symptoms by the age of 14 and three quarters before their mid-20s.
- Mental ill health is more common in the most deprived parts of the city.
- The Marmot report 2010, clearly demonstrates that increases in unemployment lead to increases use of mental health services and suicide
- The Mental Health Needs Index indicates that Sheffield has a 15% higher than predicted admission rate for severe mental health problems than England as a whole. Women are one-and-a-half times more likely to be affected by anxiety and depression; there are higher rates of depression in non-white ethnic groups.
- Although deaths from suicide and undetermined injury in Sheffield are lower than the average for England, local audit has indicated that depression was a key factor in 40% of deaths between 2006 and 2010.
- There is clear evidence of the adverse effects of domestic violence on women's mental health, that it can last for many years and that it leads to increased use of mental health services. A

meta-analysis of 18 studies found an average rate of post-traumatic stress disorder among victimised women of 64%, a rate of depression of 48% and a suicide rate of 18%.[8]

Housing

Housing has a major impact on health and wellbeing and we have some significant challenges in Sheffield. Only 55% of the city's existing private rented sector housing meets the decent homes standard with 37% classed as 'non-decent' and a fifth having Category 1 hazards.[9] Category 1 hazards pose a major risk to people's wellbeing and the estimated cost of addressing all these in Sheffield is £186m (mainly in owner occupied properties). The challenging economic climate means that there is limited new housing development in the city and demand for housing is increasing, driving up the average rents in the private rented sector. Further, **homelessness** increased by 31% between 2009/10 and 2010/11, which has severe implications for people's health and wellbeing.

However, in reality the root causes of ill-health go much deeper than this, with a poor start in life, low educational attainment, unemployment, deprivation, discrimination and low quality housing all contributing to poorer levels of health and wellbeing. In particular, we know that a focus on parenting, pregnancy and early years of life can help to develop the secure emotional and physical foundations upon which good health, wellbeing and life chances are built.



Outcome 3: Health inequalities are reducing

Sheffield is a city with stark inequalities between different groups of people and between different geographical communities. These inequalities are present regardless of which issue is being looked

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[8] Golding, J.M. (1999) Intimate Partner Violence as a Risk Factor for Mental Disorders: A MetaAnalysis Journal of Family Violence 14 2 99-132

[9] 'Category 1 Hazards' are things which are highly likely to cause a serious accident in the home.

at. The life expectancy difference between the top 10% and bottom 10% of the city is 10.9 years for men and 7.0 years for women. There are 29 neighbourhoods in the city that are within the 20% most deprived in England, and 28% of the city's population live in these areas. Between the 'best' and the 'worst' wards in the city we have:

- a 2 fold difference in achievement at Early Years Foundation Stage
- a 4 fold difference in infant mortality rates
- a 7 fold difference in smoking in pregnancy

People in the most deprived parts of Sheffield still experience a greater burden of ill health and early death. This reflects the key issue that inequalities in health and wellbeing are intrinsically linked with wider social, cultural and economic conditions.

There are similar inequalities between different groups of people in the city – generally speaking, Black and Minority Ethnic (BME) people in the city have lower attainment at school, are more likely to be victims of crime and anti-social behaviour and are less likely to be able to find work than Sheffield's population as a whole.

Similarly, there is clear evidence that particular BME communities also have a range of specific health and wellbeing needs, reflecting distinct communities of people with strong identities, and different cultural backgrounds, beliefs and experiences. Many of these communities, although not all, experience relatively poor health and wellbeing, and a number experience relative poor health in respect to coronary heart diseases (stroke is 70% more common among African Caribbean and South Asian populations); Type 2 diabetes (six times more prevalent in South Asian communities); and mental health (31% of people detained under the Mental Health Act were from BME communities in 2006/7, although BME communities only make up around 15% of Sheffield's population).

Homelessness in Sheffield increased by 31% between 2009/10 and 2010/11 and homelessness often has profound implications for physical and mental health and wellbeing and is particularly associated with drug and alcohol problems.

The second biggest cause of homelessness is domestic abuse and both domestic and sexual abuse are well known to have a significant impact on health. Domestic and sexual abuse are strongly associated with a number of major health issues including substance misuse and alcohol misuse, depression, post-traumatic stress disorder, eating disorders, self harm and coronary heart disease. Studies show that in children, domestic violence seriously impairs emotional, behavioural and cognitive development. In 2009, Home Office estimates suggested that **16,616** women and girls were victims of domestic and sexual abuse in Sheffield and **8,576** women and girls were victims of sexual assault. Estimates also suggest that there are between **1,092 and 3,185** hospital attendances a year in Sheffield which are directly attributable to domestic abuse.

The estimated the number of carers in Sheffield will be 66,715 by 2015, higher than the national estimates suggest.[10] Although caring can be an immensely positive experience, there is also evidence that caring can increase physical stress, lack of sleep and long term limiting illness, with a strong association between long hours of caring (50+) per week and mental health issues, including

[10] Sheffield's Carers Health Needs Assessment (2012)

increased stress, anxiety and depression. Caring commitments can reduce opportunities for training and education, loss of income (including increased likelihood of poverty and reliance on benefits), increased costs and reduced levels of social interactions and friendships. There are also inequalities in caring, with a higher proportion of carers providing at least 50 hours care per week in the more deprived areas of Sheffield.

Children and young people with learning difficulties and disabilities experience particular inequalities. These include geographical inequalities in diagnosis: for instance in the more deprived areas of Sheffield, diagnoses of autism are lower whereas diagnoses of Behavioural, Emotional and Social Difficulties (BESD) are higher. This can lead to different educational outcomes and opportunities. 30% of young people with BESD in Sheffield are Looked After Children and/or from Black Minority Ethnic communities. There are also geographical inequalities in risk of becoming 'Not in Employment, Education or Training' (NEET): in December 2011: 90 (13%) young people with LDD from the North East of Sheffield were NEET compared to just 3 (1.9%) from the South West.

The relationships between the various variables of deprivation, social behaviours, life choices and health outcomes are complex and not amenable to straightforward analysis. For example, Sheffield's teenage pregnancy rates have improved markedly over the last few years, and the trend has been steadily downwards since 2004, and Sheffield now has the lowest rate of all Core Cities and is close to the national average.

Nevertheless it remains the case that health inequalities are a blight on the city – it has been shown that more equal societies achieve better outcomes for everyone (not only the most deprived).

