SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 12 September 2012

PRESENT: Councillors Mick Rooney (Chair), Janet Bragg, Roger Davison, Tony Downing, Adam Hurst, Jackie Satur, Garry Weatherall, Joyce Wright, Sue Alston, Katie Condliffe, Diana Stimely, Anne Ashby, Helen Rowe and Sioned-Mair Richards (Substitute Member)

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Cate McDonald, and Councillor Sioned-Mair Richards attended as substitute Member. An apology for absence was received from Alice Riddell (LINK), and Laura Abbott (Chilypep) attended as a substitute.

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest from Members of the Committee.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting held on 18th July 2012 were approved as a correct record, and, arising therefrom, it was noted that point 7.9 (LINK's involvement with the Dementia Care review), had been rectified the day following the meeting.

5. APPOINTMENT OF DEPUTY CHAIR

5.1 **RESOLVED:** That Councillor Roger Davison be appointed Deputy Chair of the Committee for the municipal year 2012/13.

6. PUBLIC QUESTIONS AND PETITIONS

6.1 There were no public questions or petitions submitted to the meeting.

7. JOINT HEALTH AND WELLBEING STRATEGY

7.1 The Committee received a presentation upon the draft Joint Health and Wellbeing Strategy (JHWS) and in attendance for this item were Laurie Brennan (Policy Officer, Sheffield City Council), Louisa Willoughby (Commissioning Officer, Sheffield City Council) and Tim Furness (NHS Sheffield).

7.2 Mr. Furness explained that the draft Strategy was the result of many months of

work with members of the Health and Wellbeing Board (HWB), and added that the Strategy would be owned and updated by the HWB, which had been meeting in shadow form for the past six months.

7.3 The Strategy set out Sheffield's aspirations to improve the long term health of people living in the City, and improve the health, social care, public health, housing and children's services to support people to be healthier throughout their lives. The Strategy's mission was to-

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

7.4 The Strategy was based on five outcome areas which it was hoped would transform health and wellbeing in the City. These were as follows:-

Outcome 1: Sheffield is a healthy and successful City
Making health and wellbeing part of everything the City does, recognising that the City needs to be healthy to be successful and successful to be healthy. Tackling the wider determinants will not happen overnight so this must be a long-term aim for the city over the next 30 years.

Outcome 2: The health and wellbeing of people in Sheffield is improving all the time
Focusing on specific aspects of children's and adults' health and social care and the wider determinants of health, in order to improve health and wellbeing in Sheffield. Unlike Outcome 1, this is focused on the ongoing, shorter term improvements in health and wellbeing which we need to be a well and healthy City in the long-term. We need to reduce some of the health and wellbeing issues which are problems now and which may cause bigger problems in the future. This outcome applies to the present, and we aim to make a difference over the next 10 years.

Outcome 3: Health inequalities are reducing
Focusing on those people and communities who experience the poorest health and wellbeing. In a similar sense to Outcome 2, we need to address some of the major health and wellbeing issues affecting Sheffield today, particularly in those communities who experience the worst health and wellbeing inequalities. Therefore, the focus for this outcome is also over the next 10 years.

Outcome 4: People can get health, social care, children's and housing

services when they need them, and they're the sort of services they need and feel is right for them
How people of all ages should experience health, social care, children's and housing services in Sheffield. This is about Sheffield's health and wellbeing system working better based on the needs of people in the city and we need to make these changes now to support the achievement of outcomes 1, 2, and 3. We will aim to deliver this change over the next five years.

Outcome 5: The health and wellbeing system in Sheffield is affordable, innovative and delivers excellent value for money
This is about how Sheffield's commissioners and service providers will deliver health, social care, children's and housing services. As with Outcome 4, it is our intension to make the changes to the way the health and wellbeing system works in Sheffield over the next 5 years to make the system sustainable and affordable in the long-term.

It was further noted that there were five work streams within the Strategy-

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

7.5 The idea of the HWB, and the Strategy, was to improve local democratic accountability for the health service, and to increase the integration of services. Key focuses of the HWB were to prevent ill health, reduce health inequalities across the City, reduce dependency upon health services, and ensure the long-term sustainability of health care in the City.

7.6 It was noted that the majority of the City Council's work had an influence on health issues, and that the reintegration of public health back into the Council would have positive effects across all portfolio areas. The HWB members were being aspirational, yet realistic about what could be achieved.

7.7 It was noted that the make-up of the HWB in Sheffield was balanced between members of the Clinical Commissioning Group (CCG) and the City Council, and it was further noted that the Healthier Communities and Adult Social Care Scrutiny Committee would have the responsibility of scrutinising the function and work of the HWB.

7.8 Members were keen that, in order for the Scrutiny Committee to be able to effectively scrutinise the work carried out by the HWB, there should be a detailed list produced of relevant and measurable performance indicators.

