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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 17 April 2013 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, Katie Condliffe, Roger Davison, Tony Downing, Adam Hurst, Cate McDonald, Pat Midgley, 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.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Scrutiny Policy Officer on 0114 27 35065 or email emily.standbrook-shaw@sheffield.gov.uk.

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
17 APRIL 2013

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 of the Committee held on 20 February 2013

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

7. **Major Trauma - Update**
   Ian Atkinson and Daniel Mason, NHS Sheffield Clinical Commissioning Group to report

8. **Sheffield Children's Hospital NHS Foundation Trust - Quality Account**
   John Reid, Director of Nursing and Clinical Operations to report

9. **Self Directed Support Update**
   Report of the Director of Adult Social Care

10. **Quality Account Responses**
    Policy Officer (Scrutiny) to report

11. **Work Programme and Cabinet Forward Plan**
    Policy Officer (Scrutiny) to report

12. **Date of Next Meeting**
    The next meeting of the Committee will be held on Wednesday, 8 May at 10.00am in the Town Hall

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

New standards arrangements were introduced by the Localism Act 2011. The new regime made changes to the way that members' interests are registered and declared.

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -
  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) -
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either
  - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
  - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Under the Council's Code of Conduct, members must act in accordance with the Seven Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership), including the principle of honesty, which says that 'holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest'.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life.

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

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

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Standards Committee in relation to a request for dispensation.

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

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 20 February 2013

PRESENT: Councillors Mick Rooney (Chair), Janet Bragg, Katie Condliffe, Roger Davison, Tony Downing, Adam Hurst, Pat Midgley, Jackie Satur, Diana Stimely, Joyce Wright and Clive Skelton (Substitute Member)

Non-Council Members (LINK):-

Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Cate McDonald, with Councillor Clive Skelton attending as a duly appointed substitute, Councillor Sue Alston and Anne Ashby.

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 Councillor Clive Skelton declared a Disclosable Pecuniary Interest in Agenda item 6 (Sheffield Teaching Hospitals – Quality Report 2012/13 – Overview), as his wife was a doctor, but chose to remain in the meeting during consideration of that item given that no material decision was to be made.

Councillor Diana Stimely declared a personal interest in relation to Agenda item 12 (Provision of Daily Living Equipment Costing Less Than £50), which was to be considered as an emergency item of business, in that she had campaigned on behalf of the Sheffield Royal Society for the Blind.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 There were no public questions or petitions.

5. SHEFFIELD TEACHING HOSPITALS - QUALITY REPORT 2012/13 - OVERVIEW

5.1 The Committee considered a report of Dr. David Throssell, Medical Director, Sheffield Teaching Hospitals Foundation Trust, which provided information on the quality of services delivered by Sheffield Teaching Hospitals in the year 2012/13 and identified the Quality Improvement Priorities for 2013/14. This was supported

by a presentation given by Neil Riley, Trust Secretary, and Sandi Carman, Head of Patient and Healthcare Governance.

5.2 Members made various comments and asked a number of questions in relation to the report and presentation, to which responses were provided as follows:-

- The issue of people awaiting discharge from hospital having to wait for medication from the pharmacy would be investigated.

- Processes relating to the obtaining of full information about the admission of patients suffering from dementia would be examined to ensure they were sufficiently robust.

- Cleaning was not contracted out across the Trust and there was an annual inspection which involved the quality of cleaning. The latest technology was now being used for deep cleaning and there was now more focus on this.

- The Frequent Feedback Form scheme was operated across the in-patient areas.

- The issue of pressure ulcers was a complex one involving a range of issues, but specialist equipment was available and observation was clearly an important aspect. The Trust's Board of Directors had received a presentation on pressure ulcers in order to improve their understanding of the issue.

- It was generally found that the less affluent members of society tended to use hospitals as an emergency service, whilst the more affluent used the more preventative aspects. The uptake of preventative services was important, particularly in relation to cancer services.

- Work was being undertaken on the socio-economic background of patients, particularly in relation to non-attendance and appointments.

- There had been significant change in working across seven days amongst clinical colleagues, with more consultants being available at the weekend and steps being taken for a routine consultant presence on delivery wards. It had been found that people understood that Accident and Emergency facilities were available at all times at the Northern General Hospital.

- The Trust was in the process of considering its response to the Francis Report and this would be considered alongside the Quality Report. It was hoped that, by the end of April, there would be a clearer idea of how to embed the report's findings into the Trust's strategy. It should be noted that the Francis Report also included commentary in relation to mortality and patient experience, but there had been insufficient time to consider the report for inclusion in the Quality Report objectives this year.

- Trust officers were mindful of discharged patients failing to understand the information they were provided with, which also went to their GPs, and steps

would be taken to address this. One of the objectives of the Right First Time initiative was to address issues such as this, with increased partnership working being a key feature. It was also important that those who would now be commissioning services were involved.

- In relation to cancelled operations, information on the type of operations cancelled and the reasons for their cancellation were acted upon.

- The new Friends and Family Survey forms could be responded to at the point of contact, on-line, by post or through a phone application. They were also sent out to people after they had been discharged.

- Colour coding was applied to areas in hospitals to assist dementia patients, but not necessarily in bathrooms.

- The issue of communications had this year been focused on GPs and there were good arrangements in place for those with learning difficulties. It was important that Ward Managers were aware of the care plan for each patient.

5.3 RESOLVED: That the Committee:-

(a) thanks Neil Riley and Sandi Carman for their contribution to the meeting;

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

(c) requests that:-

(i) the issue relating to the length of time that discharge patients have to wait for the issue of medication from the hospital pharmacy be added to the list of Quality Improvement Priorities for 2013/14;

(ii) a mechanism be developed whereby patient complaints and the outcome of these complaints be reported to the Committee;

(iii) a short information paper be presented to a future meeting of the Committee on the progress made in respect of the improvement of the quality of patient discharge forms to patients and GPs; and

(iv) a collective discussion on the Francis Report be held by the Committee with all appropriate partners.

6. ST. LUKE'S HOSPICE - QUALITY ACCOUNTS

6.1 The Committee considered a report of Judith Park, Deputy Chief Executive, St Luke's Hospice, on the St Luke's Hospice Quality Accounts. This provided the information on the 2012/13 Quality Priorities and set out items which were under consideration for inclusion in the 2013/14 Quality Priorities.

6.2 In attendance for this item were Judith Park, Deputy Chief Executive, St Luke's

Hospice, and Mark Harrington, Risk Management Co-ordinator, St Luke's Hospice.

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

- Funding was a major challenge for St Luke's as it was important to ensure that it was financially sustainable. A restructuring had put St Luke's in a strong financial position. The annual running costs for the Hospice to continue providing care was £4.5m, of which 31% was provided through Government funding via a contract with NHS Sheffield and the remainder via its charity fundraising activities. In addition a £5m capital appeal was underway for the new build for the Hospice In Patient Unit and, to date, £2.4m had been raised towards this. The Hospice had ten shops in the City, which for the past three years had won the best UK performing charity outlets ten and under, and the Hospice's fundraising team were successful in raising funds.

- During Phase 2 of the In Patient Unit development, capacity would be reduced to 16 beds, but on completion this would increase to the present capacity of 20 beds. This would mean that approximately 36 patients would not be able to be admitted as in patients, but an internal coping strategy meant that the Hospice would be able care for approximately 78 patients and their families within the community during that period.

- St Luke's had two nurses who provided support and education to the nursing homes in the City which made referrals. This involved work with patients, families and staff at the nursing home.

6.4 RESOLVED: That the Committee:-

(a) thanks Judith Park and Mark Harrington for their contribution to the meeting;

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

(c) recognises that funding is a concern for St Luke's Hospice and requests that a collective discussion on its funding be held by the Committee with Health and Social Care Funders.

7. YORKSHIRE AMBULANCE SERVICE - QUALITY ACCOUNTS

(NOTE: At this point Councillor Mick Rooney left the meeting and Councillor Roger Davison took the Chair.)

7.1 The Committee considered a report of Hester Rowell, Head of Quality and Patient Experience, Yorkshire Ambulance Service, on the Yorkshire Ambulance Service Quality Accounts which set out the progress made on the 2012/13 Quality Priorities and considered what Quality Priorities should be included for 2013/14.

7.2 In attendance for this item were Hester Rowell, Head of Quality and Patient

Experience, Yorkshire Ambulance Service, and David Williams, Deputy Director of Operations, Yorkshire Ambulance Service.

(NOTE: At this point Councillor Mick Rooney returned to the meeting and took the Chair.)

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

- Whilst it was a challenge for ambulances to get around any City, the Yorkshire Ambulance Service obtained up to date road and traffic information from a variety of sources, including the Council.

- A typical call procedure was described and it was emphasised that the aim was to match resources with the condition of the patient.

- The Quality Accounts formed part of the Yorkshire Ambulance Service Annual Report, surveys undertaken were used to compile an annual report of patient experience and there were focus groups which aimed to improve the patient experience for those suffering dementia.

- The high standard of the work of the Community First Responders was acknowledged.

7.4 RESOLVED: That the Committee:-

(a) thanks Hester Rowell and David Williams for their contribution to the meeting;

(b) notes the information reported and responses provided to questions and comments;

(c) acknowledges the improvement in the quality of the presentation of the Quality Accounts and in performance; and

(d) wishes to record its appreciation of the service provided by the Yorkshire Ambulance Service and its contribution to health services in the Sheffield area.

8. THE FRANCIS INQUIRY - HEADLINE IMPLICATIONS FOR SCRUTINY

(NOTE: In view of the amount of business to be considered at the meeting, this item was deferred to a future meeting of the Committee.)

9. PROVISION OF DAILY LIVING EQUIPMENT COSTING LESS THAN £50

9.1 The Chair, Councillor Mick Rooney, explained that this item had been included on the agenda as an urgent item of business, following the receipt of a public question at the Overview and Scrutiny Management Committee held on 13th February 2013, which had been referred to this Committee for consideration.

9.2 In attendance for this item were Euin Hill, representing the Sheffield Royal Society for the Blind, and Eddie Sherwood, Director of Care and Support.

9.3 Euin Hill referred the Committee to the circulated submission made on behalf of the Sheffield Royal Society for the Blind relating to the Council's proposal to no longer provide, free of charge, individual small items of daily living equipment costing less than £50. In doing so he made particular reference to the legal issues involved and the Council's Care and Reablement Strategy. In conclusion, he requested that the proposal be reconsidered and removed from the Council's budget proposals.

9.4 In response, Eddie Sherwood gave a short presentation on the proposal, making particular reference to the fact that this was an extension of current policy on the provision of items with a value of under £50 to those items that required an element of installation. He also emphasised that the proposal excluded all equipment for sensory impaired people and that such equipment would continue to be provided in cases of severe hardship. In conclusion, he stated that a review of the proposal was to take place six months after its implementation.

9.5 A short discussion then took place on the operation and effect of the proposal.

9.6 RESOLVED: That the Committee:-

(a) recognises that given the current financial circumstances, there are difficult decisions to be made;

(b) requests that it receives a report with the results of the review that is planned six months after the implementation of the proposal to no longer provide and fit, free of charge, small items of daily living equipment costing less than £50;

(c) requests that the Cabinet Member for Health, Care and Independent Living gives consideration to implementing a cap on the total amount people would have to pay if they required multiple items of daily living equipment;

(d) requests that the Cabinet Member for Health, Care and Independent Living gives consideration to setting aside funds for a hardship fund to assist those who could not afford daily living equipment; and

(e) requests that communication around the proposal be made clearer so that organisations and individuals were aware of the implications of the proposal, particularly in relation to the exclusion of equipment for sensory impaired people.

(NOTE: This item was considered by the Committee as an urgent item of business under Council Procedure Rule 26 of the Council's Constitution, on the recommendation of the Chair, in order that it could be considered prior to Budget Council on 1st March 2013.)

10. WORK PROGRAMME AND FORWARD PLAN

10.1 The Policy Officer (Scrutiny) submitted the Committee's Work Programme for 2013

and the Forward Plan for the period 1st February 2013 to 31st May 2013, for consideration.

10.2 RESOLVED: That:-

(a) the contents of the Committee's Work Programme for 2013 be approved; and

(b) the Forward Plan for the period 1st February 2013 to 31st May 2013 be received and noted.

11. DATE OF NEXT MEETING

11.1 The next meeting of the Committee will be held on Wednesday, 20 March 2013, at 10.00 am in the Town Hall.

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Briefing for Healthier Communities and Adult Social Care Scrutiny Committee

Update on progress to implement the national strategy for Major Trauma within the Yorkshire & the Humber region

17 April 2013

Purpose

Following from the paper presented in February 2012, this paper updates the Healthier Communities and Adult Social Care Scrutiny Committee on progress to implement the national strategy for Major Trauma in the Yorkshire & the Humber region.

What is major trauma?

Major trauma is used to describe serious and often multiple injury where a patient has less than 10% chance of survival, often described as 'life-changing' injuries, it includes: head injury, spinal injury, abdomen, chest, penetrating wound, gunshot, long bone amputation and injuries to the pelvis. The paramedic on the scene identifies the patient as having major trauma.

How many people suffer major trauma in our region?