- Whilst children and young people growing up in Sheffield today are generally healthier than ever, between the 'best' and the 'worst' wards in the city we have:
    - a 2 fold difference in achievement at Early Years Foundation Stage;
    - a 4 fold difference in infant mortality rates;
    - and an 8 year gap in male and female life expectancy at birth
- Sudden infant death rates are higher in Sheffield than nationally and concentrated in more deprived areas. Analysis of mothers who lose children to sudden infant death shows that 90% of the mothers smoke and 83% have social or mental health vulnerabilities
- Smoking during pregnancy is reducing but is still above the national rate and there is a seven fold difference at Community Assembly level in the proportion of women who are smoking 'at delivery'.
- Breastfeeding rates are above the national average - currently 52.3% women are breastfeeding at 6-8 weeks compared to a national average of 45.2%, but again wide inequalities exist within the city.
- There has been some successful partnership working which has helped to slow the rise of childhood obesity but downstream the problem is still significant, which will impact health outcomes in later life and demand for hospital and primary healthcare services. Partnership working targeting those most at risk has been successful in reducing Sheffield teenage pregnancy rates which are now lower than ever, although still above the national rate.

Outcome 4: People can get health, social care, children's and housing services when they need them, and they're the sort of services they need and want

Outcome 5: The health and wellbeing system in Sheffield is affordable, innovative and delivers excellent value for money

Over the next 10 to 20 years there will be a significant increase in the number of older people in Sheffield, alongside increasing numbers of children and working age adults with disabilities and complex needs. In the last ten years, the number of people aged over 85 in the city has increased by 139% to 11,800 and by 2030, around 21,000 people will be 85+. What constitutes 'old age' will continue to change, as will notions of 'career', 'retirement' and 'independent living'. Whilst we are focused on maximising the number of healthy years of life people experience, we know that this population change is likely to increase demand on health, housing and social care resources.

Currently around 9,000 older people (12% of all in city) receive some support, and by 2025 it is estimated that there will be a 23% increase in people aged over 75 years living alone, and an increase of 21% in people over 65 years old unable to manage at least one self-care activity on their own. More of Sheffield's older population are in residential care than the national average, although most people would wish to be in their own home where they can.

In Sheffield we currently have 6,382 people living with dementia and this is expected to rise to 7,342 by 2020 and 9,340 by 2030. The biggest increase will be in the people aged 85+ which will nearly double over the same period. A relatively small number of people with dementia are from black and ethnic minority groups, but this will increase substantially in future years. The increases projected in the city's population means that by 2020 there will be an increase of over a thousand older people projected to suffer from dementia; by 2030 there may be an additional 3,000 people with this illness.

This is based on the assumption that the incidence of dementia will not increase, simply the number of older people

We predict significant increases in the number of disabled people over the next 10 to 15 years. In particular, we expect there will be an increase the number of people with the most complex disabilities (including people with disabilities from black and ethnic minority groups) who require high levels of support from health, housing and social care services.

Increasing unemployment and falling incomes through the current economic crisis is likely to impact on the health and wellbeing of our population, further increasing the demands on health and wellbeing services, and exacerbating existing inequalities.

In the face of these challenges, it is unsustainable to continue providing services in the way we've done in the past. The way that health and social care services are currently provided in the city needs to change to improve health and wellbeing throughout life, prevent avoidable ill health and dependency, and assist recovery. At the present in Sheffield, we don't get people back up on their feet quick enough:

- the average length of stay in hospital following an emergency admission in Sheffield is 6.4 days which is 28% higher than the national average and is the joint highest nationally
- our performance on achieving independence for older people through rehabilitation or intermediate care is only 'average'
- an audit in 2010 showed that of a sample of people aged over 75 that were admitted to hospital urgently, 49% did not meet the criteria for admission and could have been managed through either Home Care, sub-acute rehabilitation, a lower level of care or managed as an outpatient.

- Sheffield has a higher proportion of emergency admissions to hospital than the national average.
- However, Sheffield has relatively short average lengths of stay in the Children's Hospital.

Evidence suggests that hospital beds numbers could be reduced if admission to hospital only occurred for those with medical necessity, with other more appropriate services being delivered to support people with other levels of need.

We need to increase the amount of community based health and social care resources that promote health and wellbeing throughout life with the intention of reducing the demand for acute services in older age. Further, we need to ensure that the health system in Sheffield prioritises the maintenance and maximisation of independence for people of all ages. We will enable people to access health services, care and support if they need it in a way which meets their individual needs. We will aim to support people to access services at home or in their local community so that people can carry on with their lives as far as is possible and we will strive to deliver the right services which prevent problems getting worse.

- There is currently high use of children's emergency care with the highest
  - <5yrs A and E attendance from the most deprived areas of the city. In 2010/2011
  - there was a total of 51,540 visits to Sheffield's Children's Hospital A&E department, of which 25,512 were under 5s.
- Sheffield benchmarks very poorly against the national average and core city average for A&E attendances and emergency admissions for the under-fives e.g. emergency admissions rate (09/10) for respiratory conditions in 0-4 year olds in Sheffield is highest in England at 239.41 per 10,000 compared with Bristol (98.05) and nationally (115.26) (ChiMat 2009/10). Local data show that the highest use of A&E attendance in Sheffield is from the most deprived areas where rates are up to 50% above the city wide average
- There has been a large increase in the number of children and young people with a learning disability since 2000, and in the last ten years the number of 10 to 20 year olds with a learning disability increased by 120%, although in the last five years the number increased by 38%, suggesting that the rate of increase may be slowing. The number of young people affected is small compared to other health issues, but care costs are high
- Data also indicates a significant increase in the number of people in Sheffield with severe or complex needs, and again particularly in younger age groups. The overall number of people with such needs rose by 17% between 1998 and 2008. However, the number of 15 to 19 year olds with severe or complex needs increased by 70% over the same time.

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

12th September 2012

Report of: Richard Webb, Executive Director, Communities

Subject: **Transforming Support for People with Dementia who live at Home – an Involvement Exercise**

Author of Report: **Howard Waddicor, Commissioning Officer, Communities 0114 2057103**

Summary:
This report is a summary of the responses to the Dementia Involvement Exercise undertaken from June 2012 to August 2012.

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

Reviewing of existing policy	X
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:

- Scrutiny is asked to comment on the themes identified and recommend others to be included in the Cabinet report

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Background Papers:
List any background documents (e.g. research studies, reports) used to write the report. Remember that by listing documents people could request a copy.

Category of Report: OPEN

Report of the Director of Communities – Richard Webb

Transforming Support for People with Dementia who live at Home – an Involvement Exercise

1. Introduction

1.1 Sheffield has a long established, multi-agency Dementia Programme Board chaired by Richard Webb, Executive Director (Communities) with representation from Sheffield City Council, NHS Sheffield, Sheffield Health and Social Care Foundation Trust, Sheffield Teaching Hospitals, Dr Steve Thomas as the CCG Dementia lead and the Sheffield Alzheimer's Society. Its function is to deliver on the National Dementia Strategy (2009) built on by the Prime Minister's Challenge launched in March 2012.[1]

1.2 To inform some of the changes needed to modernise the support for people with dementia who live at home, a report was submitted to the Sheffield City Council Cabinet on 26th May 2012 seeking approval to engage in a three month involvement exercise.

