SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 21 November 2012

PRESENT: Councillors Mick Rooney (Chair), Sue Alston, Janet Bragg, Katie Condliffe, Tony Downing, Adam Hurst, Jackie Satur, Diana Stimely, Garry Weatherall, Joyce Wright and Sioned-Mair Richards (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 and Councillor Sioned-Mair Richards attended as a substitute Member, and Anne Ashby (LINk).

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 Mick Rooney declared (a) a personal interest in Item 7 on the agenda (Birch Avenue/Woodland View - Update) and (b) a disclosable pecuniary interest in Item 10 on the agenda (Grenoside Grange West Wing), as a non-executive Director of the Sheffield Health and Social Care Board. He left the room during the consideration of Item 10 and Councillor Roger Davison took the Chair for this item.

4. PUBLIC QUESTIONS AND PETITIONS

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

5. MINUTES OF PREVIOUS MEETING

5.1 The minutes of the meeting of the Committee held on 17th October 2012, were approved as a correct record, subject to (a) the removal of Councillor Sue Alston from the list of Members interested in taking part in the Working Group to be convened in order to scrutinize the provision of food in hospitals and (b) the deletion of the words “City Council’s” in the fourth line of paragraph 6.6 of Item 6 – Partnership Review – Sheffield City Council/Sheffield Health and Social Care NHS Foundation Trust and, arising therefrom:-

(i) with regard to the Nutrition and Hydration in Hospitals Working Group, convened to scrutinize the provision of food and drink in hospitals, the Scrutiny Policy Officer stated that:-

(A) she had contacted Sheffield Teaching Hospitals (STH), further to the Committee's request for her to investigate why the LINk Action Plan and subsequent recommendations on hospital food had not been implemented by STH, and had informed Anne Ashby, LINk, of such discussions; and

(B) the first meeting of the Working Group would hopefully be arranged for December 2012; and

(ii) the Scrutiny Policy Officer stated that, in the light of the apparent confusion as to whether details on the briefing on Memory Services had been circulated, she would circulate such information to Members of the Committee and the Sheffield LINk representatives following this meeting.

5.2 RESOLVED: That, in the light of the withdrawal of Councillor Sue Alston from the Nutrition and Hydration in Hospitals Working Group, Councillor Roger Davison be appointed as a Member of the Working Group.

6. BIRCH AVENUE AND WOODLAND VIEW - UPDATE

6.1 The Committee received an update on the current position regarding the Birch Avenue and Woodland View Care Homes, and in attendance for this item was Tim Furness, Chief of Business, Planning and Partnerships, NHS Sheffield Clinical Commissioning Group (CCG).

6.2 Roger Bolsover, relative of a resident in Woodland View, expressed his concerns with regard to the lack of staff in the cottages at Woodland View, as well as the high number of temporary staff.

6.3 Tim Furness stated that he accepted that staffing at Woodland View remained an issue and that he would be seeking assurances from Sheffield Health and Social Care NHS Foundation Trust that the Trust would take the necessary action to resolve the issues at the earliest possible opportunity.

6.4 Members of the Committee and representatives of LINk raised questions and the following responses were provided:-

- Further to the recommendations of this Committee relating to the views that, following the operation of the Care Homes by the South Yorkshire Housing Association (Birch Avenue) and the Sheffield Health and Social Care NHS Foundation Trust (Woodland View), the Care Homes would become Centres of Excellence, it had been determined that, whilst the model of care was different to that at other care homes, the Primary Care Trust (PCT) had not commissioned the Homes to be Centres of Excellence on the grounds of affordability, for example, regarding the cost of staff training other homes. It

was expected that the Foundation Trust would continue sharing best practice, but it was important that the new role of the Homes was firmly "bedded in" before offering to share best practice.

- Although the Foundation Trust only took over the operation of Woodland View with effect from 1st July 2012, it had been hoped that a Manager would have been appointed by now, and Tim Furness would seek assurances from the Trust that a Manager would be in post as soon as possible.

6.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the information now reported and the responses to the questions raised; and

(b) requests the Scrutiny Policy Officer to make arrangements for a visit by Members of the Committee and representatives of LINk to Birch Avenue and Woodland View, and agrees that further discussions on the proposals regarding the Care Homes becoming Centres of Excellence, take place following the visit.

7. END OF LIFE CARE

7.1 The Chief Operating Officer, NHS Sheffield, submitted a report providing an update on progress towards achieving an increase in the preferred place of death for Sheffield residents.

7.2 Kate Gleave, Senior Commissioning Manager, End of Life Care, NHS Sheffield, stated that the report had been prepared following a request by the Committee at its meeting held on 21st November 2011, and contained details of the progress made since that date. Ms Gleave added that, as part of the progress of work undertaken, an outline business case, based on the new End of Life Care (EOLC) Home Care Model, had been produced and would be submitted to NHS Sheffield for approval in December 2012, and to the City Council's Cabinet in March 2013. It was envisaged that the new model would be in place by October 2013.

