SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 15 October 2014

PRESENT: Councillors Mick Rooney (Chair), Sue Alston (Deputy Chair), Jenny Armstrong, Olivia Blake, John Campbell, Katie Condliffe, Qurban Hussain, Anne Murphy, Denise Reaney, Jackie Satur, Brian Webster and Pat Midgley (Substitute Member)

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Philip Wood and Joyce Wright, with Councillor Pat Midgley attending as Councillor Joyce Wright's substitute.

2. EXCLUSION OF PUBLIC AND PRESS

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

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 17th September 2014, were approved as a correct record, subject to an apology being recorded for the Healthwatch representative, Helen Rowe. The Committee also noted the Action Update attached to the minutes.

5. PUBLIC QUESTIONS AND PETITIONS

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

6. END OF LIFE CARE IN SHEFFIELD

6.1 The Committee received a report of the Chief Operating Officer, NHS Sheffield Clinical Commissioning Group (CCG) which provided an update on issues raised at the Committee meeting on 19th January 2014, sought to answer questions raised subsequent to that meeting and introduced the draft Sheffield End of Life Care Strategy for 2014/19, a copy of which was appended to the report. The report also provided an update on changes in national policy

regarding End of Life Care and the work which was taking place locally to address this.

6.2 A presentation was jointly given in support of the report by Jackie Gladden, Senior Commissioning Manager, NHS Sheffield CCG, Dr Anthony Gore, GP and End of Life Clinical Lead, NHS Sheffield CCG, Peter Hartland, Chief Executive, St Luke's Hospice and Dr Kay Stewart, Lead Clinician for Palliative Medicine in Sheffield Teaching Hospitals NHS Foundation Trust and consultant at the Sheffield Macmillan Unit for Palliative Care at the Northern General Hospital site. Also present for this item were Dr Andrew Gibson, Deputy Medical Director and Consultant Neurologist, Sheffield Teaching Hospitals, Dr James Davies, Service Improvement Leadership Fellow and Judith Park, Deputy Chief Executive, St Luke's Hospice.

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

- Different types of training were provided for different groups of professionals including Care Home staff. When training was offered to GPs and other members of the primary healthcare team it was expected that every practice would send a representative so that information could be disseminated. The CCG had no power to mandate attendance from primary care but it was possible to use contractual levers to mandate attendance for care home staff.

- With reference to bereavement support, if families were known to the same GP practices as patients approaching the end of life, they may be identified and signposted to appropriate NHS services as well as other support, but there was no mechanism for informing different GPs due to issues of confidentiality.

- In relation to the co-ordination of information, all GPs used electronic systems and there were governance and technical issues to be overcome in order to enable record data sharing. Sheffield Teaching Hospitals were moving to a fully electronic system. Reference was made to the benefits of an Electronic Palliative Care Co-ordination System, as mentioned in the strategy and the presentation, and some progress had been made towards the development of one in Sheffield.

- Consideration had been given by the CCG to what would happen if St Luke's was not able to continue to provide its current services. An exercise had been undertaken to identify the core services which the CCG would need to commission from other providers and this would be costed. However, it was emphasised that the first priority would be to support St Luke's, so that it could continue to deliver these and its other services to the community, especially as it funded 70% of its activity through community fundraising. A statement to this effect was being added to St Luke's contract with the CCG. Regular reporting and monitoring of St Luke's finances by the CCG had started, so that there would be very early

warning of any potential difficulties. The CCG had also given St Luke's a two year confirmation of funding to 31 March 2016, to assist it with planning its service delivery.

- End of Life was defined nationally as the last year of life. Confusion arose with the terms terminally ill, palliative treatment and palliative care. Attempts were made to explain that a person could be terminally ill for some period (in that their illness would end their life prematurely and was not reversible) but that this could be months or years. Palliative treatment was non-curative but again could give a patient weeks, months or years. A recent study undertaken in Lancaster and Sheffield showed that, using Gold Standard Framework criteria, 70% of the population asked had symptoms that could be addressed by a palliative care approach, but that half of these were recognised by the medical team caring for them and only half of these were referred for palliative care review. This identified that recognising when someone could benefit from palliative care input was variable. Also the Neuberger Report and One Chance to get it Right (referenced in the presentation) applied to the last few days and hours of life, although the philosophy behind it could be applied earlier in a person's illness.

- Predicting when death would occur was always difficult. Cancer patients often had a more predictable decline, but for patients with other long term conditions the date of death was less predictable.

- All teams had the opportunity to attend advanced communication skills training, and this was also included in the recent training for GPs providing a locally commissioned service for Care Homes. The focus was on training GPs to have the appropriate conversations with their patients who had been identified as approaching the end of life.

- The CCG was working with the Public Health Team to formulate an Action Plan to identify which groups and communities were not accessing specialist end of life care services. This piece of work was referenced within the forward plan section of the End of Life Care Strategy, and it was hoped that it would be completed by the end of March 2015.

- The CCG supported the national Dying Matters campaign, the aim of which was to encourage people to think about end of life issues and make appropriate plans.