1.3 The purpose is to understand the key issues for people affected by dementia in order to plan support for the future. The growing number of people with dementia represents a significant issue for the city. The existing support arrangements will not meet the increase in demand or the changing expectations of people with dementia

1.4 This report draws together some of the emerging themes which will form the basis of a Cabinet Report on 26th September 2012 and sets out the next steps.

2. What did we ask?

2.1 The exercise began on 1/6/2012 and will finish on 31/8/2012. The key questions were:

- How can Sheffield communities better understand the needs of people with dementia so that living at home is a safe and positive option?
- What types of support work best for people with dementia living at home?
- What are the features of good support for carers of people with dementia?
- How can we facilitate change but protect existing users of services?
- How can health and social care providers work closer together for the benefit of people with dementia?

1.2 Responses were sought from:

- People with dementia
- Carers of people with dementia
- Providers of support

[1] Prime Minister's challenge on dementia, DH, March 2012

- Community groups and organisations
- Other interested parties including NHS Sheffield, housing providers, the wider council and the voluntary community and faith sector

1.3 A range of activities were used to engage people:

- A carers' event was held on 31/7/12 at the Town Hall attended by over 50 carers. This has produced a significant amount of information, much that could have been predicted, but a number of important suggestions and comments on how services should be delivered.
- On Tuesday 21/8/12 a 'Talk to Us' day was held at the Showcase Sheffield exhibition centre, a shop-front on the corner of Pinstone Street and Cambridge St. inviting responses from
- Sheffield Alzheimer's Society has undertaken to work with a group of people with dementia and produced a report about their specific views.
- A postcard has been co-produced with carers inviting people to suggest ways in which Sheffield can lead the way in becoming a dementia friendly city by 2015 (see **Appendix A**)
- There have been specific meetings with a range of providers to invite comments from their perspective about what works
- A number of visits have also been made to carers who were unable to attend events
- All stakeholders have been invited to produce written responses to the 5 questions.

3 What does this mean for the people of Sheffield?

3.1 To help understand what the response means for future investment in dementia services representative contributions have been ordered in **APPENDIX B** into the different levels of social care investment. These levels reflect the intensity and cost of delivering support. Broadly Levels 1 and 2 and 2b include those support services that help people (including carers) before they have an eligible social care need. Level 3a delivers support to people who live at home including specialist interventions. Level 3b is for those people in care homes.

3.2 The responses summarised below in general emphasise the need to increase investment in a wider range of support for people with dementia in the early and middle stages to make sure that people have the best chance of living well at home.

3.3 Through better support for people at home we should successfully delay, or prevent, the need to fund more expensive support for people at Level 3b (care homes). Currently by far the biggest proportion of funding is at Level 4. A relatively modest shift in the proportion of people supported at this level would similarly enable an increase in the proportion of funding at the lower Levels 1, 2a and 2b.

3.4 What came through very strongly was that whilst this shift can reduce admissions to care homes it support needs to be maintained for the relatively small proportion of people with the most complex needs at home. This refers to those people, some of whom are currently

supported by the resource centres, who are most at risk of admission to a care home (Level 3a).

3.5 Key themes emerging included:

Levels 1 and 2 and 2b

- The importance of creating a **dementia-friendly city**. Whilst health and social care support is crucial to living well, people with dementia and their carers also live in communities which need to better understand the issues they face. This is particularly important in the early stages when people still want to do the things that they have always done.

- There is a clear view that there is **no single answer** to what is right for people with dementia. The experience of dementia and the resources each individual has to manage varies which means that a range of support opportunities is required.

- **Early diagnosis** is crucial and early access to support to help plan for the future is something most people recognise, often with hindsight, is valuable.

- There is too little **information** for people about what is available and what might help. It was also recognised that people need help understanding what the right kind of support is.

- Providing opportunities for **carers** to have a break – both planned and in a crisis - enables them to live their own lives and be confident about the support offered to the person with dementia. In addition all those involved with the person with dementia need to understand the emotional impact on the carer and take time to acknowledge that.

Level 3a

- Improving the way **health and social care** and other public services work together to support people to live at home can improve the experience of people with dementia. This applies especially to people with dementia discharged from hospital to make sure they are safe and that the levels of community support is adequate to sustain them.

- It was very clear that people with more **complex needs** should have access to the right amount of individualised support, using community resources, alongside an integrated range of more formal health and social care interventions. This was viewed as vital to reduce the likelihood of admission to a care home or hospital. The key message is that the support for this group should have the same personalised approach but be delivered by skilled staff in settings that are appropriate to their needs. Not everybody who was at this level was able to be supported through the existing resource centre model.

- **Home support** providers even specialist support, seem to lack the skills and understanding of how to support people with dementia. Particular concern was raised about those people who live alone.

Level 3b

- **Care Homes** Though not specifically part of the exercise, views were expressed about the support that people have received in residential and nursing care. Though many found the support good there was evidence of inconsistencies and a lack of skill in supporting people with dementia – even in specialist units.

3.6 Similarly, views were expressed about services that are the responsibility of NHSS / Clinical Commissioning Group (CCG). People reported the need for improvements in:

- The level of **understanding in primary care** about the impact of dementia. Many respondents highlighted the role that particularly GPs have in prompt referral to the memory service and the subsequent support for the patient and any carer.

- Some people reported **delays** following referral to the memory service although many reported positively on the support they received both during and after diagnosis.

- Many carers recounted very difficult and distressing experiences for people with dementia in **hospital**. In particular they expressed concern about a lack of tolerance and understanding of the way in which dementia affects people.

4. What will happen next?

4.1 The results will be analysed in more detail and the implications for existing investment in dementia services will be considered including opportunities for joint commissioning with NHS/CCG.

4.2 An outline plan for how services will be changed will be drawn up and included in a report to Cabinet on 26th September 2012. This will include any comments made by Scrutiny

5. Recommendation

5.1 Scrutiny is asked to comment on the themes identified and recommend others to be included in the Cabinet report

Howard Waddicor

Commissioning Officer

August 2012

APPENDIX A: Dementia Friendly City Postcard

Sheffield Leading the Way - a dementia friendly city by 2015

Tell us what a dementia friendly Sheffield looks and feels like by 2015 in words or pictures:-

NO STAMP NEEDED

Freepost NEA5527
Quality & Development Team
Corporate Mail Facility
Town Hall
Sheffield
S1 2ZZ

"I have dementia... but I also have a life"

For more information please visit www.sheffield.gov.uk/dementia
or contact Howard Waddicor, Phone: 0114 205 7130
Email: practicedevelop@sheffield.gov.uk

DP12194

Alternatively, return to us in person: Main Reception, Redvers House, Union Street, Sheffield S1 2JQ