The number of people across the region who experience major trauma is relatively small at around 660 cases per year, which equates to less than 0.2% of Emergency Department activity.

Nationally it has been estimated that 91% of hospitals will see less than one major trauma case per week and 75% of hospitals will see less than one case per fortnight. These are small numbers of patients who require specialist care.

What are the plans for improving major trauma care in the region?

NHS organisations in Yorkshire and the Humber want all injured patients to receive excellence in standards and safety of care, from time of injury to rehabilitation.

The vision is for a Yorkshire and the Humber major trauma network ensuring that responses to major trauma are co-ordinated to provide consistent, cost-effective, high-quality care.

Better coordination and reduced variation in the care of patients who have been subject to a major trauma will save lives and allow more people to regain a better quality of life.

Evidence tells us that we could manage major trauma in a far more effective way for both adults and children. This can be achieved through our acute hospitals,

ambulance service and rehabilitation services working together as a whole system, with common protocols and agreements.

Introducing a new system means we will:

- Save lives with an approximate 20% reduction in lives lost.
- Significantly improve chances of making a full recovery, reducing the chance of long term debilitation. 75% of patients are currently left with a significant disability following a major trauma.
- Improve access to specialist services regardless of where in the region someone is injured
- Improve access to and choice of rehabilitation services closer to home
- Improve the management and treatment of trauma for all

Developing a regional network will help improve both quality and a productivity. DH estimates that a regional inclusive trauma system could aim to reduce deaths from major trauma by 20%, this equates to more than 160 lives in Y&H per year. There is the potential for a regional network to improve rehabilitation, to reduce length of stay and recovery for patients.

How are we ensuring improvement happens?

Since April 2012, commissioners in Yorkshire and the Humber have been overseeing a programme of work that involves clinicians and managers from all NHS organisations in the region. Three sub-regional major trauma groups were established and these are overseen by a regional network executive group. The work is clinically led and every Hospital Trust in the region participates.

Implementation includes:

- A phased approach with full development by April 2014; first phase went live 1 April 2012.
- In the first phase of implementation the patient's destination has been informed by clinical condition and service capacity.
- Continued learning during the first year about patient flows, workforce and service capacity implications, has allowed better planning for phase 2 of the network development

What does this mean for local hospitals?

All hospitals in the region have a part to play in the regional major trauma network. A list of Major Trauma Centres and Trauma Units are at appendix 1. Major trauma centres (in Hull, Leeds and Sheffield) offer specialist skills (e.g. neurosurgery). They work with a number of trauma units that optimise patients care and receive them from major trauma centres following specialist interventions. Local hospitals that are not trauma units have an important role in the network offering rehabilitation.

Progress since April 2012

During the last 10 months NHS organisations in Yorkshire and the Humber have begun the transformation of major trauma treatment and care. The following improvements in care can now expect the following level of care:

- All patients are assessed at the roadside using a standard national approach
- Paramedic in the ambulance control room co-ordinate the decision making on admissions and transfers
- The most serious cases of major trauma are taken directly to a Major Trauma Centre if they are within 45 minutes travel time. Where this is not the case they are taken to the nearest trauma unit for stabilisation prior to transfer on to the Major Trauma Centre.
- All secondary transfers from a trauma unit to a major trauma centre take place within 48 hours
- All transfers out of the major trauma centre for repatriation/rehabilitation take place within 48 hours of referral to the trauma unit
- Rehabilitation prescriptions are completed for all major trauma patients

Our approach from April 2013

During this second phase of development from April 2013 to March 2014:

- All patients with major trauma are taken directly to a Major Trauma Centre if they are within 45 minutes travel time. Where this is not the case they are taken to the nearest trauma unit for stabilisation prior to transfer on to the Major Trauma Centre.
- There will be improvement of all areas clinical care (from injury to rehabilitation) in line with nationally recommended standards for best practice. This will require additional investment into trauma services in the region.
- Further work will be progressed to understand the future requirements for rehabilitation services for patient who have had major trauma.

During this phase improved information collection will help us to understand the impact of the changes and ensure that significant improvement in care has been achieved.

Daniel Mason for

Ian Atkinson, Accountable Officer, NHS Sheffield Clinical Commissioning Group

Appendix 1 - Major Trauma Centres and Trauma Units

West Yorkshire

Major Trauma Centre: Leeds General Infirmary

Trauma Units: Bradford Royal Infirmary; Airedale Hospital; Huddersfield Royal Infirmary; Halifax Royal Hospital; Pinderfields (Wakefield) Hospital.

South Yorkshire

Major Trauma Centres: Northern General Hospital (Sheffield) and Sheffield Children's Hospital

Trauma Units: Barnsley Hospital; Rotherham Hospital; Doncaster Royal Infirmary.

North and East Yorkshire and the Humber

Major Trauma Centre: Hull Royal Infirmary

Trauma Units: Diana Princess of Wales Hospital (Grimsby); Scunthorpe General Hospital; York District Hospital; Scarborough Hospital.

Each sub-region will also have links to the bordering sub-regional areas, including to the networks in the North East, North West and East Midlands.

Sheffield Children's NHS
NHS Foundation Trust

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REPORT TO THE SCRUTINY COMMITTEE MEETING HELD ON 17 April 2013

Quality Report (Incorporating Quality Accounts) 2013 Draft Report

Trust objectives supported by this paper

- The paper supports the achievement of all Trust Objectives

Purpose of the paper

To summarise the performance of Trust in 2012-13 in relation to quality of care. To set the quality priorities for 2013-14 in consultation with our families, governors and agency partners.

This paper is a draft report that will be consulted upon with all of our key stakeholders, as set out in the February Board schedule paper. The report will form the quality section of the Trust Annual Report to Monitor.

Summary of key points

- The Trust has processes to provide assurance of safe quality standards
- There is a framework that supports identification of risk and poor patient experience and involves the Board and Governors in monitoring of action plans.
- Lapses in performance are known to the Board and investment of resources is appropriately targeted to resolve these.

NB. Blank areas in yellow highlights await end of year reports and will be included in the final report to be published in June.

Board Action required

Approval of the Quality Report

Author:	J Reid	**FOR APPROVAL**
Executive Sponsor:	J Reid	

SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST
QUALITY REPORT

1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

Sheffield Children's NHS Foundation Trust is one of the best performing Foundation Trusts in the country as recorded by Monitor (the Foundation Trust regulator) and the Care Quality Commission. We have responsibility for most aspects of child health care in Sheffield including hospital, community and mental health; and are a major provider of specialist hospital care for South Yorkshire and beyond. We are proud of the high satisfaction survey results that we obtain and the quality of care we provide. In keeping with our promise to correct some of the cramped and inadequate clinical accommodation; building starts in the summer for a new £40 million patient wing. It is our expectation that this will materially improve the areas of below average experience such as, parking, privacy and dignity, parental accommodation, and way-finding.

Our community services and our child and adolescent mental health service are key components of a holistic child health system in Sheffield and beyond. We have been working closely with local authority partners to ensure that our teams are integrated with social care and education to obtain the best outcomes for our families. We do this through joint child protection arrangements, shared public health priorities and good communication. The local partnership helps us address areas of public concern e.g. the recent investment in community speech and language services to reduce appointment delays.

The Trust has rates of infection that are amongst the lowest in the country although, in common with most other trusts, we have seen a slight increase this year, particularly in community acquired diarrhoea and vomiting. Complaints to the trust have risen this year with 120 received. The most common reasons are where parents disagree with a diagnosis or treatment plan, or in relation to complications of treatment. We investigate every complaint with the family involved, but believe that improved communication is the key to correcting the above trend.

The Quality Report set out below is accurate, to the best of my knowledge, and is a balanced and accurate reflection of the quality assurance processes, structures and outcomes in use at Sheffield Children's NHS FT.

I hope you will find the report informative and that it will encourage you to engage with our activities to improve children's health.

Signed

Mr Simon Morritt

2 PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 Quality Improvement Priorities Identified for 2012-2013

2.1.1 PERFORMANCE ON QUALITY PRIORITIES 2012-2013

Last year, the Trust set itself a number of quality improvement priorities measured by performance targets.

- **Improvement of the Sheffield Children's Hospital Facilities for Resident Families. Coordination of three year plan to build:**
    - **New Out-patient Facilities** – easy access to centralised clinic and support departments, e.g. Pharmacy, Therapies, X-ray and Diagnostics.
    - **New In-patient Facilities** – wards based upon best design evidence with 70% single en-suite family rooms, dedicated play and school facilities.
    - **New Home from Home** - for resident parents of children in Critical Care and Neonatal Care, built in conjunction with the Sick Children's Trust.

  Approval was obtained from Monitor in early 2013 to proceed with construction of the new wing and completion is expected by late 2015. Demolition of existing buildings will commence this summer.

  The Children's Trust has commenced conversion of existing Northumberland Road villas into a home from home for resident parents. The facility will be linked by corridor to our critical care floor and is expected to be complete this summer.

- **Improvement of Pathway for Outpatients and Inpatients – Reducing Delay and Improving Communication.**
    - **Review of Outpatient Administration** - installation of new patient administration software to improve written and electronic communication with families and redesign of booking arrangements for clinics to reduce cancellations and delay.
    - **Review of In-patient Pathway** – setting up of a separate day care unit for children not requiring surgery or anaesthetic. The surgical day care unit will then be used for day surgery and as an admissions unit for all children booked to come in for an operation.
    - **Changes to GP Referral Pathway** – pilot scheme of a Consultant Paediatrician available to advise GPs on safe community management of acute childhood conditions that normally come to Accident and Emergency.

  The Trust has contracted with System C to replace our patient administration software. Transfer of data and staff training will be taking place over this year to prepare for switch on early next year. The new software includes new systems for A&E patient management, bed management, clinic booking and patient enquiries. We will combine this with a new electronic document management system to improve the patient notes available to clinicians and speed up communication with GPs.

  The Trust has opened up a Research and Medical Treatment Lounge and plans to extend this during the summer. The new facility provides a day unit for children who need to have blood tests, allergy tests, occasional intravenous medication or other hospital visits that require a short stay but not on a ward. It is also where children and families can participate in research to improve treatment and outcomes.

Surgery has been transformed by increases in day surgery, routine pre admission clinics and the development of a Theatre Assessment Unit. The TAU provides a single point of entry to elective surgery. It resembles a clinic and allows the child to play, doctors to examine the child in the privacy of a consultation room and only requires the children to be in bed after the surgery has been carried out.

We have worked with our GP and midwifery colleagues to change their access to paediatric medical advice. A paediatrician is available each day to discuss cases with GPs and avoid unnecessary attendance at A&E. We have worked to transfer the Sheffield Out of Hours GP Service to a clinic base within the hospital. This simplifies the pathway that families have to follow and gives GPs access to our diagnostic and clinical support. Four pathways for common conditions have been jointly updated to ensure that GPs, maternity and A&E staff are all working to the same guidelines and referral criteria.

- **Implement New Ways of Working With GP Commissioners and Partners to Improve Community Care.**
    - **Work with Partners to Set up Health and Wellbeing Board** – New forum to coordinate public health, GPs, Hospitals and community services to work in concert with Social Care and Education to improve the welfare of Sheffield Children.
    - **Expand Health Visitor Numbers** – work with university to train the additional health visitors and integrate them into workforce. Redesign health visiting to provide better universal services with additional focus on those areas of the city that need an enhanced service.
    - **Improve Coordination of Social Care and Health in Sheffield Districts** – work with the three Service Areas to allocate link health visitors in the teams that prioritise child protection resources.

We are key stakeholders in the Sheffield Health and Wellbeing Board and have used the membership to incorporate health visitors and school nurses into the “Integrated Front Door”, simplifying the public access to community health, social care and education resources. Initiatives to improve access to Speech and Language services for children and improved Breast Feeding Friendly services for families in hospital have also been agreed.

Health Visiting recruitment and training has been continuing according to the four year plan agreed with our commissioners, we are on track to have 22 additional health visitors in Sheffield by 2014/15. In addition, we are working closely with commissioners to redefine the service that is needed from school nurses, emphasising public health and preventative interventions.

Child protection arrangements have been reviewed with all our partners and we have reorganised Named Nurses for acute and community services. We have allocated safeguarding specialist nurses to each of the three main Sheffield service districts to work with the ‘Integrated Front Door Teams’, participate in multi agency risk assessments and carry out combined safeguarding training.

Our other results are discussed in detail in Part 3 of this document.

2.1.2 HOW PERFORMANCE WILL CONTINUE TO BE MONITORED

Whilst the patient safety and clinical effectiveness indicators have changed to reflect new priorities, the areas of patient experience will continue to feature in our annual out-patient, A&E and in-patient surveys. Should our performance be below average in any area, we will again include it in our quality report as an area for improvement.