- The withdrawal of the Sheffield End of Life Care Pathway (Last few days of life) (SEOLCP) was explained. The pathway had been based on the Liverpool Care Pathway (LCP) which had been widely criticised in the media and was the subject of a review led by Baroness Neuberger, published in 2013. That report stated that fundamentally the pathway was not a bad thing, but how it was used was the problem, leading to distress and misunderstanding at times, though some people felt it had improved care in the last few days of life. The result however, was to withdraw the

LCP and hence also the SEOLC pathway on 14 July 2014. In its place the Leadership Alliance for the Care of Dying People had developed guidelines published as One Chance to get it Right on 26 June 2014 and local guidance was being developed, based on the five priorities of care and St Luke's Hospice had developed and implemented a system of communication and documentation entitled "ADD CARING".

- In Sheffield Teaching Hospitals (STH), guidance had been produced based on the SBAR system of communication (Situation, Background, Assessment and Recommendation) on how to recognise that someone was dying, how to approach a conversation with the patient and their relevant others, with the expressions 'death' or 'dying' having to be used in any conversations, and the development of a personalised palliative care plan subsequent to the initial conversation. It was felt that there was a different client population within STH and St Luke's Hospice and therefore different systems were more suited to the different settings. There was however, work ongoing to bring the two approaches together, so that community staff caring for patients in their own home did not have two systems to work with. However, at present, the majority of hospital patients identified as dying in the next few hours would remain in their current setting and were unlikely to be transferred out to the care of the community staff.

- Nationally, there was evidence that members of the Black and Minority Ethnic (BME) communities did not access specialist palliative care services as much as the White British population and this was replicated for more deprived groups. How far this was the case in Sheffield, and if so how to address it, would be considered in the piece of work which was being undertaken by the CCG and Public Health Team. Recent data collected by St Luke's Hospice supported the need for this work to be undertaken, and St Luke's had offered to contribute to funding this research if needed. In addition, the Care Quality Commission (CQC) was undertaking a piece of work on this issue. In terms of the Macmillan Unit, members of the BME community who were patients were more likely to be suffering from cancer than other terminal conditions. . A good translation service operated at the Unit, but the translators often needed support in dealing with the difficult conversations which they were likely to have with patients.

- The direction of travel with regard to people's desired place of death was improving and it should be noted that a Care Home was often the patient's home. Figures for desired place of death were comparable with other core cities, particularly since the Sheffield Macmillan Unit for Palliative Care figures at STH were included within hospital deaths figures. These should be considered as hospice deaths and there were moves afoot nationally to correct this.

- There was a need for GPs to identify when a patient's condition was deteriorating and they were approaching the end of life. This should be

discussed by GPs within their practice, so that planning could take place to ensure that the patient's wishes were followed. It was recognised that GPs were the main hub in this process as they received copies of all hospital letters and should enter appropriate patients on the End of Life Care Register. It should be noted that NHS England Area Teams were not resourced to monitor these situations but CQC inspections would look at end of life care.

- Organisations were working to try to get people to register with a GP to allow end of life care to reach more people.

- It was acknowledged that some practices were having their core funding cut which may have an impact on staffing and could result in closures. However, patients would be transferred to other practices if this occurred.

- End of life care for children was covered by the Children's portfolio at the CCG.

- There was periodically a waiting list for admission to both the Macmillan Unit, and to St Luke's Hospice. People were admitted to the units routinely during the day, and emergencies were taken out of hours. Occupancy was counted as live patients in a bed at midnight, so if a patient died before midnight, the bed was counted as empty, so achieving 100% occupancy was rare. However recent national statistics had put the units near the top of national occupancy for specialist palliative care in-patient units, with occupancies being around 94%, compared with the national average of 74%. There was also a "quick fill" of the beds when one became vacant, with the Sheffield 'time spent unoccupied' of a bed being the lowest in the country. With this high occupancy, responding to emergencies was difficult and the flow out of the beds needed to be addressed. Of those admitted to the Macmillan Unit, 70% died (a function of being so close to NGH that patients could be transferred there by internal ambulance who were not well enough to be transferred to any of the surrounding hospices). Of those admitted to St Luke's, 40% of those admitted as in patients were discharged after treatment, with 60% dying. Discussions were taking place as to how to improve the flow of patients through the Macmillan Unit and there was a need to ensure appropriate use and that support services were available. The End of Life Care Strategy would cover this issue.

- When dying in the place of choice was suggested as a CQUIN (Commissioning for Quality and Innovation) scheme, representatives of STH explained that patients did on occasion change their mind about where they wanted to die, but it was difficult to show the process of transition. It was explained that the evidence for patients wanting to die at home had been refined over the years, from a yes/no answer to qualifying statements within different disease groups. However, at different stages within their illness, when fear, unexpected deterioration and carer fatigue or crisis occurred, patients and their families changed their minds on

preferred place of death. This was difficult to capture sufficiently robustly to support a CQUIN scheme. It was hoped that the Electronic Palliative Care Co-ordination System would assist in tracking this. The present aim was to achieve the place of death in line with the patients' wishes where this was clinically possible.