APPENDIX B: Key Themes Identified

Level	Types of support	People with dementia	Themes emerging
1. Promoting lifelong health and wellbeing	• Support for everyone. • Building personal and community resilience • Public Information.	• Awareness campaigns • Stroke reduction campaigns	• Dementia Friendly Communities can make a difference but this will be a long term impact – less relevant for people with dementia now • Importance of awareness for all – individuals carers and professionals – especially in primary care • Dementia Alliance would be welcomed – anything that gets people to understand the needs • Early diagnosis crucial – especially important for early onset dementia. Helps people make adjustments and plan for the future. It gives people access to anti-dementia medication • Using 'well- being' cafes (similar to Muslim Elder Support Projects) is a way to share healthy lifestyle information and reduce vascular dementia • Organisations like banks often unhelpful to people who forget passwords or where one partner looses capacity to manage finances and will sometimes refuse to deal with carers • "Increasingly organisations, including Sheffield City Council, require people to conduct business online, or in person. This presents barriers to people with dementia and others. There is learning here from some utility companies such as British Gas who have established a vulnerable people team that can respond flexibly and sensitively"

Level	Types of support	People with dementia	Themes emerging
2. Early, short term, or one off interventions promoting recovery and independence	**a) Community based** Support for people who are close to needing significant support. • Investment in third sector and community organisations. • Self Help • Specialist advice and information • Carer support • Befriending • Assistive technology • Lunch clubs	• Dementia Cafes • Dementia Adviser service • Peer support • Link to primary care to support post diagnosis	• Dementia cafes are well regarded. Key features are the peer support and the availability of experienced, thoughtful staff who can help advise informally. • Question about whether there should be cafes solely for people with dementia? • Caring and Coping, Coping with Forgetting are valuable in terms of understanding and managing but also create basis for peer support - Needs to be available for all – waiting lists are too long • Proactive information, advice and support crucial. The Dementia Adviser service could be a basis for local model. To cope with increasing rates of diagnosis there needs greater investment • Blue Badges for people with dementia? – the criteria is not currently not clear but people with dementia are not excluded • Carer's need information about what is available. The type of information they require varies depending on their own circumstances and level of need • The needs of the carer and the person with dementia are not always the same but the carer needs to be sure that the person with dementia is safe and is getting the right support. • Flexible, personalised services that respect individual difference are fundamental. There is no one solution • Dignity and respect should be at the heart of all interventions • Admiral Nurses – a helpline available online and via telephone. There is a debate to be had about whether Sheffield would benefit from the service • 'Singing for the Brain' and 'Lost Chord' work well for people who find other forms of communicating difficult • Carer breaks fund help carers decide what support they need • Accurate and early information about contributions to the cost of services help people make decisions • The 'Help Yourself Directory' is a good source of information for people at all stages

Level	Types of support	People with dementia	Themes emerging
	b) Acute or specialist • Short term or intensive support. • Reablement. Equipment and adaptations		• Long delays were reported in the social care assessment process • Some expressed concern that self-directed support may exclude people with dementia. Some carers reported that it was could be onerous at a time when support should be timely. Others welcomed the opportunity but found it more problematic as an individuals capacity to choose diminished. • There is a concern that support planners lack specialist knowledge • Joined up working health and social care is – access to Rapid Response Team and CPNs • Responses to crises need to be better co-ordinated and if need be truly rapid if admissions to care are to be avoided • Avoid too many people being involved – co-ordinate care better • Crises can be avoided by effective contingency planning • Home support, even specialist services, seem to lack the skills and understanding of how to support people with dementia. Particular concern was raised about those people who live alone.
3. Medium to long term care and support focused on stability and quality of life	**a) Community based** • Personal Budgets. • Medium to long-term assistance to continue living at home. • Home support • Day opportunities		• Resource centre model works well for people with most complex needs, though not everybody wants this. • People value the skills offered by resource centres – they say that for some people the private sector cannot offer the same level of care • Can the private sector be trusted to deliver the quality of support? • People need good care not just en-suite facilities • Consistent care – familiar faces make a difference to the wellbeing of people with dementia • Not all support should be in day centres or respite care – some people do no want that or say that the experience only adds to their confusion and distress • “My dad would hate to go to a day centre but my mum needs a break”

Level	Types of support	People with dementia	Themes emerging
	b) Acute (or away from home) • Medium to long-term 24 hour assistance to live safely. • Residential and nursing care.	Residential and Nursing care	Concern about the skill levels in some care homes

Report to Health Scrutiny & Policy Development Committee September 2012

Report of: Tim Furness- Associate Director of Business Planning and Partnerships

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Subject: CAMHS waiting times and performance

Author of Report: Kate Laurance- Senior Commissioning Manager Children and Maternity NHS Sheffield

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Summary:

Child and Adolescent Mental Health Services have been significantly redesigned between 2010 and 2012.

There has been a significant investment into specialised inpatient provision to meet national standards and ensure care is delivered closer to home for vulnerable young people. This means enhanced facilities for vulnerable groups and those with the most complex and significant needs.

There has been a decrease in investment into Tier 2 services (primary mental health services) and Tier 3 services community specialist services. This has required a redesign of community CAMHS to make the service more efficient.

There has also been a large increase in referrals during 2010/11 and this has significantly impacted upon waiting times for community services.

Work is still underway to reduce waiting times and improve access to and performance of community services.

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	V
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:
Review the progress and next steps planned to reduce waiting times within community CAMHS

Background Papers:

The Sheffield Emotional Wellbeing and Mental Health Strategy 2011-14 online at https://www.sheffield0to19.org.uk/professionals/ewbmh.html

Interim Budget Report 2010/2011 Report to Cabinet
http://meetings.sheffield.gov.uk/council-meetings/cabinet/agendas-2010/agenda-26-july-2010#download

Report to Healthier Communities & Adult Social Care Scrutiny Committee
20th February 2012

Category of Report: OPEN

Child and Adolescent Mental Health Service (CAMHS) Performance and waiting times

1. Performance Management of Tier Four CAMHS

1.1 Highly specialised inpatient CAMHS provision is performance managed by the Specialised Commissioning Group with support from NHS Sheffield.

1.2 The providers report monthly on activity, length of stay, presenting conditions/diagnosis, referrals not accepted as well as details of the profile of patients admitted.

1.3 By taking a regional approach to performance management, it is hoped that a more consist approach can be applied between providers and standards will become consistent across inpatient provision nationally.

2. Performance Management of Specialist Community CAMHS

2.1 Specialist Community CAMHS is performance managed jointly between NHS Sheffield and Sheffield City Council, through a series of monthly, quarterly and annual reporting. The analytical services team at Sheffield City Council map trends and changes in the activity and commissioners in NHS Sheffield and Sheffield City Council meet quarterly with CAMHS management and clinicians to discuss fluctuations in performance. The aim is to ensure access to services remains consistent particularly for vulnerable groups, reduce waiting times to a minimum but improve performance so all teams are working towards operating within 18 weeks. The framework also enables continued needs assessment to be undertaken by developing a profile of presenting problems and ethnicity range etc.