2.2 Quality Improvement Priorities Identified for 2013-2014

2.2.1 PRIORITIES

- **Implement the Dept. of Health Response to the Mid Staffordshire Public Enquiry, 'Patients First and Foremost'**
    - Review and define the culture of the organisation
    - Publish nursing strategy
        - Assess nursing establishments against workload annually
        - Invest in Ward Sisters and Charge Nurses – Free up from other duties to provide a role model and visible ward presence
        - Review and prioritise nurse training
    - Involve governors and families in inspection and oversight of our services

- **Publish regular information on our quality performance and the experience of our families**
    - Evaluate the experience of families in the community
    - Regularly evaluate experience of families in A&E using a child friendly derivative of the family and friends test.
    - Produce quality indicators for children and benchmark with similar health providers
- **Minimise disruption to the public from our construction of the new hospital wing**
    - Improve communication and signposting of access restrictions
    - Provide a park and ride solution for parents and families
    - Control noise, dust and disruption to normal services
    - Manage services in the community, where possible

2.2.2 RATIONALE FOR SELECTION

These priorities are based upon the priorities of our families or partners and have been consulted upon with our Trust Executive Group and Clinical Governance Committee. The priorities have also been circulated to wider stakeholders and reflect health commissioner and local authority priorities.

The Mid Staffordshire Public Inquiry produced evidence of serious failings in how the health service cares for patients and families. Although the report has concentrated on the care of adult patients, it is notable that one of the earliest indications of concern was the failure of the hospital to comply with standards in The Care of Critically Ill and Critically Injured Children's Peer Review in 2006. In accepting responsibility for the care of sick children, it is right that hospitals should be subject to the most exacting standards. The failures highlighted in the report have wider application to all hospitals, the health service and our regulators.

This Trust wishes to use the lessons learned to review how we provide care and the culture we have in our organisation. We wish to test our assumptions and to set out our priorities. It is our intention to show how we balance the need for compassionate care with the importance of speedy access to treatment and the financial discipline that taxpayers expect.

To retain the confidence of families and to embrace the spirit of openness advocated by the Mid Staffordshire report, we will survey areas of our services that have not been previously reviewed. We employ health visitors and school nurses but do not systematically review the experience of the families they come into contact with. We will conduct the pilot for just such a review.

The friend and family test is now routinely used to evaluate adult care, although it is accepted that it is not well understood by children. We will develop a child friendly version and use it to evaluate our scores against those used in adult A&E units. We think we give good care generally but can we evidence it? We will constantly assess and publish how we perform on key indicators of quality care and benchmark ourselves with other children's units.

In planning to undertake a major building project over the next few years, we cannot forget that we will still be treating sick children on the site. Families need to be protected from the effects of building work and still be able to access a high quality setting that lends itself to healing. It will not be easy but we believe that we can protect our families and staff from the worst effects of the construction. This requires innovation, cooperation and communication.

2.3 Statements of Assurance from the Board

2.3.1 GENERAL ASSURANCE

During 2012/13 Sheffield Children's NHS FT provided and/or sub-contracted 102[1] relevant health services.

Sheffield Children's NHS FT has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2012/13 represents 100% of the total income generated from the provision of relevant health services by Sheffield Children's NHS FT for 2012/13.

2.3.2 PATIENT SAFETY

Patient Safety **AREA REVIEWED**	**NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD**	**PERFORMANCE 2011/12**	**TARGET PERFORMANCE 2012/13**	**ACHIEVEMENT 2012/13**
Infection Control **Maintain levels of MRSA and C Difficile infection within Monitor Thresholds for best practice.**	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132045.pdf pp 64 and 68	MRSA: 0 Cases C Difficile: 3 Cases	To stay within Monitor guidance for best practice levels. (<12)[2]	MRSA 0 Cases C Difficile 8 Cases
Never Events **The Dept. of Health has published 25 Never Events for 2012-13. These are serious incidents that should never occur in a safe hospital.**	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132352.pdf	Nil events	Nil events	Nil events

[1] Based upon the services specified in the NHS Provider Contract for 2012-13.

[2] http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/browse-category/guidance-foundation-trusts/mandat-7, p 46, note L.

Patient Safety AREA REVIEWED	NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD	PERFORMANCE 2011/12	TARGET PERFORMANCE 2012/13	ACHIEVEMENT 2012/13
The Trust will do a gap analysis against these and report on progress quarterly.				
Management of Aggression **Management of children and young people in Child and Adolescent Mental Health in a safe and secure environment.** **Staff should be trained to a national standard appropriate to the psychiatric speciality and risk assessment.** **Individual risk assessments should be up to date.**	http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/NHS_SMS_Workplace_Safety_Report_FINAL_MERGED.pdf p29	Violence and aggression incidents graded moderate: 149	10% reduction i.e. no more than 114 incidents for similar period.	24 Incidents

These initiatives all addressed key areas of child safety. Infection control is a high priority for acute hospitals and is a difficult area to control in children and neonates, who are particularly susceptible to infection. In 2012, we increased the time available to our Director of Infection Prevention and Control, to ensure that there is a continuous onsite presence, 52 weeks per year. Despite this, our Clostridium difficele rate increased. Most cases of C difficile associated disease in children are derived from the child's own bowel and not as a result of cross infection. Small numbers of organisms may be present in the normal bowel and when conditions are favourable they may begin to overgrow and produce toxin, resulting in diarrhoea. Situations that make children prone to this include

- Antibiotic treatment of serious infection
- Chemotherapy
- Malignant disease
- Immune deficiency

The Trust is still within the safe level of 12 cases per year specified by Monitor for all trusts, since all were isolated cases. Monitor accepts that results below that level will fluctuate for reasons beyond the control of hospitals. Nevertheless, the Trust has now increased the hours available to Infection Control Nurses to ensure that they are similarly available 52 weeks per year and has increased the cleaning frequency and monitoring of infection control within the oncology unit of the hospital.

The DH Guidance on Never Events is designed to protect patients from the 25 events named by the guidance. Events that lead to death or severe harm include: wrong site surgery, wrongly prepared high-risk injectable medication, transfusion of ABO-incompatible blood components and misidentification of patients. I am pleased to record that there were no Never Events recorded by the Trust in that period.

Child and Adolescent Mental Health has seen an increase in the numbers of young people referred and an increase in the numbers of young people in crisis. This often manifests itself in violent behaviour, frequently directed at staff. The Trust committed itself to reduce the actual harm from these incidents both to the young people and staff concerned. As a result of specially adapted staff training in managing aggressive behaviour and environmental risk assessments, the number of such incidents at the Becton Centre for Young People has reduced from 149 to 24 incidents per year. The unit is working closely with our health and safety and security advisors to maintain this reduction.

2.3.3 CLINICAL EFFECTIVENESS

Clinical Effectiveness **AREA REVIEWED**	**NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD**	**PERFORMANCE 2011/12**	**TARGET PERFORMANCE 2012/13**	**ACHIEVEMENT 2012/13**
Achieve compliance with agreed national standards for Safe and Sustainable Paediatric Neurosurgical Services	http://www.specialisedservices.nhs.uk/library/31/Developing_the_Model_of_Care.pdf	New Standard under national development	Compliance by independent assessment.	National standards still under development. Self assessment indicates compliance with provisional standards.
Achieve compliance with agreed national standards for children's major trauma. As set out in the NHS Operating Framework.	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133585.pdf p76.	New Standard under national development	Compliance by independent assessment	Written report awaited. Peer Review 12 March 2013
Achieve compliance with agreed national standards for best practice in children's diabetes	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133585.pdf p59.	New Standard under national development	Compliance by independent assessment	Attainment of compliance. Peer Review 24 Feb 2012

These indicators are based upon nationally identified patient quality indicators. The three areas impact on core services for families in Sheffield and South Yorkshire. The Safe and Sustainable Standards for Neurosciences and consequent peer assessment, are still being agreed.

2.3.4 PATIENT EXPERIENCE

Patient Experience **AREA REVIEWED**	**NATIONAL OR HISTORICAL PERFORMANCE THRESHOLD**	**PERFORMANCE 2011/12**	**TARGET PERFORMANCE 2012/13**	**ACHIEVEMENT 2012/13**
Initiate 850 patient postal survey of experience in children's A&E **Tool should record child and parent experience**	No child specific national tool available Commission tool in conjunction with other hospital Children's Services	Not available – new survey	To highlight areas of below average performance and problem scores greater than 50%	Completed http://www.sheffieldchildrens.nhs.uk/Patient-views.htm
Complete an 11 bedded Home from Home for resident parents of children in Critical Care. **Work with the Sick Children's Trust to ensure that parents' needs are reflected in design.**	Poor performance against resident parent facilities scores: p3 http://www.sheffieldchildrens.nhs.uk/Downloads/Patient%20views/Inpatient%20Survey%20Results%202011%20pdf.pdf	Facilities for parents staying overnight rated as fair/poor 25%	Less than 25% dissatisfied score resulting from re-survey.	The Home from Home was not available during the survey and accordingly the result remains at 28%. The facility is currently under construction and should be complete by Summer 2013.
Ensure that family needs are reflected in design and working practices associated with new hospital Out-patient and In-Patient facilities being built from 2012 - 2015	No child specific national tool available	Patient surveys have reported on existing practices and facilities rather than what parents and children want.	Set up family focus groups to assess the priorities of families. Publish responses and incorporate findings in planning of new facilities.	University of Sheffield has been contracted to carry out focus group research this year with families and staff. Research findings will be published to advise new ways of working in 2014.

The Trust has largely based its capital building plan on family feedback. The needs expressed in the annual surveys have informed the access, way finding, clinic environment, ward facilities, resident parent facilities and working practices of the new hospital wing. Our A&E facilities and the satisfaction results obtained have informed the decision of local commissioners to relocate out of hours GP care to a clinic within the hospital, thus simplifying Sheffield wide provision.

2.3.5 AUDIT AND NATIONAL CONFIDENTIAL ENQUIRY ASSURANCE

During 2012-13, 15 national clinical audits and zero national confidential enquiries covered NHS services that Sheffield Children's NHS FT provides.

During 2012/13 Sheffield Children's NHS FT participated in 100% of national clinical audits which it was eligible to participate in. Sheffield Children's NHS FT was not eligible to participate in any national confidential enquiries in 2012/13.

The national clinical audits that Sheffield Children's NHS FT was eligible to participate in during 2012/13 are as follows:

National Clinical Audits for which the Trust was Eligible	**% of eligible cases submitted**
RCPCH Childhood epilepsy 12	100%
PICANET Paediatric intensive care	100%
RCPCH Paediatric Diabetes	100%
RCP (UK IBD Audit) Inflammatory Bowel Disease	100%
BTS Paediatric pneumonia	100%
BTS Paediatric asthma	100%
NHS BT Potential donor audit	(100%)
POMH: Topic 10b - Reaudit of Prescribing Antipsychotics for Children and Adolescents	100%
CE (CORP) RCPCH Child Health Audit Clinical Outcome Review Programme/Child Health Reviews-UK (CHR-UK)	100%
CE (CORP) RCoP National audit of Asthma Deaths	100% (No reportable deaths)
DH A& E Data Sharing	100%

National Clinical Audits for which the Trust was Eligible	% of eligible cases submitted
CEM Fever in Children	100%
TARN Trauma	77%
NHS BT Audit of the labelling of blood samples for transfusion	100%
ICNARC Cardiac Arrest Procedures	100%

The reports of 14 national clinical audits were reviewed by the provider in 2012/13 and Sheffield Children's NHS FT took the following actions to improve the quality of healthcare provided.

POMHS: Prescribing Antipsychotics for Children and Adolescents – Audit and Re-audit

Actions: The initial audit highlighted the need to raise awareness about the importance of undertaking physical examination, improved documentation in case notes and monitoring of medication using an agreed or individual pro forma.

The Re-audit found an overall improvement in the above. National Leaflets and Monitoring Sheets have been purchased to consolidate good practice.

NCEPOD: 2011 Surgery in Children report, "Are We There Yet"

Actions: Gap Analysis and Action Plan produced. Evidence to support final compliance includes:

- Ratification of Transfer Policies and Procedures
- Multi-disciplinary pre-operative meeting minutes
- Consent and information for parents relating to risk of death
- Additional clinical audits for special care review

College of Emergency Medicine (CEM): Feverish Children

Findings:

- The local audit report found that the Emergency Department had a very low Antibiotic prescribing rate and complied with NICE guidance relating to no administration for patients without an obvious focus.
- Improved provision of adequate safety net advice following the use of the febrile child advice leaflet

Actions in progress/completed:

- Increased education for triage nurses and medical staff regarding the assessment of CRT and conscious level on febrile children on arrival
- Medical staff to improve the documentation of repeat observations prior to discharge.

- A febrile child proforma has been designed and is currently being piloted in the department – if successful the proforma will be incorporated into the QSM electronically.
- All medical staff informed and all new cohorts to be informed during induction and teaching.
- It was proposed that an IT solution be looked into to ensure full observations were completed but the IT Lead has stated that this is not possible

College of Emergency Medicine: Pain in Children

Actions:
- Increased education and training in pain assessment to nursing staff
- Recording of pain assessment is now included in the triage form
- Pain assessment box has been added to the observation charts to enable ongoing monitoring

PICANET 2011 (CA223)

The National Report demonstrates that our standardised mortality is improving in line with national secular trends and compares favourably with other ICUs in the region. Therefore there have been no actions arising from this report.