7.9 Members were keen that the 'good start in life' work stream included the provision of fruit for children in schools, as many families did not include fruit as part of their weekly shop.

7.10 There were concerns raised about the level of pollution in the City, and the

detrimental effects on health. One member cited an example of the 83 bus route, and how life expectancy changed in different areas, as the bus travelled across the City.

7.11 Members were keen that key factors influencing health, such as alcohol consumption, stress and child obesity were included in the Strategy, and Mr. Furness confirmed that, at present, only the headlines were outlined, whereas more detail would be added in as the work of the HWB progressed.

7.12 Members requested that a glossary of key health terms be produced (i.e.: HWB, JHWS, CCG) in order for all Members to be fully versed on the key terms that would define the new structures of Health within the City Council.

7.13 Members were pleased to see that the Strategy took a proactive and preventive approach to good health, and focused upon 'what makes people well'.

7.14 Members were keen that the theme of health and wellbeing was cross-cutting across all of the Scrutiny Committees.

7.15 Members were keen that the work of the HWB linked into national campaigns in order to maximise on the resources and opportunities available.

7.16 Members were keen that the potential health impacts of planning applications on the local environment and individual health were taken into consideration at Planning Committees.

7.17 Members were keen that the 'small steps to health' were addressed, such as the provision of benches for people to use when out shopping, in order for people to maintain their independence. Members spoke favourably of the outdoor gym equipment which had been installed in many parks across the City, which could be used by all age groups. It was suggested that this approach linked well to Sheffield's new age-friendly cities framework ('A city for all ages: making Sheffield a great place to grow older') which would focus on more tangible interventions to improve wellbeing for people of all ages.

7.18 Members felt that there should be as much emphasis on a 'good end to life' as on a 'good start to life', and that the Strategy should take into consideration the City's ageing population. This included ensuring that there were plenty of opportunities for retired people to undertake activities, so that they did not become lonely or depressed.

7.19 There was a great emphasis placed upon the importance of mental health, and building mental resilience, as this affected all areas of health and wellbeing.

7.20 The Chair thanked officers for their presentation.

7.21 **RESOLVED:** That the Committee requests that:

(a) in order for the Scrutiny Committee to be able to effectively scrutinise the work carried out by the HWB, there should be a detailed list produced of relevant and

measurable performance indicators;

(b) a glossary of key health terms be produced (i.e.: HWB, JHWS, CCG) in order for all Members to be fully versed on the key terms that would define the new structures of Health within the City Council, and

(c) the theme of health and wellbeing be picked up by all five of the Council's Scrutiny Committees as a workstream.

8. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) UPDATE

8.1 The Committee received an update upon CAMHS, and in attendance for this item were Tim Furness (NHS Sheffield), Jon Banwell (Sheffield City Council), Kate Laurance (NHS Sheffield), Shona Ashworth (NHS Sheffield) and Dr. Clare Pearson (Team Leader, Beighton CAMHS).

8.2 It was noted that this item had been submitted to the Committee following concerns raised at a previous meeting over unacceptable Tier 3 CAMHS waiting times.

8.3 Dr. Pearson outlined how the waiting list numbers had been reduced, and how the average waiting time now was 17 weeks. The Sheffield CAMHS model had been redesigned to make the service more efficient. It was clarified that emergency cases were still seen as a priority and did not have to wait the full 17 weeks.

8.4 Dr. Pearson stated that the demand upon the service was huge. It was clarified that there had been a one-off injection of money into the service, which had helped to clear some of the backlog of cases, and that the new service model was more effective and sustainable in terms of dealing with cases more efficiently. It was clarified that no other service areas had suffered as a result of working hard to clear the CAMHS waiting list backlog.

8.5 Members were satisfied that waiting times had been reduced, but were still concerned that 17 weeks was too long a wait for families. It was confirmed that the CAMHS team delivered training sessions upon what signs to look for in children potentially suffering from mental health problems to teachers, social workers and other health professionals. There was also a named person now at each school across the City who was responsible for looking after children with mental health problems. Members wished to know how many health professionals had attended these training sessions.

8.6 Children accessing CAMHS were suffering from a wide range of mental health problems, including depression, anorexia, psychosis, anxiety, Obsessive Compulsive Disorder (OCD), Attention Deficit and Hyperactive Disorder (ADHD) and autism, to name a few. It was noted that case referrals were increasing from all areas of the City. Interpreters were always arranged if necessary at CAMHS. There was no definite set period of time for which children stayed with CAMHS; it was a case of how long was required per individual case.

8.7 Concerns were raised by Members that bad diet in children and young people was contributing to the rise in the number of cases seen of ADHD, and that children's erratic lifestyles (including excessive playing of computer games, lack of sleep and exercise, and poor diet) were contributing to increases in mental health problems. It was confirmed that CAMHS did use social networking to help young people, but that there were often confidentiality issues, so use of facebook and other sites was carefully controlled.