2.2 A performance reporting framework has been jointly agreed between NHS Sheffield, Sheffield City Council, and Sheffield Children's NHS Foundation Trust the schedule includes the following: -

a) Monthly reporting on

- Referrals accepted - numbers
  - source
  - number rejected
- Waiting times
- Waits over 18 weeks
- Primary Health Care Worker – activity in Tier 2
- Number of training sessions offered

b) Quarterly reporting on

- Team composition
- 24/7 crisis response
- Open Cases by age, gender, and ethnicity
- Number of open cases receiving regular treatment –

(a snapshot report of the number of open cases which had an appointment on average every 6 weeks)

- New to follow-up ratio
- Number of cases receiving brief treatment (i.e. 8 sessions)

c) Six monthly reporting on

- Number of cases 16+ on caseload
- Number of cases transitioned over to adult MH
- DNA by team
- Presenting problem at referral

d) Annual reporting on

- Training report
- Access to specialist CAMHS (Number of LAC, refugee, etc. on open caseload)
- Age range of open caseload
- Ethnicity profile of open caseload

2.3 The performance group will also agree 3 detailed reviews to be completed on specific issues or areas of delivery where a more detailed qualitative review could help improve performance or the service for specific groups of patients.

3. Waiting Times and current performance

Specialist community CAMHS is not subject to an 18 week referral and treatment target contractually, currently there is also no national directive to enforce 18 week performance targets of CAMHS. However it is a standard we seek to achieve locally which is why it features within the performance reporting locally.

3.1 Waiting times

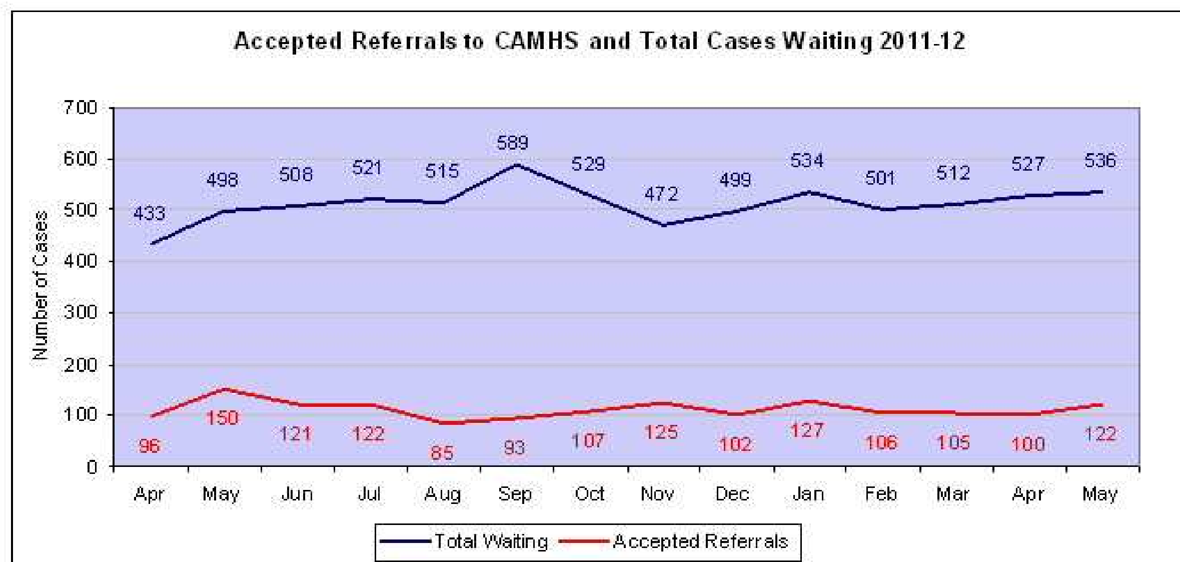
a. The Tier 3 'MAPS for Looked After Children', 'Forensic/Vulnerable Children's' and 'Learning Disability' – Mental Health services target specific sub-groups of our most vulnerable young people and are able to work closely with the relatively small group of professionals and referrers working with them. These teams have generally maintained low numbers waiting for an appointment, along with low waiting periods. Since January 2012, only one child waiting longer than 18 weeks for all of these services combined.

b. In contrast, the generic community teams, comprising just 33 practitioner staff, potentially respond to the full 11,000 children and young people in Sheffield with mental health problems and perhaps 1000 potential referrers of which 350 or more are general practitioners and family doctors.

c. Although the generic Community CAMHS services have generally experienced higher numbers waiting and longer waiting times, between 2006 – 2009 the service made significant progress in reducing the numbers of children waiting. This dropped from 359 children on the waiting list in 2006 to 105 in February 2009.

d. However, it was recognised that following the service redesign and the consequent service re-organisation, the generic Community Teams would see and did see an incremental rise in both the numbers waiting and the waiting times. The purpose of the redesign was to improve access to services and make them more efficient, with an understanding that the same activity could be achieved with reduced resources. However through any service redesign a dip in performance is expected. At the same time as the redesign referral to the service increased. Chart 1 below, shows the peak in the total number of children waiting in September 2011, the numbers subsequently reduced, but have begun to show a gradual increase since February 2012.

Chart 1 Accepted Referrals and Waiting Times 2011/2012



e. Chart 2 below, shows how the numbers waiting over 18 weeks for the specialist teams have remained generally low, but increased for community teams, peaking in September / October 2011, since which they have started to show a steady gradual decline**.** While chart 3 shows that the percentage of children waiting longer than 18 weeks showed an overall declined from October 2011 until March 2012, since which there has been a slight increase (see 4.2).