National Inflammatory Bowel Disease (IBD):

Actions taken:

- Guidelines for management of acute severe colitis have been established
- Consideration for a named Clinical Lead for IBD
- Administration support for the designated lead
- IBD nurse to initiate and maintain IBD database prospectively

The reports of 265 local clinical audits service evaluations were reviewed by the provider in 2012/13. The reports were reviewed by clinical teams. Examples of the actions taken or intend to be taken by the Trust to improve the quality of healthcare provided include:

Pharmacy: CA363: Audit of prescribing errors and clinical interventions made for out-patients

Action identified and / or implemented
- Slides added to level 3 medicines management training (& junior doctor induction)
- Promotion of addressographs label use ongoing.
- Presented findings at peer, medical and surgical audit forums
- New pharmacy Standard Operating Procedures (SOPs) to be developed ensure all staff covering reception know to check all relevant information
- Future re-audit planned

Child protection: SE21 User feedback in Clinical Assessment Unit
Results showed
- Overall feedback obtained was generally positive from patients, carers, and professionals alike.
- Individual comments about the doctor, where obtained, were entirely positive.
- Regarding the service as a whole, the vast majority of comments from all the user groups were positive, with few negative comments around parking, and occasionally about waiting times.

Haematology and Oncology: CA380 Oral Anticoagulant Annual Audit 2011
An audit was performed to show compliance to National Patient Safety Agency (NPSA) alert 18 concerning 'Actions that can make anticoagulant therapy safer'.

Actions included:

- A copy of the anticoagulant results spreadsheet to be placed in the patient's medical notes at six monthly intervals.
- A formal pathway to deal with non-attendance for indicator testing was developed.
- Revised non-compliance letters sent to GP
- Provide written dosing instructions when parents forget to bring their yellow books

Surgery: CA412 Audit of Pre-operative World Health Organisation (WHO) Theatre Checklist

WHO launched a second Global Patient Safety Challenge, 'Safe Surgery, Saves Lives', to reduce the number of surgical deaths across the world. The WHO checklist is part of this initiative.

Actions included:

- Audit feedback to Surgeons and Theatre staff that they must write their full name, in the staff identity section.
- Emphasise importance of putting a patient details sticker and the date on the second page of the checklist.
- Checklist form revised to include: 'staff name', 'staff role, bleep number and then 'signature'.

ENT: CA244 ReAudit of Prescribing in Paediatric Tonsillectomy
This project was to re-audit the prescription of steroids and antibiotics during tonsillectomy following awareness and departmental teaching recommended from a previous audit project.

Actions Include:

- Steroids prescribed to all children undergoing tonsillectomy unless contra-indicated, and any contra-indications documented in notes. *[Note: the following has been added to Theatre Lists for patients undergoing Tonsillectomy - "Dexamethasone if not contra-indicated"]*
- Antibiotics not prescribed post-operatively to children undergoing tonsillectomy unless clinical reason documented in notes and no contra-indications.
- Dissemination of information regarding the use of antibiotics/steroids in the undertaking of this procedure

CA224: Re-audit of Completion of Sheffield Paediatric End of Life Care Pathway (EOLP)

The appointment of a Palliative Care Consultant has resulted in increased awareness and education. The use of the EOLP is being more widely used in the Trust, Community and Local Hospice.

Actions Included

- Adapt current EOLP to make it clearer aspects that warrant completion
- Encourage prescribers to consider medications to combat side-effects of pain killers where indicated eg. Laxatives - Continued education
- Poster presented, European Congress of Paediatric Palliative Care, Rome November 2012.

Further examples of actions resulting from completed audits are available on the Trust Website or from the Clinical Governance Department.

2.3.6 CLINICAL RESEARCH

The research portfolio of the Trust is growing following the Board approval of an ambitious research strategy in July 2012. The number of our patients receiving NHS services provided or sub-contracted by Sheffield Children's NHS Foundation Trust (as well as family members and healthy volunteers) choosing to participate in our research so far in 2012/13 is 1,117.

Two examples of the research carried out during the year are given below:

2.3.6.1 Title: The Effect of Body Weight on Trabecular and Cortical Bone Structure and Strength from 8-30 Years. The Role of Hormones and Osteokines (The Body Weight and Bone Study - BWAB)

The BWAB study is being run in collaboration with researchers from the University of Sheffield and Sheffield Teaching Hospitals. This study is being conducted in both our Trust and at the Centre for Biomedical Research at the Northern General Hospital, Sheffield. The research involves both our patients and healthy volunteers and recruitment is well underway.

Overweight children appear to have lower bone mass relative to their body size and fracture more. Therefore, this study is designed to understand the differences in bone mass, geometry, microarchitecture and strength in a loaded (distal tibia) and a partially loaded (distal radius) skeletal site between obese and lean participants aged between 8 and 22 years. Furthermore, this study aims to determine relationships between fat-derived hormones and factors controlling bone turnover that may explain why overweight children are at greater risk of fracturing. By using the high resolution Xtreme CT scanner (only one of two in this country), this study will provide detailed information about the effect of excess fat mass on cortical and trabecular bone structure over a wide age range. The use of an engineering model (microfinite element analysis) will help to determine the effect of being overweight on bone quality and strength. Analysis of hormones that affect bone turnover in children and young adults will help to define pathways that may help to explain the relationship between fat and bone as children progress through puberty into adulthood.

2.3.6.2 Title: Hypertonic Saline in Acute Bronchiolitis: Randomised Controlled Trial and Economic Evaluation

The SABRE trial is a Trust sponsored multicentre randomised controlled trial which aims to determine whether the addition of 3% hypertonic saline to usual care results in significant reduction in the duration of hospitalisation of infants with acute bronchiolitis. The trial has now run for two winter seasons with a possibility of an extension to run later this year to allow a 3rd season of recruitment.

The primary hypothesis of the trial is that the addition of 3% hypertonic saline to usual care results in significant reduction in the time to when infants admitted with acute bronchiolitis are 'fit for discharge'. Secondary hypotheses are that the addition of nebulised 3% hypertonic saline to usual care is associated with:

- improved quality of life outcomes for carers
- shorter length of stay
- improved quality of life for the infants

- reduced health care utilization in the month after discharge
- cost effectiveness for the NHS
- the effect is independent of the underlying virus

2.3.7 USE OF THE CQUIN FRAMEWORK

A proportion of Sheffield Children's NHS FT income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between Sheffield Children's NHS FT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at *http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275*

The amount of income in 2012/13 conditional upon achieving quality improvement and innovation goals was £3,005,004 and the amount achieved in 2011/12 was £XX.

A more detailed commentary on our achievement against the CQUIN quality indicators is given below:

CQUINs for Specialist Services

Title	Description	Outcome
Tier 4 Child and Adolescent Mental Health	ESQ service evaluation questionnaires to be offered to all patients/ parents	Achieved
Critical Care	PICU - out of region transfers 5% or less	Achieved
Haemophilia	Consistently submitting data on severe episodes & days lost from education	Achieved
Dashboards	Quality outcome data on all specialist commissioned services to be submitted quarterly	Achieved

CQUINs for Core Services

Title	Description	Outcome
Patient experience – Outpatient clinics	95% of patients to be seen within 45 minutes after their booked outpatient clinic time in the specified clinics	Achieved
Patient experience – A&E	Commission an 800 patient survey and produce an action plan to address problems identified.	Achieved
Patient experience – Parent Hotel	Commission and construct a Parent's Accommodation block for parents with children on critical care floor.	Achieved
Improving the management of common conditions	Agree common pathways for: • Loss of birthweight • Neonatal jaundice • Bronchiolitis	Achieved
Domestic Violence Indicator	All cases of Children from families with evidence of Domestic Violence from the data base will be flagged on SCH A&E systems All identified children will be alerted to Health Visitors and School Nurses of children who do not attend clinic for more than 3 months	Achieved
Looked after Children Indicator	All Looked after Children from the local authority data base will be flagged on SCH A&E systems All identified children will be alerted to Health Visitors and School Nurses of children who DNA for more than 3 months	Achieved
Referral to Sheffield Stop Smoking Service	Number of referrals each quarter to the SSSS by Health Visitors to equal 25	Achieved
Asthma Management	90% of patients attending with a diagnosis of acute exacerbation of asthma who are not admitted should be discharged home with a completed care bundle	Partially Achieved

- The Trust set out to improve its patients' experience by reviewing the administration of its clinics. 95% of clinics achieved this target but we are aware that complicated diagnostic tests can unexpectedly lengthen the duration of the visit. We aim to be clearer about the expected duration of clinic visits and to shorten these wherever possible.

- The Trust has capitalised on its innovative patient safety net, whereby vulnerable patients are flagged up and followed up in the community, if they attend A&E or do not attend clinics. Looked after Children and children in households known to have domestic violence are now included.

- Despite achieving compliance with the target in the first of two audits; the second audit showed less than 90% of children were able to have the full bundle of care that was agreed for chronic asthma. The two areas where most improvement was required were: Checking inhaler technique and improved communication with GPs. Work is ongoing with A&E staff to ensure that this position improves.

2.3.8 REGISTRATION WITH THE CARE QUALITY COMMISSION

Sheffield Children's NHS FT is required to register with the Care Quality Commission and its current registration status is unconditional. The Care Quality Commission has not taken enforcement action against Sheffield Children's FT during 2012/13.

Sheffield Children's NHS FT has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13:

Unannounced Inspection: Sheffield Children's Hospital, 16 October 2012

The Inspection report said:

"Sheffield Children's Hospital was found to be meeting all the essential standards of quality and safety."

"What people who use the service experienced and told us:"

"All children, young people and their parents spoken with said that they had been provided with relevant information which helped them understand the care and treatment choices available to them (or their child). They said that they had been involved in care and treatment decisions and that staff always involved them and listened to them. Children and young people said that staff were approachable and explained things in a way they could understand. Their comments included; "The nurses have always explained the choices for treatment and ask for consent to any treatment before they start." "They (staff) are very good at explaining things. They always check that we (parent and child) have understood and are happy with what is happening."

"People told us their privacy and dignity was respected by staff. They told us that staff were polite and respectful. Their comments included; "There are no issues about privacy. They (staff) always close the curtains, even if it is just for a chat, and they lower their voices." "A doctor took us into a side office so that we could be private, and so that he could explain things properly to us. They were very good." "If they (staff) need to speak to us they always pull the curtains around the bed. They are very respectful and always introduce themselves. They speak professionally to us and maintain confidentiality." "They give (my child) lots of respect and let them make decisions."

"During this inspection we observed interactions between nurses and parents and their child. Staff were seen to be polite and respectful. Nurses took time to talk with people to offer support and reassurance. Nurses were also overheard to ask people's opinions and check that they were satisfied."

"Children and young people told us that they felt safe. Parents felt that there was enough staff on duty and that as a result their children were safe. Their comments included; "I really believe (my child) is very safe here. I have never had any concerns about their safety." "I feel very safe here. There is no reason not to be." "I have absolutely no worries about (my child's) safety. I feel able to leave them and know they are in good hands. I couldn't do that if I was worried at all."

"We spoke with six nurses and a support worker from two wards at the hospital. Staff told us that they felt supported to provide care and treatment to children and young people staying at the hospital. A clinical nurse educator was employed to provide training and support to staff. Staff said that the support and training provided was excellent. They told us that they were provided with induction and mandatory training each year that covered topics such as moving and handling, infection control, child protection, medicines management, risk management and fire. Staff said they also had access to specialist training such as dealing with specific medical conditions, communication, dealing with challenging behaviour and equality and diversity."

http://www.sheffieldchildrens.nhs.uk/Downloads/CQC%20Reports/CQC%20report%20November%202012.pdf

2.3.9 PERIODIC REVALIDATION OF MEDICAL STAFF

Medical revalidation is the process by which all doctors who are licensed with the General Medical Council (GMC) regularly demonstrate that they are up to date and fit to practise. Doctors will normally revalidate every five years. Revalidation is based on a local evaluation of doctors' practice through appraisal; its purpose is to affirm good practice.

In addition to the responsible officer all eight of the first tranche of doctors recommended for revalidation have been approved by the GMC.

2.3.10 INFORMATION ON THE QUALITY OF DATA

Sheffield Children's NHS FT submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 99.5% for admitted patient care; 99.9% for outpatient care; and 99.2% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was: 100% for admitted patient care; 100% for outpatient care; and 100 % for accident and emergency care.

Sheffield Childrens NHS Foundation Trust Information Governance Assessment Report overall score for 2012/13 was 68% this was graded green (satisfactory).

Sheffield Children's NHS FT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were XX%. The final report has not yet been received by the Trust.

At total of 200 Finished Consultant Episodes were scrutinized during the audit. The following services were reviewed within the sample:

- 50 FCEs from Paediatrics
- 50 FCEs from Trauma & Orthopaedics
- 100 A&E Attendances

(The results should not be extrapolated further than the actual sample audited)

Sheffield Children's NHS FT will be taking the following actions to improve data quality:

- awaiting PBR final report

2.3.11 INFORMATION ON THE QUALITY OF DATA

The following section sets out the data made available to Sheffield Children's NHS FT by the Health and Social Care Information Centre. The indicators below represent those relevant for the services provided by this trust.

Prescribed Information	National Average	National Highest Value	National Lowest Value	SCFT Period 1 Value	SCFT Period 1 Value
The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period					
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.					

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

XXXX

The Sheffield Children's NHS FT intends to take the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by:

XXXX

Prescribed Information	National Average	National Highest Value	National Lowest Value	SCFT Period 1 Value	SCFT Period 1 Value
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.					