8.8 It was confirmed that referrals to CAMHS came from a wide variety of sources, including schools, social workers, Multi Agency Support Teams and GP practices.

8.9 Cases were not necessarily seen on a 'first come, first served' basis; there was a team of people who screened cases on a daily basis to ensure that priority cases were seen first and emergencies were dealt with.

8.10 A family therapist was assigned to work with each family, and this person also helped the parents of the child to deal with the issues in hand.

8.11 Deborah Woodhouse from Asbergers Children and Carers Together (ACCT) told the Committee that there were currently 250 families in ACCT and that she was being made aware by parents that they were being told by GPs if their child was suffering from OCD, 'not to bother' CAMHS, which she felt was a very negative position, as OCD could have serious effects upon a child's mental health.

8.12 It was clarified that CAMHS offered a more effective 'triage' service than previously, and that they referred cases to other agencies and partners as and when appropriate.

8.13 **RESOLVED:** That the Committee:

(a) notes the contents of the report now submitted;

(b) wishes to know how many health professionals have attended the training sessions arranged by CAMHS, and

(c) requests that the Scrutiny Policy Officer put arrangements in place to set up a working group upon CAMHS waiting times to comprise at least three Members of the Committee, with meeting dates and times and terms of reference to be confirmed in due course.

9. TRANSFORMING SUPPORT FOR PEOPLE WITH DEMENTIA WHO LIVE AT HOME: AN INVOLVEMENT EXERCISE

9.1 The Committee received a report upon Transforming Support for People with Dementia who live at Home, and in attendance for this item was Julia Thompson, Strategic Commissioning Manager, Sheffield City Council. It was noted that Howard Waddicor, Commissioning Officer, sent his apologies.

9.2 It was noted that Sheffield had a solid history in partnership working in the area of dementia, with a long established, multi-agency Dementia Programme Board chaired by Richard Webb, Executive Director (Communities) with representation from Sheffield City Council, NHS Sheffield, Sheffield Health and Social Care Foundation Trust, Sheffield Teaching Hospitals, and the Sheffield Alzheimer's Society. The function of this Board was to deliver on the National Dementia Strategy (2009) built on by the Prime Minister's Challenge launched in March 2012.

9.3 It was further noted that, in order to inform some of the changes needed to modernise the support for people with dementia who lived at home, a report had been submitted to the Sheffield City Council Cabinet on 26th May 2012 seeking approval to engage in a three month involvement exercise.

9.4 The purpose of the report now submitted was to understand the key issues for people affected by dementia, in order to plan support for the future, as the growing number of people with dementia represented a significant issue for the City. It was confirmed that the existing support arrangements in the City would not meet the increase in demand or the changing expectations of people with dementia.

9.5 Members were keen that sufficient support and training was provided to carers, so that the health of carers did not suffer as well. It was recognised that early diagnosis of dementia was also essential. This could be achieved through an effective training programme, and competent management to ensure that a consistent level of support for people with dementia and their carers was being offered across the City. It was noted that all staff at Northern General Hospital were now trained upon looking for the early signs of dementia.

9.6 Members were also keen that work was done with the patients at an early stage of dementia to discuss options for care at more advanced stages of the illness. An integrated response to early intervention was strongly supported, and Members wished to see an emphasis on the wider determinants of wellbeing being considered in the way that services were improved.

9.7 Members wished to have more information provided to them upon the work of the 'Memory Clinic' in Sheffield, including its location, opening hours, role, funding arrangements, patient flow, waiting times and staffing structure.

9.8 A request was also made for further information to be provided about how the needs of people from BME communities were being responded to.

9.9 Members emphasised the importance of creating a dementia-friendly City, with particular importance placed around managing the early stages of the illness when people still wanted to do the things that they had always done.

9.10 Members highlighted the self-directed support assessment process as being too bureaucratic for people with dementia. They asked whether this could this be simplified and whether there was the potential to introduce an advanced decision making approach.

9.11 The number of people in care homes without a formal diagnosis was seen as being inappropriate. An update upon the dementia care homes at Birch Avenue and Woodland View was also requested.

9.12 **RESOLVED:** That the Committee;

(a) notes the contents of the report now submitted;

(b) recognises the importance of training and skills development across the statutory and independent sector and requests that this be considered in the final action plan;

(c) requested further information upon the work of the 'Memory Clinic' in Sheffield, including its location, opening hours, role, funding arrangements, patient flow, waiting times and staffing structure;

(d) requests further information about how the needs of people suffering from dementia from BME communities are being responded to, and

(e) requests an update upon the dementia care homes at Birch Avenue and Woodland View.

10. WORK PROGRAMME

10.1 **RESOLVED:** The Committee received and noted a draft work programme for the municipal year 2012/13, and the latest version of the Cabinet Forward Plan for information.

11. DATES OF FUTURE MEETINGS

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