Chart 2: Numbers waiting over 18 weeks by team

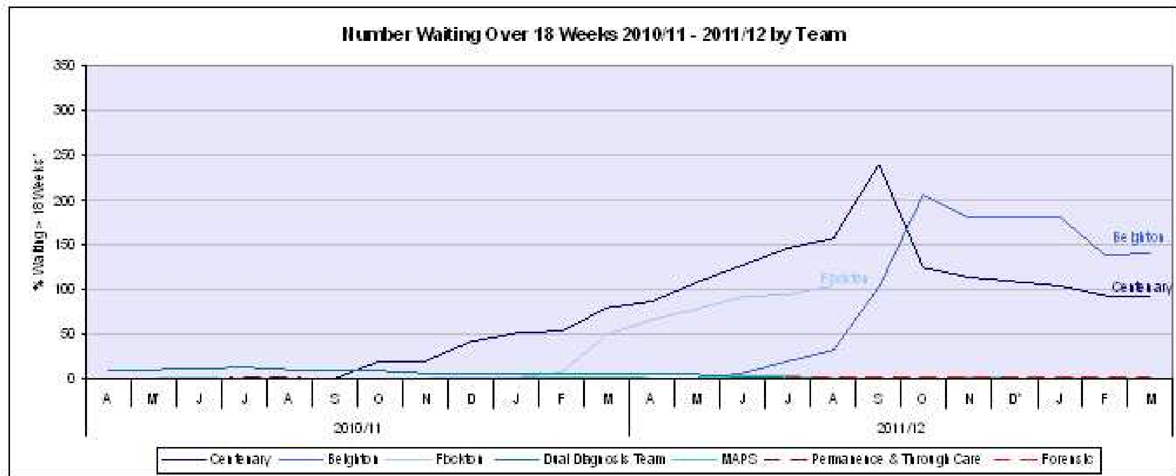


Chart 3: Percentage waiting over 18 weeks

4.1 Plan to improve Performance

a. The initial priority and focus was to ensure that the most vulnerable children currently receiving care and the most urgent cases waiting continued to receive a service which was both safe and effective. The service continued to offer consultation support to waiting families and their referrers; this includes the re-prioritisation of any cases which have become more severe and require an urgent response. A daily clinical triage takes place with all new referrals to enable urgency to be assessed.

b. The service has worked hard to ensure provision for the most vulnerable, and no untoward incidents have been reported. For those receiving a service, the feedback from a patient experience survey undertaken at the completion of the re-organisation moves in November 2011, was very positive

c. Subsequent to the re-organisation the Service has worked with the PCT to redesign service delivery in the long term. As part of this the specialist community CAMHS service is working closely with General Practitioners and MAST to ensure that children young people and their families can receive an effective and efficient service from an 'extended CAMHS' provision which offers timely support at the right level.

d. In the short term, following completion of the specialist CAMHS re-organisation in September, active steps were taken to address these detrimental waiting times. Sheffield Children's and NHS Sheffield agreed to establish and fund as part of the change arrangements a time limited, multi-faceted Waiting & Referral Intervention Project (WRIP) introduced from October 2011.

In October 2011 prior to the WRIP initiative, the waiting list at its peak comprised 655 cases with 67% of waits in excess of 13 weeks and some in excess of 52 weeks. Waiting list cases equated to 5 month's referrals for the entire service.

4.2 Waiting List & Referral Intervention Project (WRIP)

The WRIP provides re-triage, telephone intervention and brief intervention clinics or assessment (BIC) running both during the week and on Saturdays. All patients receiving brief interventions are asked for outcome and service experience feedback.

The first phase of the WRIP from October 2011 removed very substantial numbers from the waiting list but the numbers on the list reduced to a substantially lesser extent as the reorganisation after-effects were still ongoing. 496 patients had been involved with the WRIP at 29 May 2012 with 277 being discharged, 174 preferring to wait for 'treatment as usual' (now termed 'Extended Intervention') and 160 being seen by the Brief Intervention Clinic, (now 'Core Intervention'). Parents' understanding and ability to manage their family problems improved by more than 2 levels (of 6) and the majority of parents rated the helpfulness of the service

as 6 on a scale of 6. DNA rates at first appointment were less than 2% compared with 16% for treatment as usual.

The WRIP was staffed by 1.0wte existing staff practitioners extending their contracts or working overtime; the latter proved unsustainable and the WRIP has reduced to just 0.4wte until external recruitment has been achieved, in effect, from September 2012. (The Children's IAPT initiative is removing substantial numbers of suitable practitioners from the labour market on long term temporary contracts). WRIP phase 1 staffing costs have been approximately £70,000 including unsocial hours and overtime payments, and not including non-pay, management or indirect costs including additional building facility costs.

Over 4 months, the WRIP initiative reduced the waiting list by 201, reducing it from its peak of 655 in October 2011 to 453 in mid February 2012. However, as the WRIP wound down from March and many patients opted to wait the waiting list has risen to 531.

4.3 WRIP Phase Two 2012-13

Aim

To remove 300 patients from waiting list reducing the waiting list to approximately 200 cases (approx 6 weeks referrals) by April 2013, provided that referrals and capacity are brought into balance.

Plan

a. To increase and extend the WRIP to 3.0 wte practitioners (plus support staff) over 6 to 9 months at cost of £148,000, (including additional staff payments but excluding organisational costs, as above). Although some staff are already available, the timing and availability of external recruitment will make the WRIP fully operational from October 2012.

b. To remove at least 300 further cases from the waiting list. (Progress will be slower with fewer quick discharges and more, approximately 40%, requiring 'Extended Intervention').

c. To embed the approach within the Sheffield Model to improve efficiency and demand and capacity matching. It is intended that this will, at least, bring capacity and demand into balance.

d. To continue with and embed patient outcomes and experience monitoring

e. Not withstanding patient outcomes and risk considerations, it is essential that the project is completed and the numbers waiting reduced to approximately 1/12 annual number (ie 4 weeks of

referrals) in order to re-establish service efficiency. It is intended that the waiting list will be reduced by April 2013 but there will be a significant 'treatment overhang', particularly as a greater proportion will require extended intervention.

f. Embedding the learning

Key learning features of this project have informed the Sheffield Model CAMHS redesign including the administrative support & co-ordination, the core intervention & assessment clinic. Saturday working is highly valued by patients and clinically efficient for many cases but significantly more expensive in cash terms.

5. 2010/11 and 2011/12 Overall Funding and planned investment for 2012/13

Table 1: 2010/11 2011/12 and 2012/13 Sheffield Joint Funding into CAMHS for all tiers

	NHS Sheffield	***SCC***	***Total Investment***
2010/11	£7,591,400	£1,288,700	**£8,880,100**
2011/12	£10,386,737	£911,564	**£11,298,301**
2012/13	£10,991,149	£984,564	**£11,975,713**

Note that some of the SCC contribution is for internal services, or other contracts therefore not all of this amount goes to SC FT as the main provider

5.1 2012/13 Funding

Going into 2012/13 both SCC and NHS Sheffield (CCG) are working to protect future funding into community CAMHS provision and have committed to the 12/13 contract value to sustain the redesigned service. NHS Sheffield have also agreed to fund the WRIP to reduce the waiting times and with other plans to improve referral pathways and brief interventions and consultation at Tier 2 it is hoped capacity and demand within specialist community teams will balance from April 2013.

Summary

Specialist inpatient provision is now contract managed by SCG as a specialised commissioned service. This should enable equality of standards, access and outcomes to be aligned nationally.

Specialist Community CAMHS continues to be jointly performance managed by NHS Sheffield and Sheffield City Council as a jointly commissioned service.

Work is underway to reduce waiting times and improve access to specialist community CAMHS as well as continue to redesign services and develop MAST interventions for CAMHS and work with G.P's.