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

XXXX

The Sheffield Children's NHS FT intends to take the following actions to improve this percentage and so the quality of its services, by:

XXXX

Prescribed Information	National Average	National Highest Value	National Lowest Value	SCFT Period 1 Value	SCFT Period 1 Value
The percentage of patients aged 0-14 yrs readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the					

trust during the reporting period.					
The percentage of patients aged 15 yrs or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.					

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

XXXX

The Sheffield Children's NHS FT intends to take the following actions to improve this percentage and so the quality of its services, by:

XXXX

Prescribed Information	National Average	National Highest Value	National Lowest Value	SCFT Period 1 Value	SCFT Period 1 Value
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.					

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

XXXX

The Sheffield Children's NHS FT intends to take the following actions to improve this percentage and so the quality of its services, by:

XXXX

Prescribed Information	National Average	National Highest Value	National Lowest Value	SCFT Period 1 Value	SCFT Period 1 Value
The trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.					

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

XXXX

The Sheffield Children's NHS FT intends to take the following actions to improve this percentage and so the quality of its services, by:

XXXX

Prescribed Information Per hundred thousand bed days	**National Average**	**National Highest Value**	**National Lowest Value**	**SCFT Period 1 Value**	**SCFT Period 1 Value**
The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.					

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

XXXX

The Sheffield Children's NHS FT intends to take the following actions to improve this rate and so the quality of its services, by:

XXXX

Prescribed Information Per thousand bed days	**National Average**	**National Highest Value**	**National Lowest Value**	**SCFT Period 1 a. Value**	**SCFT Period 1 Value**
The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.					

The Sheffield Children's NHS FT considers that this data is as described for the following reasons:

XXXX

The Sheffield Children's NHS FT intends to take the following actions to improve this number and/or rate and so the quality of its services, by:

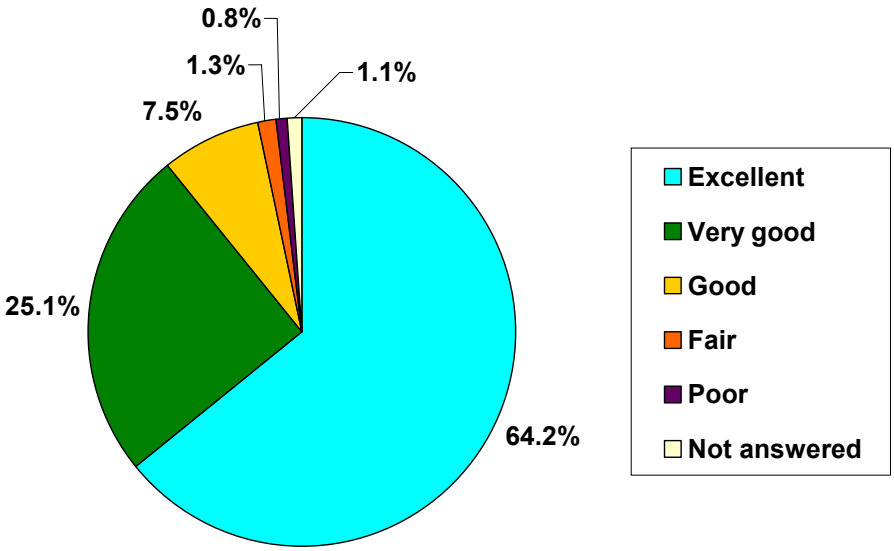
XXXX

other information

2.4 Patient Experience

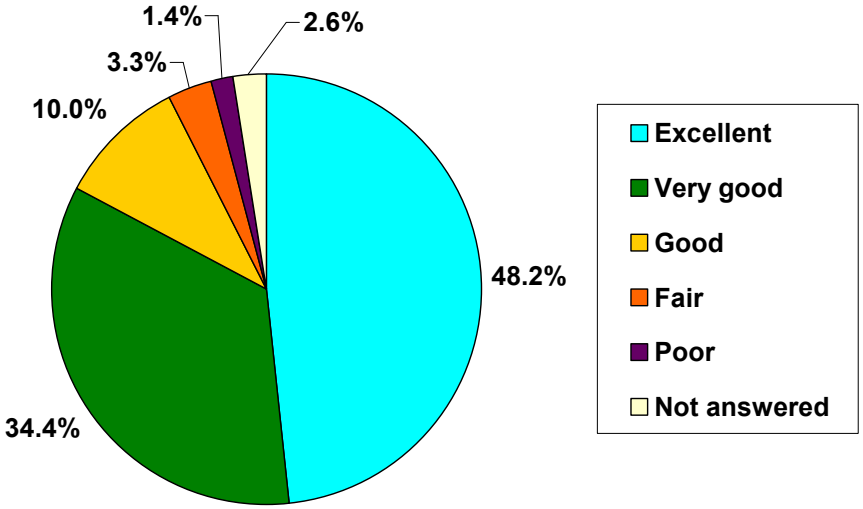
2.4.1 OUT-PATIENT SURVEY 2012 -13

The 2012 Out-patient Survey of 850 families (31.2% response) showed that the majority of our clinic patients ranked their care well:



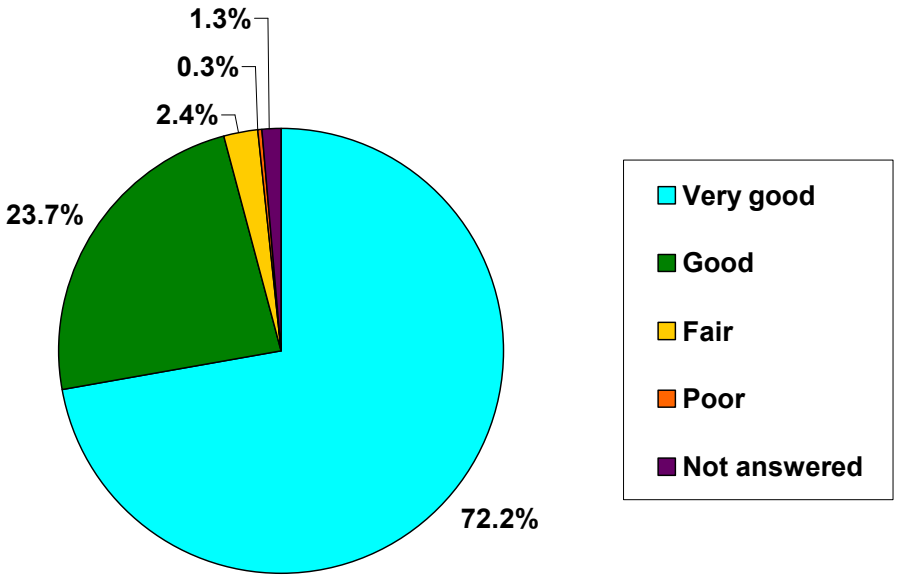
2.4.2 IN-PATIENT SURVEY 2012 -13

The 2012 In-patient Survey of 850 families (35% response) showed that the majority of our ward children and parents ranked their care well:



2.4.3 A&E PATIENT SURVEY 2012 -13

The 2012 A&E patient Survey of 850 families (30.8% response) showed that the majority of our patients ranked their care well:



All surveys demonstrated that the chief problems were with access, car parking, way-finding and the facilities. We intend that our building plan will improve all of these issues over the next three years.

Comments included:

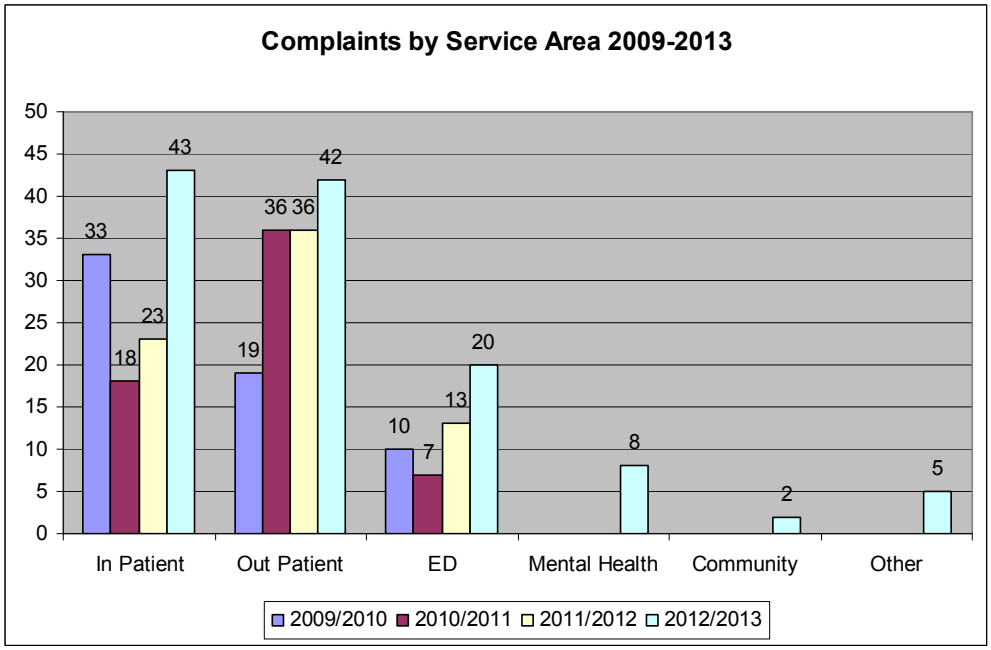
- A&E: “The caring nature of all staff. The speed at which we were seen was fantastic. The parking worry is taken away with the spaces outside on the main road leaving you able to focus on your child.”
- A&E: “Because I was suffering and really scared. So I was not feeling safe with them and also that a piece of glass was stuck in my foot and I told them to do a x-ray on my foot but they didn’t listen to me and I am still a bit more scared.”
- In Patient:” We lost all confidence in our local hospital. The children’s hospital has always picked up the pieces and cured the problem. This is our 1st choice hospital and would recommend it to anyone. Wish we could find an adults hospital that we had as much faith in! Thanks.”
- In Patient:” It was very noisy & no one told anyone when to be quiet. Why did they ask my bedtime which is about 8pm if there was not going to be any quiet until midnight?”
- Out Patient:” My child is acutely sensitive and I explained this to the staff on arrival that she does not respond well to negative words and to pass this on to the consultant. The nurse did so and the consultant handled her very well.”
- Out Patient:” Not having to be left in the foyer whilst my mum or dad parks the car. (We travel from 60 miles away & I can’t walk far).”

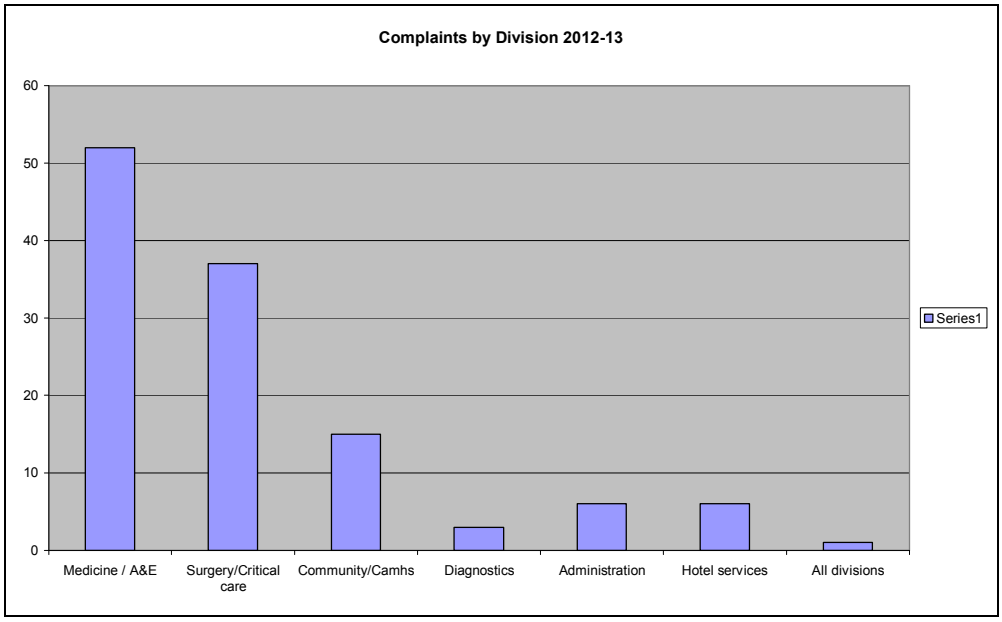
2.5 Complaints

During the financial year 2012/2013, a total of 120 formal complaints were received as at 31 March 2013. The rate of complaints is set out in the following table:

Year	Episodes of care	Complaints	No of complaints per 10,000 episodes
2004 - 2005	131,162	60	4.57
2012 - 2013	187,667	120	6.39

Further analysis shows the following are the main services receiving complaints:





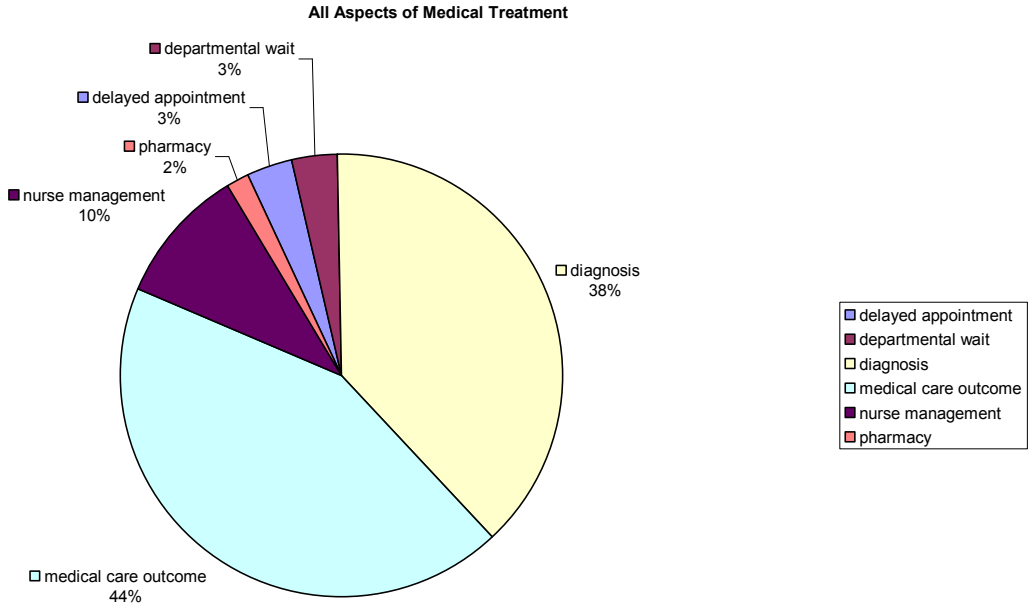
2.5.1 REASON FOR THE COMPLAINT

Complaints are coded according to national coding descriptions:

Type of Complaint	No.
All aspects of clinical treatment	61
Appointments, delay / cancellation (out patient)	17
Attitude of staff	9
Admission, discharge & transfer arrangements	9
Communication written and oral	6
Appointments, delay / cancellation (in patient)	4
Personal records	3
Transport	2
Breach of confidentiality	2
Condition of premises	2
Failure to follow agreed procedure	1
Car Parking	1
Consent	1
Equipment	1
Mortuary & PM Arrangements	1

* 8 complaints were jointly made to more than one health care organisation and require a response from us because of our involvement in transporting infants from district maternity unit to neonatal critical care units at Jessop Hospital or Leeds.

The main types of complaint received in the 'all aspects of clinical treatment are as follows:



Many of these complaints have several elements but there are recurrent themes that the complainants are not satisfied with:

- The diagnosis – this varies from the family not accepting the diagnosis to the diagnosis being shown to be inaccurate.
- Medical care outcome – this varies from the treatment not correcting the symptoms to the child experiencing known complications of treatment.
- Nursing care - this extends from poor communication to poor resident parent facilities on wards.

- Appointment frustrations feature again within this category – from extended waits within departments to appointments being delayed.

2.5.2 LEARNING FROM COMPLAINTS

Although there are some complaints which we cannot do anything about, we take the view that the need to make a complaint demonstrates a failure in communication of our services. If a child experiences known complications of a treatment then it should not come as a surprise to the family; if a family is subject to delays then these should be reasonable and the family should have a right to be warned about them.

Some of the complaints which were made include:

- Confusing guidelines for the management of an intravenous line (Portacath).
- Blood sugar monitoring failed to be carried out on a patient with diabetes who had been admitted for an unrelated condition.
- Miscommunication and misunderstanding led to a family to believe that surgery would be carried out on a certain date.
- Dissatisfaction with post operative care and poor communication before and following surgery.
- Perception of Inappropriate referral for safeguarding assessment.
- Poor attitude of catering staff
- Lack of pain relief
- Conflicting advice from medical staff
- Expectation of transport home following admission
- Cancellations and delays associated with appointments.

The following describes some changes in practice as a result of lessons learnt following complaints:

- Review and redraft of care plans and guidance for Portacaths which resulted in the production of an SCH Policy for the Management of Portacaths in addition to the production of a Portacath Information Leaflet.
- All patients with diabetes will have their blood sugar monitored even if the admission is not related to their diabetes.
- The booking form for patients coming in for surgery has been amended to enable additional information regarding admission to be recorded.
- Nurse Educator to address specialised nursing care and effective communication with all staff.
- Safeguarding protocols and procedures reviewed and additional safeguarding training for junior medical and surgical staff identified.
- Appropriate internal process with Human Resources
- Departmental staff receiving updated training on application of pain relief.
- Additional training delivered by the Consultant to junior medical staff to prevent conflicting advice in relation to application of eye drops.
- Redesign of our appointments booking processes and transformation of our hospital pathways to reduce the duration of processes such as pharmacy dispensing and discharge letter production.

There is an ongoing process to improve communication; we plan to launch a new website this year with increased patient access to leaflets, patient pathways and directed enquiries. We intend our new patient administration software to reduce some of the cancellations that result from overbooking, appointments reminders go out via SMS texts. Training remains a priority, with all nursing areas now having access to clinical skills training and dedicated training time being facilitated.

2.5.3 REFERRALS TO THE OMBUDSMAN

During the last financial year, a total of 2 complainants referred their complaint to the Parliamentary and Health Services Ombudsman (PHSO).

Complaint Ref	Division	File to PHSO	Summary of Complaint	PHSO Decision
COM 50	Medicine	February 2012	Lack of information provided to family	Awaiting decision
COM 82	Medicine	March 2013	Safeguarding procedures initiated due to persistent use of alternative remedies against medical advice.	Awaiting decision

2.6 Serious Untoward Incidents

During the last financial year 2012/13, the Trust reported **7** Serious Untoward Incidents.

- Communication failure: Following death, a patient was transferred to an external hospital without consent of the Coroner and in breach of local guidelines.
    - Discussions and guidance agreed with Coroner, review and dissemination of local guidelines
- Confidential data management – Medical records were left unattended in a public area by a contracted third party courier during delivery. No breach of confidentiality resulted.
    - Review of contracts held by Trust with postal service provider
- Delay to escalation of care: Communication between clinical teams did not result in timely transfer of care between ward and CCU..
    - Revised observation chart with clear thresholds to seek assistance and timed instructions on required medical response.
- Delay in return of samples to families: Delay in returning samples, retained with family consent, after agreed examination period.
    - Merger of two internally used databases and change to oversight of service.

The following investigation reports have yet to be approved by the SCH Risk Management Committee:

1. Over dosage of opiate to a child who had not previously had opiates.
2. Potential delay in diagnosis in Emergency Department. Patient was later transferred out of Trust for specialised care.

3. An unnecessary X Ray scan on two patients.

Reports relating to the Serious Untoward Incidents are shared with the relevant Manager and Clinical Director or equivalent in addition to being presented at the Risk Management Committee. Following the Risk Management Committee and in order to facilitate organisational learning, the reports are discussed at each Directorate Board meeting with any recommendations being monitored through the Risk Management Committee.

All Serious Untoward Incidents are subject to a root cause analysis and the result shared with the Risk and Audit Committee.

3 ANNEX A. STATEMENT OF DIRECTORS RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012-13;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2012 to June 2013
    - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
    - Feedback from the commissioners dated xxxxx
    - Feedback from governors dated xxxxx
    - Feedback from Local Healthwatch organisations dated xxxxx
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, entitled Risk Management Annual Report, April 2013
    - The In-patient survey 2012
    - The Outpatient Survey 2012
    - The national staff survey 2012
    - The A&E Survey 2012
    - The Head of Internal Audit's annual opinion over the trust's control environment dated xxxxx
    - CQC quality and risk profiles dated xxxxx

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

4 ANNEX B. CONSULTATION IN THE PREPARATION OF THE QUALITY REPORT

A number of staff, families and organisations were involved in the consultation process to produce this report and the Trust is grateful for the time and effort of all who have contributed. The final version has tried to accommodate the comments received or the minutes of the meetings at which it was discussed but it is accepted the production of the report is ultimately the responsibility of the Board of Directors.

4.1 Consulted Agencies or Groups:

4.1.1 SHEFFIELD CLINICAL COMMISSIONING GROUP

The first draft report was provided to NHS Sheffield on xxxxx. A final draft was supplied on xxxxx.

SCH QUALITY ACCOUNTS 2012/13

STATEMENT FROM SHEFFIELD CLINICAL COMMISSIONING GROUP

xxxxx

4.1.2 SHEFFIELD HEALTH WATCH

The first draft report was provided to Health Watch on xxxxx and a meeting was held with key members of Health Watch and the Director of Nursing and Clinical Operations on xxxxx. The following response was received:

Sheffield Children's NHS Foundation Trust Quality Report 2012-13
Statement from Sheffield Health Watch

xxxxxx

4.1.3 YORKSHIRE OVERVIEW AND SCRUTINY COMMITTEE

The first draft report was provided to the South Yorkshire Oversight and Scrutiny Committee on xxxxx . The Director of Nursing and Clinical Operations attended the Committee on xxxxx. The following response was received:

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Sheffield City Council – Healthier Communities and Adult Social Care Scrutiny Committee

Response to Sheffield Children's Hospital NHS Foundation Trust Quality Report

xxxxx

4.1.4 COUNCIL OF GOVERNORS SHEFFIELD CHILDREN'S NHS FT

The first draft report was provided to the Governors on xxxxx. The draft was the subject of a discussion on xxxxx between the Director of Clinical Operations and the Council. The attached is an extract from the minutes of the meeting.

Extract from the draft minutes of the council of governors meeting held on xxxxx

Draft Quality Report

xxxxx

4.1.5 TRUST EXECUTIVE GROUP

The Trust Executive Group was sent the Quality Report on xxxxx and considered the document at the meeting on xxxxx. The committee comprises of clinical directors, general managers and executive directors and is the principle management forum within the Trust.

QUALITY REPORT

xxxxx

4.1.6 CLINICAL GOVERNANCE COMMITTEE

The Clinical Governance Committee was sent the Quality Report on xxxxx and considered the document at the meeting on xxxxx. The committee comprises of lead clinicians and directorate representatives from across the specialities within the Trust, it is also attended by a representative from NHS Sheffield. The attached are the minutes of that meeting.

User Involvement – Quality Report

xxxxx

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

Report of: Eddie Sherwood, Director of Adult Social Care

Subject: Update on Self Directed Support and Personalisation

Author of Report: Jeanette Thompson, Service Manager - Personalisation
Jon Brenner, Programme Manager

Summary:

The report provides and update to the Scrutiny Committee on the progress in the choice and control given to people receiving adult social care. It also gives an overview how personalisation will continue to be implemented across Adult Social Care.

Type of item:

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

The Scrutiny Committee is being asked to:

Note and comment upon the update.

Background Papers:
Self Directed Support Programme Closure Report
Self Directed Support Programme Benefit Reports

Category of Report: OPEN / ~~CLOSED~~

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Healthier Communities and Adult Social Care Scrutiny Committee

Update on Self Directed Support and Personalisation

What are we going to cover?

- A reminder: What is Self Directed Support
- What have we done in Sheffield?
- Achievements
  - Choice & Control
  - Process Redesign
  - Market Development
- What impact has it had?
- On-going Challenges
- How do we compare to other authorities?
- What next for personalisation in Sheffield?

A reminder: What is Self Directed Support?

- The approach we take to support people to have control and make decisions about their life
- Enabling people to choose their own support
- Working together to decide how the person's needs can be met
- Giving people control over their lives and the support they receive by telling people up front how much money they are entitled to in order to plan their support and life. (a personal budget for people with critical or substantial needs).
- Maximizing all that is available to a person including help from family, friends and the local community
- It is about people in Sheffield having a good life, being happy, safe and well

What have we done in Sheffield? Headlines

- Changed how the system works so that after a person's needs are assessed, they are given an allocated an 'indicative budget' within which they can plan
- People are supported to work out how they want their needs to be met, within their indicative budget. Either by an independent planner or a member of assessment and care management
- People can choose to plan with family/friends to work out how to meet their needs – or do it by themselves if they prefer. There are tools available to support people to do this
- The support is then put in place, either arranged by the Council or through a Direct Payment when the funding is transferred to the individual
- The system has been designed to give people control and keep them safe, while preventing abuse of the freedom

What have we achieved? Choice and Control

- Development of options for the management of people's personal budgets which gives them different levels of control and provides accountability for the Council
- Progress towards a culture across the portfolio where change is coproduced by the Council and citizens of Sheffield. Developed a co-production framework and have developed tools, resources and guidance in a coproduced way and have started to embed this approach into business as usual.
- Increased proportion of people with Personal Budgets. Currently there are 8,208 people in Sheffield with a Personal Budget, which is 63.11% of those eligible for services.
- Increased the proportion of people with Direct Payments. Currently there are 3,030 people in Sheffield who have a Direct Payment, which is 23.3% of those eligible for services.
- Developed a broad range of information and advice for support workers and people with a personal budget. These include; Employee Handbook, Coaching and Mentoring Handbook and a DVD
- Progress towards a single Resource Allocation System that generates indicative budgets for people to plan their support, putting people in control and ensures a fairer allocation of funding.