6.4 RESOLVED: That the Committee:-

(a) thanks the representatives for their contribution to the meeting;

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

(c) notes the joint work being undertaken by the NHS Sheffield Clinical Commissioning Group and the Public Health Team on identifying groups and communities who were not accessing health services and requests that a copy of the resultant report and action plan be made available to it; and

(d) agrees that the Chair, Councillor Mick Rooney, writes to the Care Quality Commission to express the Committee's concerns about GPs identifying those patients approaching the end of life and having the appropriate conversations with them.

7. SHEFFIELD DEMENTIA STRATEGY AND COMMISSIONING PLAN

7.1 The Committee received a joint report of the Director of Business Planning and Partnerships, Sheffield Clinical Commissioning Group (CCG) and the Director of Commissioning, Sheffield City Council, which provided details of the Dementia Strategy and Sheffield Commissioning Plan, within the context of a joint health and social care commissioning approach. Appended to the report was the Joint Health and Social Care Commissioning Delivery Plan for Dementia 2014/15 and 2015/16.

7.2 In attendance for this item were Sarah Burt, Senior Commissioning Manager, NHS Sheffield CCG, and Joanne Knight, Strategic Commissioning Manager, Sheffield City Council.

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

- In relation to short term care, 20 short term care beds were currently block funded and consideration was being given to the use of day care services in the same facility. It was proposed to ask people what the best solution was to reconfigure the service and come up with innovative solutions.

- There were several provider lists for the provision of respite care, which covered a number of eventualities and there was always the opportunity for

people to self-fund.

- Each dementia home should have members of the team who had experience and training in dementia.

- It was accepted that better systems were required for listening to people's views in relation to the care they received and this was being looked into. Meetings had been held with interested parties aimed at obtaining details of residents' experiences, with buddying being under consideration as part of this. An observational tool was being used by the Care Quality Commission to look at interactions with patients to see how any training was being put into practice.

- The Adopt a Care Home Pilot linked young people to care homes and this would be evaluated by the University of Sheffield.

- The Big Lottery funding to tackle isolation and loneliness would not exclude those in residential care homes.

- Officers would check as to whether there was a figure that could not be exceeded from personal budgets and report back. If someone chose a different standard of care, they may only get the amount as assessed, but that amount should be enough to meet their needs.

- There were good examples of how people with dementia had flourished as a result of being introduced to different and new experiences.

- The high turnover of care staff could be a result of it not being regarded as a profession, often being paid the minimum wage and being mainly female.

- Dementia prevention was included in the work being led by Kath Horner, Sheffield City Council. Further guidance was awaited from NICE (National Institute for Health and Care Excellence) and this would contribute to local plans in the future.

7.4 RESOLVED: That the Committee:-

(a) thanks Sarah Burt and Joanne Knight for their contribution to the meeting;

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

(c) requests that:-

(i) officers check that dementia training of care homes' staff was taking place and being implemented and that this be included in a formal Monitoring Plan for Care Homes; and

(ii) a progress report on the implementation of the Dementia Strategy be presented to the Committee in six months' time, to include

details of preventative actions.

8. MINOR ORAL SURGERY PROCUREMENT

8.1 The Committee received a report of the Policy and Improvement Officer which provided details of the way NHS England was planning to change the way minor oral surgical services were provided in Sheffield and requested the Committee's comments on these proposals.

8.2 RESOLVED: That the Committee:-

(a) notes the proposed changes to the way in which minor oral surgical services were provided in Sheffield; and

(b) requests the Policy and Improvement Officer to communicate the Committee's concerns about these proposals to NHS England in relation to:-

(i) the impact of the changes on Sheffield Teaching Hospitals, specifically on its teaching role and the potential reduction in learning opportunities for dental students;

(ii) travel and access issues relating to the location of services in non-central locations; and

(iii) the potential for an adverse effect on the standard dental services at the successful providers' practices.

9. WORK PROGRAMME 2014/15

9.1 The Committee received a report of the Policy and Improvement Officer which outlined the Committee's Draft Work Programme 2014/15.

9.2 RESOLVED: That the Committee:-

(a) notes the Draft Work Programme as detailed in the report; and

(b) requests that the Policy and Improvement Officer circulates the appropriate papers to all interested parties in respect of the Learning Disability Service Petition update which was to be considered at its next meeting.

10. ADULT SAFEGUARDING BUSINESS PLAN - UPDATE

10.1 RESOLVED: That the Committee:-

(a) notes the contents of the Adult Safeguarding Business Plan update report now submitted; and

(b) requests the Policy and Improvement Officer to send a copy of the Council briefing on Child Sexual Exploitation to Helen Rowe, Healthwatch Sheffield.

11. DATE OF NEXT MEETING

11.1 The next meeting of the Committee will be held on Wednesday, 17th December 2014, at 10.00 am in the Town Hall.