There are no plans to make further efficiencies within specialist community CAMHS, consideration of developing programmes to support early intervention and prevention are a key focus of the emotional wellbeing and mental health strategy for children and young people.

Report by Kate Laurance NHS Sheffield

On behalf of Tim Furness NHS Sheffield

Report to the Healthier Communities & Adult Social Care Scrutiny and Policy Development Committee
12 September 2012

Report of: **Emily Standbrook**
Policy Officer (Scrutiny)
emily.standbrook@sheffield .gov.uk; 0114 27 35065

Date: 12 September 2012

Subject: **Work Programme and Cabinet Forward Plan**

The Committee's draft work programme is attached for consideration.

The Committee is asked to identify any further issues for inclusion in the work programme as agenda items, or in depth task and finish reviews.

To ensure that information coming to the Committee meets requirements, Members are requested to identify any specific approaches, lines of enquiry, witnesses etc that would assist the scrutiny process for items on the work programme.

The latest version of the Cabinet Forward Plan is also attached. Consideration of issues at an early stage in the development process gives scrutiny an opportunity to make recommendations to decision makers and maximises scrutiny's influence. The Committee is therefore requested to identify any issues from the Forward Plan for inclusion on a future agenda.

Recommendations:

That the Committee:

- Considers the work programme and Cabinet Forward Plan
- Identifies further issues for inclusion on the work programme

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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Draft Work Programme
Last updated 30 August 2012

What	Why	How	When
Transforming Support for People with Dementia Living at Home.	*To consider the results of the consultation prior to submission to Cabinet.*	Report	12th September 2012
Child and Adolescent Mental Health Services - update	*To update the Committee on progress made in reducing waiting times to access CAMH Services.*	Report	12th September 2012
Joint Health and Wellbeing Strategy	*To contribute to the consultation on the Joint Health and Wellbeing Strategy.*	Report	12th September
Experience of Care and Support – performance review	*To consider and comment on activity being undertaken to improve experience of care and support*	Report	17th October 2012
Sheffield City Council/Care Trust Review	*To consider and comment on the review of the partnership between Sheffield City Council and the Sheffield Health and Social Care Foundation Trust.*	Report	17th October 2012
End of Life Care	*To consider progress on the End of Life Care Strategy – particularly around meeting the needs of the increasing number of people who*	Report	21st November 2012

	choose to die at home.		
Intermediate Care	*As part of its review into the future of intermediate care resource centres, the Committee expressed concern about the length of time it is taking to find a suitable site for the planned intermediate care facility. An update was requested.*		21st November 2012
Local Account	*To consider and comment on the Council's Local Account, detailing performance in*		21st November 2012
Adult Safeguarding	*To consider the annual safeguarding adults report and any issues arising from it.*	Report	16th January 2012
Protocol for the Scrutiny of Health in Sheffield	*To refresh the protocol for the Scrutiny of health in Sheffield to reflect the changes to health and wellbeing structures in Sheffield brought about by the Health and Social Care Act 2012.*	Report	20th March 2012
Self Directed Support	*To consider progress made in rolling out personalised budgets*	Report	TBD
Anti Social Behaviour Review	*With a particular focus on impact of anti social behaviour for people with learning disabilities.*	TBD	TBD
Right First Time	*To consider the progress, future plans and outcomes from the Right First Time programme*	TBD	TBD

Quality Accounts	*To consider and comment on the annual quality accounts of NHS providers in the City, as required by the Department of Health*	TBD	TBD
Sheffield Food Plan	*To scrutinise progress of the Sheffield Food Plan*	TBD	TBD
Diabetes in South Asian Communities	*To consider how best to improve and target information at at risk groups*	TBD	TBD
Paediatric Cardiac Surgery	*To scrutinise outcomes for children in Yorkshire and the Humber following the decision to reconfigure children's heart surgery centres.*	Through the Yorkshire and Humber Joint Scrutiny Committee.	Ongoing

Cabinet Forward Plan of Key Decisions

Date decision is expected to be taken and who will take the decision?	Description of decision K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Committee	Who will be consulted?	What documents will be considered by the decision maker?	Who can I contact about this issue?
12/9/12 Cabinet	Revenue Budget and Capital Programme monitoring 2012-13 (Month 3) (K)	Councillor Bryan Lodge Overview and Scrutiny Management		Cabinet report	Resources Allan Rainford Tel: 2752596 Allan.rainford@ sheffield.gov.uk
12/9/12 Cabinet	Community Heating Metering Project (K)	Councillor Harry Harpham Safer and Stronger Communities	Users of community heating services, (including leaseholders and freeholders as well as current Council tenants)	Cabinet report	Place Robert Almond Tel: 273 4193 Robert.almond@ sheffield.gov.uk
12/9/12 Cabinet	Proposed Sheffield City Council (Ford Lane, Stocksbridge) Compulsory Purchase Order (K)	Councillor Leigh Bramall Economic and Environmental Wellbeing		Cabinet report	Place David Ambrose Tel: 2735539 David.ambrose@ sheffield.gov.uk
13/9/12	Sheffield 20mph Speed Limit	Councillor Leigh	All Community	Cabinet	Place

Date decision is expected to be taken and who will take the decision?	Description of decision K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Committee	Who will be consulted?	What documents will be considered by the decision maker?	Who can I contact about this issue?
Cabinet Highways Committee	Strategy: Programme for 2012/13 and 2013/14 (K)	Bramall Economic and Environmental Wellbeing	Assemblies, the Police	Highways report	Simon Nelson Tel: 273 6176 Simon.nelson@sheffield.gov.uk
13/9/12 Cabinet Highways Committee	Upperthorpe & Netherthorpe Permit Parking Scheme Outcome of the Traffic Regulation Order Consultation Process	Councillor Leigh Bramall Economic and Environmental Wellbeing	Local residents, Community Assemblies	Cabinet Highways report	Brian Hey Tel: 2736086 Brian.hey@sheffield.gov.uk Cate Jockel Tel: 2734192 Cate.jockel@shefield.gov.uk
26/9/12 Cabinet	Stocksbridge Older People's Accommodation (K)	Councillor Mary Lea Healthier Communities and Adult Social Care	Older people affected directly by the changes. The Stocksbridge Town Council and other local older people's and community groups affected by the changes	Cabinet report	Communities Angela Rowland Tel 205 7138 Angela.rowland@sheffield.gov.uk
26/9/12 Cabinet	A City for All Ages. (K)	Councillor Mary Lea	All key stakeholder groups, committees	Cabinet report	Communities Julia Thompson