What have we done? Process Redesign

- A process to support people to get consistent support from social care across all services
- A process of person-led assessment where individuals can express their needs in their own words
- Introduction of the Support Planning process which helps people to understand their choices and consider using more community based options to meet needs.
- Developed a process where decision making is closer to the person and created systems and tools to enable transparency in relation to decision making and ways that the person can challenge decisions made about their needs and support without having to go through the complaints process.
- A different focus on workforce development to support the delivery of personalisation

What have we done? Market Development

- Development of the external support planner market which engages the voluntary, community and independent sectors in support planning and encourages people to consider more creative ways of planning their support. 1,839 support plans done externally in 2012/13.
- Promote diversity and innovation in the external provider market through the Provider Innovation Fund
- Supported the development of the provider market through Help Yourself Database and Connecting Sheffield and by establishing the Recognised Provider List
- Framework agreement for care and support
- Establishing on on-going partnership with providers, educational establishments and citizens to support stakeholder development
- Established training programmes in personalisation relating to care/ support and support planning that were delivered to internal and external workforces
- Developing the eMarketplace project within the Business Systems & Information Programme.

What have been the benefits?

The benefits to individuals are:

•I have high quality support that is directed by me and is responsive to meet my needs.

•I have the right amount of choice and control to plan and change my support when I need to.

•I have access to a range of support that helps me live the life I want and remain a contributing member of my community.

•I am supported in my role as a carer and have the right amount of flexibility and choice to care for the people in my life.

•I can get involved in work with the Council to change the way they do things.

The benefits to the organisation are:

•Professional time for delivering services (Self Directed Support) is focussed, efficient, and with no unnecessary delays for the customer.

•Financial savings for budget planning and reinvesting in reablement and prevention.

What impact has it had?

- It's changed people's lives - allowing them to be more independent and happier
- The appendix gives 2 stories on how it has changed people's lives, These are just 2 of the 8,000+ people across Sheffield who now have more control over their lives
- Growth in employment opportunities for personal assistants and support planners.
- It doesn't just help people who receive care – also supports family, friends and carers

What impact has it had?

Extract from DVD

How do we compare to other authorities?

- Above the national average direct payment figures
- Better offer for older people
- Risen to the challenges in applying within mental health world.
- Increased use of community options
- Other authorities in the region are very interested in our approach to support planning, Individual Service Funds and Direct Payments support service
- Genuine culture change
- Taking us longer to reach the national targets

On-going challenges
a long learning curve.

- Simplifying the communications.
- Culture change
- Consistent quality and assuring this.
- Leaner processes
- Timeliness
- Responsiveness
- Switching infrastructure resources for the increase in direct payments and less traditional contract arrangements.
- Getting the balance between freedom to choose and setting boundaries for managing risk, safety and financial probity.
- Partnership approach across the city to budget challenges

What next for personalisation in Sheffield?

In Adult Social Care:

- The Council continues to be committed to the principles of personalisation
- Are now moving from a programme of change, to permanently embedding our experts into the adult social care service
- Build the ongoing measurement of benefits into performance monitoring arrangements
- Working closely with senior managers to look at innovative ways we can support people while Council budgets reduce
- Continuing work towards greater consistency between the services
- Continue to help managers drive up quality

What next for personalisation in Sheffield?

Elsewhere in the city:

- Personal Health Budgets
- Quality Assurance and practice development framework
- Individual service funds
- Just enough support
- Developments to the resource allocation process
- Leaner processes
- Work with Children's Social Care?
- Other services and areas?

Personalisation within the context of prevention, promoting independence, and greater use of universal services and local communities.

Any questions or comments?

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Nan's Story

Jeanette Thompson, March 2013

Nan was 95 years of age when her daughter first heard about self directed support. Nan was registered blind, deaf and had pernicious anaemia. She was also very fragile. At that time, Nan was starting to feel like a burden to her family, something she really struggled with. She had always been the centre of the family and had supported everyone else and kept them strong. At 95 she felt like her body was giving up on her and that she could no longer do the things she wanted to do or had always been able to do. More importantly she could no longer be the support to her family that she wanted to be. When talking to her about this she said she often cried but didn't want her daughter to worry about her so she always said everything was fine, demonstrating her absolute strength of character.

The first personal budget in Sheffield

The timing of Nan telling her daughter all was not fine coincided with the start of the work in Sheffield to put in place self directed support. This meant that the opportunity was there for Nan to have support that was designed to work for her rather than the respite or day care she had previously been told about. Nan was clear that being placed in group settings where she needed to 'trouble' or ask people for support, such as to go to the toilet, was not for her. She wanted to stay at home where she felt safe and loved.

Nan was part of the very first group of people to start planning to have a personal budget in Sheffield; in fact she became the first person to have one. She came to an event where everyone in the room was planning what they wanted their support to be like. The start of this process was to describe who you are as a person. This is crucially important when planning with someone as it is the start of a logical journey to understanding what support someone might want to keep them safe and help them to live their life.

Telling her story

Nan told everyone about all the things she had done as a child and as she grew up and became a mum, a grandma and a great gran! She told everyone about the time she went to the pictures when her dad thought she was somewhere else; how as a child she were in awe of the village bobby; about meeting her husband, having her children, losing children, taking in other kids that were struggling and the challenges some of her family members had. Most of all she told us about the love for her family and for life that she had. As she told the story Niki (her support planner) was drawing and writing this up on a huge graphic. At the end of the session the graphic was full of stories, anecdotes and information about Nan. She was thrilled, if not a bit overawed that people had spent time listening to her story and writing it up. She was amazed to see her life story on paper in front of her. She was even more impressed when she realised it was hers to keep and she could take it home.

Choosing a personal assistant

Nan had a simple support plan; she did not want the earth, she never did. She wanted a personal assistant to support her, to help her garden and grow tomatoes, to help her wash up, re-cover her sofa, to visit her brother and sister and to visit the places that she had grown up in. Nan found a wonderful PA, Rachael. Rachael has supported Nan

brilliantly for the last 4 years. She has become a part of the family. She has helped Nan to wash, when her daughter found this particularly difficult, she has taken her to visit relatives and all her favourite old places, amongst many other things.

Support for the whole family

Rachael has also been an amazing support for the whole family and particularly for Anita (Nan's daughter), when Anita has had challenges in supporting her mum, such as when she broke her arm. Rachael has stepped in and been flexible about the support she offered (paid via Nan's contingency). Equally, when Anita and her husband were about to have their first holiday together as a couple in many years I was stunned but pleased when I got a call (whilst I was on holiday) telling me that they were all going; Anita, Tony, Nan and Rachael. At that time I felt respite breaks was about being away from the person and was initially a little worried. But as a family they all went to the same place, did their own thing during the day and got together on an evening over dinner. It was a fabulous break for all concerned; they had a break from the routine and chores of everyday life and got time to enjoy each other's company. Even more importantly Nan started telling everyone she came into contact with that they needed some of this 'self directed support stuff' and when they thought it was just a freebie from the local authority, she corrected them - very firmly.

A pioneer for self directed support

When she was not quite so poorly, Nan used to do conference presentations for us. We videoed one of these; the experience of hearing her talk to a room full of people, knowing many of them were sceptics, was inspiring. Particularly when she told the room full of social workers that if she were well enough she would be knocking on the door of every older person in Sheffield telling them all about self directed support, but as she couldn't, she expected everyone in the room to do the same. She was a powerful lady who inspired lots of people to do something wonderful for the people around them.

Flexibility and control

Nan had a budget for over 4 years. In that time her needs changed and her budget increased, but she continued to be supported at home by her family and Rachael. This and the flexibility to support her kept Nan safe for a long time, when she had urine infections and has been singing and marching 24 hours a day Anita has flexed the budget as much as she could, often not as much as she needed. When Nan went into hospital, Anita worked tirelessly to get her home as soon as possible and was able to use Nan's personal budget to help make that happen.

During the last 4 years Nan's brother passed away. Nan was distraught by this but remained steadfast and determined not to give up, as she had to tell lots more people about self directed support and personal budgets. Anita has said on more than one occasion that this kept Nan alive at a very difficult time.

The legacy of a great lady

Recent years saw Nan become increasingly frail and ill. The last few months were particularly challenging as Nan went in and out of hospital with a range of difficulties. She was also singing constantly, 24 hours a day, week in week out, all her favourite oldies. Singing like this was almost her signature when she was particularly ill and is

one of the things I will always remember about her when I think of her and her family. Nan passed away three weeks ago, just a month before the end of the programme that she has been such an advocate for and such a symbol of inspiration. She died peacefully and when she was ready to, at the age of 99.

Today (12.3.13) was her funeral and people from the self directed support team attended the service. The vicar read out her support plan as part of her eulogy; he described Nan as a pioneer and said that she had left a legacy for the whole of Sheffield thanks to her work with personal budgets. He said that he was delighted that because of self directed support he was able to do something he had never been able to do before - tell people about the person's life in their own words. He also expressed thanks to the team on behalf of the family for helping Nan to stay independent to the very end.

Self directed support gave Nan her freedom and independence to the end of her life, a gift greater than any other. But it also gave those of us who knew her the opportunity to know an amazing and inspirational lady. She has helped to keep me grounded with what is important while I have been working to implement self directed support in Sheffield.

Wayne's Story

March 2013

Wayne is 32 years old and from Sheffield. He has a rare degenerative disease that took 13 years to diagnose. He is also half way through his second year of a social work degree, hoping to graduate in summer 2014.

Wayne has been through the self directed support process; he wrote his own support plan and has had his support in place since April 2012. He went through his assessment stage with a student social worker called Laura. This is his story.

Great social worker; great assessment

I started the process at the back end of 2011 with Laura; she managed to do my assessment with me from start to finish. We ended up meeting three times, a couple of hours each time. It was more than I expected, but it worked great. She got everything; she got it coming from myself, from the social perspective and from my nurse's perspective as well. So when her assessment came back it was really good. Laura came and explained all about the indicative budget, about how it could be spent, how it could work. She informed me, she were really good!

Choosing to plan on my own

She told me that I could get someone in to do me support planning; she gave me all the options, but I did actually choose to do it myself, which I think actually should be encouraged a bit more. I know its staffing and time, but if people have got capacity and they are able to, I think it's giving people more sense of achievement, and saving

money from their indicative budget. And you know where it's coming from; the person that's living with that disability and knows how it works.

Laura emailed me all tools; it was very daunting. Mine took from September to January, and the process was very detailed but that worked great for me; it helped me doing my course on top of it, and that's why I wanted to do it [on my own]. I had more input and it were more of a choice; I understood what I were asking for and why. I got a lot of insight through the assessment, 'cause it's you talking through the questions. It really did work well for me that way.

Some challenges along the way

So, we got the indicative budget, then I did me support plan, and I spent it! Easy! They gave me this amount of money to spend, and I've managed to spend it; I've showed you how I'm gonna spend it, when it's gonna be spent, how it's gonna be spent, detailed it all to the T, but then they came back to me and said it's not all there for spending.

So that made it more difficult, I had to go back and reassess everything, so that were a bit disheartening and a bit disempowering. I'd spent all that time, that effort; its not that it were difficult, but it were very time consuming, to sit and do it properly. I got more quotes, got this and got that, got things reduced, and juggled it all, and then it went back again.

Choosing the support, making the changes, getting it agreed

I'd gone through every outcome, used things from the toolkit, got some ideas from that, and I knew roughly what I needed to change. For my one off payments for example, I was struggling with me kitchen because I couldn't bend and get into me fridge [or oven] so I designed it [but] we had to cut [the cost] down, which is fair enough. I'd worked out how my PA could support me and how that could be implemented. Other one off payments like a mobility scooter, to help me round uni, things like that.

But then there are examples that say some people had put down a weekend break and pay a PA to take them; so I put down for £700 a long weekend break to go to a caravan park with my PA. I had got a big thing for my enjoying/achieve outcome that I wanted to meet: to have a bit more of a social life, to be able to get out with a bit more support. My mobility scooter were one of those things; [the holiday] was just another way to meet that need. But the [duty] social worker came back to me saying you can't be putting this money down for holidays.

Don't get me wrong though, they gave me some ideas, perhaps that, for my university friends, [who give me support] I could gift them a meadowhall voucher to say thank you. So they gave me some good advice that way.

In the end, we did manage to agree it. At the time, there were times when I were fff… flipped off! It were a back and forth thing. Towards the end of it, of the support planning stage, I were thinking has this all been worth it? And it has, now looking back in hindsight.

Challenges at the Financial Assessment stage

It were all working well when the financial assessment came through. Laura told me about it at the beginning but they didn't get in touch with me till I were about half way through the support plan. When they did the assessment, the support plan was in place. When it came back, they told me that I owed them x amount of 100s of pounds, plus I had to pay £75 a week. I were like, hold on a minute…

Well, it were an error, but I had to argue with them, and I don't like arguing at the best of times. In the end they [realised] they'd counted two lots of money along the way which meant I were paying too much, so in the end it came back that I'm paying £14 a week towards it. Originally they'd said £75…!

That were a frustrating time and I remember getting really upset about that. They don't explained it in layman's terms, I couldn't understand what I were paying and why I were paying it, and they couldn't really explain it either! It were a nightmare!

But… how much difference my kitchen has made to my life… I can access things independently without having to rely on someone to get into fridge. I can't do a full shop, but if I get a few bits I can put them in the fridge, whereas before I couldn't get down to it. That has made a big difference to my life.

Choosing to have a personal assistant

I am quite independent, but if am going places I do like to make sure I'm with someone, just in case I do fall. My PA, he's my mate, he's a big guy and he can just help me up. We've lived together for a long time. He works full time but in the morning it's great when he gives me that support. I am needing more support each time; putting socks on is a nightmare. You don't want to ask for help [so] it just gives me that way of saying thank you, here's a bit of cash now put me shoes and socks on! Its them little things that make all the difference, and stop the isolation. It's not much, but it's nice. I've got a contingency that I can use to pay my PA too.

I manage the money myself. I struggled to start – spending a lot of time on the phone with HMRC. But I've got all the tools on the computer so I do do it, its not TOO bad…!

Laura gave me good advice and did her research. With Jason, my PA, it works wonderful, I'm so so glad that I am able to do that. There's no power imbalance. He knows that he's appreciated, and I appreciate what he's doing. Me and Jason live together and most of my needs are around the house but if I do want to go out or go away I can feel confident because he's there to support me if I need it.

Looking back and moving forward

[Having a personal budget] has given me more confidence, more independence, more control; I'm more positive about everything. I feel confident that with [my friends] being with me at uni they can support me and Jason's there at home. I know they don't want owt for it, I wouldn't, but it is nice that I can do that. If something was to happen, you will get that support from someone and it's nice to be able to say thank you. I put some of my money into a contingency and I'm so glad I did, giving me even more flexibility. If Jason is away, I have a friend down the road who can help me and I can thank them using my contingency.

I'm in my 2nd year; I'm doing the course full time, and it has been a hard slog, I am looking forward to the summer but I know two weeks in I'll be bored, I've kept myself really busy. Perhaps before, this all started, I were just sat about feeling sorry for myself, I look back 7, 8 years, I was fed up; so it has changed, getting my diagnosis, Occupational Therpists that are interested, getting a personal budget; its giving you the confidence and the empowerment to get out and do things, giving someone a purpose; it'll keep you going longer. I think it's critically important.

It's never going to be 100% perfect but there have been dramatic changes over the past few years; it's got to be worth it.

Supporting others

Now in my role [as a social work student] I can explain things in layman's terms, I'm not an academic or anything, I'm an activist. I can explain the whole process and the benefits and I can give them real examples of how it can work for them and how they can chose things that will really make a difference for them.

I think we need to encourage people to plan for themselves – I know it's difficult to get that time, and there's always an element of support but encouraging people to do their own plans, people will get more understanding of the process and get the confidence from that. It's not about doing things for people, its empowering people to be able to do what works. Everyone's different; someone with the same disease as me, their needs will be totally different but so will what they want to get out of life, what they want to do, what they want to achieve.

Pushing the limits

Some people do these courses and want to get on a career path; it's not about that for me, it's about personal goals, get onto the course, get through uni. I'm not bothered about money, as long as I've got a bit of cash in my pocket to have a drink at the end of the week I don't mind.

It's a learning process and I'm getting there. I'm happy where I am and I will say that part of that is due to this [having a personal budget]. It is well well worth it; bit stressful some of the time, but nowt's ever going to be perfect. You know, it's a complex system and its complex people you're dealing with. It can work. Negatives at the time are frustrating but it is definitely worth it. There are stressful bits but you can pay someone to help you if you do want it.

If I'd done it differently I might not have met my exact needs and learnt exactly what I needed. Doing it myself, I could really push the limits.

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

17th April 2013

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

Date: 17th April 2013

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

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee
Draft Work Programme
Last updated 8th April 2013

What	Why	How	When
Quality Accounts	*To consider and comment on the annual quality accounts of NHS providers in the City, as required by the Department of Health*	Discussions with Trusts	Spring 2013 (STH – Feb; YAS – Feb; SHSCFT – March; SCH – April)
Major Trauma Update	*NHS CCG to update on the changes to the way Major Trauma is handled in South Yorkshire*	Report	April 2013
Self Directed Support	*Update on progress in rolling out Self Directed Support.*	Report	April 2013
Birch Avenue and Woodland View	*To discuss future Commissioning intentions for the homes.*	Report	May 2013
Right First Time	*Progress report – specific focus on financial elements of the programme.*	Report	May 2013
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	Spring/Summer 2013
Local Account	*Committee to have early input into the elements that make up the Local*	Report	Summer 2013

	Account		
Memory Clinic Waiting Times	*To consider progress in reducing waiting times and streamlining process*	Report	Summer 2013
Hospice Care in Sheffield	*To consider how hospice care is provided in Sheffield, particularly around funding.*	Report	TBD
The Francis Report	*To consider how the Health and Social Care system in Sheffield is responding to the recommendations of the Francis Report*	Report and collective discussion	TBD
Adults with Congenital Heart Disease	*A review is taking place of services for Adults with Congenital Heart Disease – similar to the Children's review that took place last year.*	The Committee has the option to carry out this work as part of a Yorkshire and Humber Joint Scrutiny Exercise	Late 2013.
Daily Living Equipment under £50	*To consider the impact of the removal of funding of daily living equipment – 6 months following implementation*	Report	Autumn 2013
Care and Support Performance Update	*To consider progress made on care and support performance indicators*	Report	January 2014
Child and Adolescent Mental Health Services	*A scrutiny task and finish exercise into waiting times for Tier 3 CAMHS*	Working Group	Ongoing
Nutrition and Hydration in Hospitals	*To consider support given to patients to eat and drink in hospitals, and to consider quality of food in hospitals*	Working Group	Ongoing
Paediatric Cardiac Surgery	*To scrutinise outcomes for children*	Through the Yorkshire and Humber	Ongoing

	in Yorkshire and the Humber following the decision to reconfigure children's heart surgery centres.	Joint Scrutiny Committee.	

SHEFFIELD CITY COUNCIL

Quarterly Forward Plan of Executive Decisions (including Key Decisions) 3 April 2013 To 31 July 2013.

(**NOTE:** 1.This schedule provides, amongst other decisions, details of those Key Executive Decisions to be taken by the City Council in 28 days and beyond as required by Section 9 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

2. The membership of decision makers are as follows:

- **Cabinet** - Councillors Julie Dore (Chair), Harry Harpham (Deputy Chair), Isobel Bowler, Leigh Bramall, Jackie Drayton, Mazher Iqbal, Mary Lea, Bryan Lodge and Jack Scott)
- **Cabinet Highways Committee** – Councillors Leigh Bramall (Chair), Harry Harpham, Bryan Lodge and Jack Scott (Substitute Members :- Councillors Isobel Bowler, Julie Dore, Jackie Drayton, Mazher Iqbal and Mary Lea.)
- Where **Individual Cabinet Members** or **Executive Directors** take Key Executive Decisions their names and designation will be shown in the Plan.

3. Access to Documents - Details of reports and any other documents will, subject to any prohibition or restriction, be available from the date upon which the agendas for the Cabinet and Cabinet Highways Committee and Individual Cabinet Member and Executive Director reports are published and accessible via the Council's web-site at www.sheffield.gov.uk. or can be collected at the Town Hall at the following address:-

Democratic Services, Town Hall, Sheffield, S1 2HH

4. Where it is intended to hold a meeting, or part of a meeting, in private a notice will be published at least 28 days prior to the meeting in accordance with Regulation 5 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

Date decision is expected to be taken and who will take the decision?	Description of decision (NOTE: This includes details of those items or parts of those items which will be considered in private and the reasons why their consideration will be in private) K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Policy and Development Committee	What documents will be considered by the decision maker?	Date agenda documents available	Who can I contact about this issue and request documents, subject to availability?

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10 Apr 2013 Cabinet	Reducing Long Term Empty Properties :Repair and Purchase Scheme (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Place.	2/4/13	Place Christine Rose Tel: 0114 2734373 christine.rose@sheffield.gov.uk
10 Apr 2013 Cabinet	An Economic Growth Strategy for Sheffield (K)	Cabinet Member for Business, Skills and Development (Councillor Leigh Bramall) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place.	2/4/13	Place Diana Buckley Tel: 0114 2232378 diana.buckley@sheffield.gov.uk

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10 Apr 2013 Cabinet	Procurement Contract for the Corporate Statutory Servicing and Repairs Contract (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	2/4/13	Resources Jed Turner Tel: 27 34066 jed.turner@sheffield.gov.uk
10 Apr 2013 Cabinet	Revenue Budget and Capital Programme Monitoring 2012/13 (Month 10) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	2/4/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov.uk

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10 Apr 2013 Cabinet	The Future Delivery of Housing Repairs and Maintenance (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Communities.	12/3/13	Place Jed Turner Tel: 27 34066 jed.turner@sheffield.gov.uk
10 Apr 2013 Cabinet	The Future of Stocksbrdge Leisure Centre (K)	Cabinet Member for Culture, Sport and Leisure (Councillor Isobel Bowler) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place.	29/4/13	Place David MacPherson Tel: 0114 2053149 david.macpherson@sheffield.gov.uk

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10 Apr 2013 Cabinet	The Future use of the Don Valley Stadium and the re-opening of the Woodbourn Athletics Stadium (K)	Cabinet Member for Culture, Sport and Leisure (Councillor Isobel Bowler) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place.	29/4/13	Place David MacPherson Tel: 0114 2053149 david.macpherson@sheffield.gov.uk
11 Apr 2013 Leader of the Council	Council Tax Hardship Scheme (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources	1/4/13	Resources Jon West Tel: 014 2037762 jon.west@sheffield.gov.uk

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19 Apr 2013 Leader of the Council	Fairness Commission Implementation Budget (K)	Leader of the Council (Councillor Julie Dore) Overview and Scrutiny Management Committee	Report of the Chief Executive.	26/3/13	Chief Executive's Matthew Borland Tel: 0114 2734529 matthew.borland@sheffield.gov.uk
8 May 2013 Cabinet	Members Allowances 2013/14 (K)	Leader of the Council (Councillor Julie Dore) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources	30/4/13	Resources Paul Robinson Tel: 27 34029 paul.robinson@sheffield.gov.uk
8 May 2013 Cabinet	Arbourthorne Fields Redevelopment Scheme (K)	Cabinet Member for Homes and Neighbourhoods (Councillor Harry Harpham) Safer and Stronger Communities Scrutiny Committee	Report of the Executive Director, Place.	29/4/13	Place Christine Rose Tel: 0114 2734373 christine.rose@sheffield.gov.uk

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8 May 2013 Cabinet	Future Use of Wisewood Secondary School site for Housing and a new Play Area	Cabinet Member for Culture, Sport and Leisure (Councillor Isobel Bowler) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place.	29/4/2013	Place Dave Mason Tel: 0114 2734617 dave.mason@sheffield.gov.uk
8 May 2013 Cabinet	Individual Service Fund Framework Agreement and Support Planning and Brokerage Framework Agreement (K)	Cabinet Member for Health, Care and Independent Living (Councillor Mary Lea) Healthier Communities and Adult Social Care Scrutiny Committee	Report of the Executive Director, Communities.	29/4/13	Communities Jeanette Thompson Tel: 0114 2735036 jeanette.thompson2@sheffield.gov.uk

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8 May 2013 Cabinet	Sheffield's Public Health Budget Allocation for 2013-14 (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Healthier Communities and Adult Social Care Scrutiny Committee	Report of the Chief Executive.	29/4/13	Chief Executive's Imogen McLean Tel: 07929 404284 imogen.mclean@sheffield.gov.uk
8 May 2013 Cabinet	Endcliffe Park Cafe - Proposed Lease Renewal	Cabinet Member for Culture, Sport and Leisure (Councillor Isobel Bowler) Economic and Environmental Wellbeing Scrutiny Committee	Report of the Executive Director, Place.	29/4/2013	Place David cooper Tel: 0114 2734350 David.cooper2@sheffield.gov.uk

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22 May 2013 Cabinet	Revenue Budget and Capital Programme Monitoring 2012/13 (Month 11) (K)	Cabinet Member for Finance and Resources (Councillor Bryan Lodge) Overview and Scrutiny Management Committee	Report of the Executive Director, Resources.	14/5/13	Resources Allan Rainford Tel: 0114 2752596 allan.rainford@sheffield.gov.uk
12 Jun 2013 Cabinet	Adult and Community Learning Fees Policy 2013/14 (K)	Cabinet Member for Children, Young People and Families (Councillor Jackie Drayton) Children, Young People and Family Support Scrutiny Committee	Report of the Executive Director, Children, Young People and Families.	4/6/13	Children, Young People and Families Dee Desgranges dee.desgranges@sheffield.gov.uk

Date decision is expected to be taken and who will take the decision?	Description of decision (NOTE: This includes details of those items or parts of those items which will be considered in private and the reasons why their consideration will be in private) K = Key Decision P = Statutory Plan - part of budget and policy framework	Cabinet Member and relevant Scrutiny Policy and Development Committee	What documents will be considered by the decision maker?	Date agenda documents available	Who can I contact about this issue and request documents, subject to availability?

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 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 the Committee Secretariat, Legal and Governance, Town Hall, Sheffield S1 2HH email to: committee@sheffield.gov.uk

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