Date decision is expected to be taken and who will take the decision?	Description of decision K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Committee	Who will be consulted?	What documents will be considered by the decision maker?	Who can I contact about this issue?
		Healthier Communities and Adult Social Care	within the Council and outside, voluntary and faith groups, community assemblies, a wide range of older people and younger people to discuss the needs and aspirations for the future.		Deputy Chief Executive's Laurie Brennan Tel 2057125 Julia.thompson@sheffield.gov.uk Laurie.brennan@sheffield.gov.uk
26/9/12 Individual Cabinet Member Decision	The Strategic Housing Review Report (K)	Councillor Harry Harpham Safer and Stronger Communities	The content of the report has already been informed by the substantial consultation undertaken with residents and other stakeholders, including councillors and council officers, to identify priorities for the Housing Strategy 2013-23. This consultation was augmented with	Individual Cabinet Member Report	Place Georgina Parkin Tel:2736915 Georgina.Parkin@sheffield.gov.uk

Date decision is expected to be taken and who will take the decision?	Description of decision K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Committee	Who will be consulted?	What documents will be considered by the decision maker?	Who can I contact about this issue?
			workshops attended by residents, housing professionals, the voluntary and community sector, and council officers		
26/9/12 Cabinet	Supporting Sheffield People with Dementia to Live Well (K)	Councillor Mary Lea Healthier Communities and Adult Social Care	If there are services that will be directly affected by any proposals there may need to be a further formal consultation	Cabinet report	Communities Howard Waddicor Tel: 20 57130 howard.waddicor@sheffield.gov.uk
17/10/12 Cabinet	Revenue Budget and Capital Programme Monitoring 2012-13 (Month 4) (K)	Councillor Bryan Lodge Overview and Scrutiny Management		Cabinet report	Resources Allan Rainford Tel: 2752596 Allan.rainford@sheffield.gov.uk
17/10/12 Cabinet	Volunteering Policy (K)	Councillors Julie Dore and Mazher Iqbal Safer and	Volunteer involving services within the Council, volunteers and potential volunteers, Voluntary Action	Cabinet report	Victoria Penman Tel: 2724755 Victoria.penman@sheffield.gov.uk

Date decision is expected to be taken and who will take the decision?	Description of decision K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Committee	Who will be consulted?	What documents will be considered by the decision maker?	Who can I contact about this issue?
		Sustainable Communities	Sheffield.		
17/10/12 Cabinet	Medium Term Financial Strategy (K)	Councillor Bryan Lodge Overview and Scrutiny Management		Cabinet report	Resources Allan Rainford Tel: 2735108 Allan.rainford@sheffield.gov.uk
31/10/12 Cabinet	Revenue Budget and Capital Programme monitoring 2012-13 (Month 5) (K)	Councillor Bryan Lodge Overview and Scrutiny Management		Cabinet report	Resources Allan Rainford Tel: 2752596 Allan.rainford@sheffield.gov.uk
31/10/12 Cabinet	Primary School Places in Sheffield (K)	Councillor Jackie Drayton Children, Young People and Families	Local Members, Local Schools (including Governors) and Wider Community (focus on parents).	Cabinet report	Children, Young People and Families Joel Hardwick Tel: 2735476 Joel.hardwick@sheffield.gov.uk
31/10/12 Cabinet	Sheffield Lower Don Valley Flood Defence Project (K)	Councillor Jack Scott	The principal consultees are business owners	Cabinet report	Place Steve Birch

Date decision is expected to be taken and who will take the decision?	**Description of decision** K = Key Decision P = Statutory Plan - part of budget and policy framework	**Cabinet Member and relevant Scrutiny Committee**	**Who will be consulted?**	**What documents will be considered by the decision maker?**	**Who can I contact about this issue?**
		Economic and Environmental Wellbeing	and land owners in the flood zone, as well as their representatives including Sheffield Chamber of Commerce and Industry and other more local associations. There is no real residential community in the project boundary (namely the flood zone – see map attached). However, the Community Assembly, local Councillors and Cabinet Members will all be engaged. Other stakeholders also include the Environment Agency and local environmental groups such as The Five Weirs Trust, whilst statutory		Tel: 27 35880 Steve.birch@sheffield.gov.uk

Date decision is expected to be taken and who will take the decision?	Description of decision K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Committee	Who will be consulted?	What documents will be considered by the decision maker?	Who can I contact about this issue?
			consultees including the Highways Agency will also be involved.		
21/11/12 Cabinet 5/12/12 Council	Gambling Act 2005 – Statement of Licensing Principles (Policy)	Councillor Isobel Bowler Economic and Environmental Wellbeing		Cabinet report	Place Stephen Lonnia Tel: 2053798 Stephen.lonnia@ Sheffield.gov.uk
12/12/12 Cabinet	Revenue Budget and Capital Programme monitoring 2012-13 (Month 6) (K)	Councillor Bryan Lodge Overview and Scrutiny Management		Cabinet report	Resources Allan Rainford Tel: 2752596 Allan.rainford@ sheffield.gov.uk
12/12/12 Cabinet	Housing Strategy 2013-23 (K)	Councillor Harry Harpham Safer and Stronger Communities	Community Assemblies Members Sheffield Homes Registered Providers Sheffield Housing Company Universities	Cabinet report	Place Georgina Parkin Tel:2736915 Georgina.Parkin@ sheffield.gov.uk

Date decision is expected to be taken and who will take the decision?	Description of decision K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Committee	Who will be consulted?	What documents will be considered by the decision maker?	Who can I contact about this issue?
			Private Landlords Developers Estate/Letting Agents Health Partners Sheffield Residents		
12/12/12 Cabinet 9/1/13 Council	Sheffield Development Framework: City Policies and Sites Document and Proposals Map – the Pre-submission Version (K)	Councillor Leigh Bramall Economic and Environmental Wellbeing	Three major consultations have already taken place. Everyone on SDF mailing list will be advised of the opportunity, which will also be advertised in the press.	Cabinet report	Place Peter Rainford Tel:273 5897 peter.rainford@ sheffield.gov.uk
12/12/12 Cabinet	Community Infrastructure Levy (Preliminary Draft Charging Schedule for Consultation) and Infrastructure Delivery Plan.	Councillor Leigh Bramall Economic and Environmental		Cabinet report	Place Richard Holmes Tel: 205 3387 richard.holmes@ sheffield.gov.uk

Date decision is expected to be taken and who will take the decision?	Description of decision K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Committee	Who will be consulted?	What documents will be considered by the decision maker?	Who can I contact about this issue?
A key decision* is one that is either part of the budgetary/policy framework, sets or shapes a major strategy, results in income or expenditure of £500,000+, is a matter of major public concern or controversial by reason of representations made or likely affects two or more wards. The full definition of a key decision can be found in Part 2, Article 13.3 of the Council's Constitution which can be viewed on the Council's Website www.sheffield.gov.uk. Requests for copies or extracts from any of the publicly available documents or other documents relevant to the key decisions, or for details of the consultation process and how to make representations, can be made by ringing the contact officer or via Democratic Services, Deputy Chief Executive's, Town Hall, Sheffield S1 2HH email to: committee@sheffield.gov.uk					

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