7.3 Ms Gleave also referred to the actions taken to address the prioritised problems and details of the comparisons between the current arrangements and the new model for End of Life Home Care, which were attached Appendices 1 and 2, respectively, to the report.

7.4 Members of the Committee and representatives of the LINk raised questions and the following responses were provided:-

- Using a set of prognostic indicators, health workers were able to identify when the majority of patients were in, or entering their last year of life and would be expected to discuss this directly with the patient and/or their carer or family at this point. In cases where patients were likely to lose their mental capacity prior to their last year of life, such as suffering from dementia, such discussions should take place earlier, in order to ensure that they could fully understand the position. NHS Sheffield was encouraging

clinicians to commence such discussions as early as possible, as well as giving them the required confidence to raise such delicate issues with patients and/or their carers and families and to detect when patients/carers did not want to discuss this.

- For some patients, there may come a point when their condition was so severe that it made it impossible for them to be cared for at home.

- The level of support and care could increase as a patient's condition worsens, but such care and support would vary for different patients. Even if a patient's condition was viewed to be stable, they or their carer could suffer some form of crisis, which would require the care they required to be increased in order to meet their needs on an as and when basis. For this reason, it had been identified that there was a need for a more flexible model.

- It was accepted that informing patients about end of life care was a very delicate and emotional issue and in the light of this, NHS Sheffield had invested in communications training to all health and social care staff in the City. This would include the necessary training to ensure that health care staff have fully explained the position to the patient and that the patient has fully understood the position that they were in. It was also accepted that a large proportion of people did not wish to know, or accept the fact that they were nearing the end of their lives and informing them of this fact was seen by many as a reason to give up any hope.

- There were measures in place to deal with those cases where patients or their families had expressed a wish to spend the remaining time of their lives in the comfort of a hospice or by receiving care at home, rather than undertaking constant visits to hospital, which could cause unnecessary upset and inconvenience for both patient and family. The planned implementation of the Assessment, Management, Best Practice, Engagement, Recovery Uncertain (AMBER) care bundle at STHFT would further support identification of such patients.

- The Electronic Palliative Care Communication System (EPCCS) was designed to improve communication between hospitals and GPs about patients in their last year of life. In the long-term, it was hoped that this system would be used to communicate information to members of the wider team involved in a patient's care, such as their care home and Accident and Emergency staff. The timing of this development is dependent on technical issues and resolving how best to obtain patient consent.

- There had been considerable debate on the issue of confidentiality, particularly with regard to patients' details being included on lists of those people in their last year of life. Currently, the EPCCS only communicated information which should be on a normal clinic or discharge letter between secondary and primary care, that is what patients would expect to be shared routinely. The sharing of this information with a wider group of clinicians involved in the patient's care would require patient consent and NHS

Sheffield was currently exploring how this could be done appropriately. It was considering developing a patient communications leaflet which fully explained the position relating to patient confidentiality.

- Whilst research had concluded that 63% of people in Yorkshire wanted to die at home, between 2008 and 2010, 57% of deaths in Sheffield had occurred in hospital, which was significantly higher than the England average of 54.5%. It was hoped that, by implementing a joint health and social care model, the number of deaths in hospitals could be reduced in the future. The service providers of this model would work closely with the Integrated Care Teams, which comprised a broader range of health and social care professionals.

- There were a number of national campaigns to get more people to talk about death and dying. One group involved in this was the Dying Matters Coalition, who organised an Awareness Week in May every year. In addition, NHS Sheffield had developed a media campaign, and had already advertised on local radio, with plans for further advertisements and announcements in the local media. It was also writing to various charities, requesting them to display information on their media communications on this issue.

- Whilst the new care model was aimed at people aged 18 or over, a need to introduce similar measures in terms of people under 18 had been identified. STHFT was in the process of developing a Limitation of Treatment Agreement (LOTA), in consultation with patients' families. There were also transition arrangements in place when such patients reached the age of 18.

- Although the number of people over the age of 80 in the City was likely to rise in future years, this would not necessarily have a direct effect the numbers of people entering the final year of their lives. There was a need, however, to ensure that plans were in place now to ensure that the correct approach was taken in respect of such people and to ensure that the health and social care system was working effectively so that the needs of the increasing numbers of people over 80 in the City could be met.

- In terms of the recent issues and concerns raised in the national press regarding the Liverpool Care Pathway, such issues had been discussed at a meeting of the Local End of Life Care Planning Commissioning Group and it had been identified that, regardless of the Government's views on the Liverpool Care Pathway, there was a need for improvements in terms of communication with patients and their relatives.

- The reference to the word 'inequitable', when describing the main barriers in terms of access to Home Care support, referred to the fact that there were about 40 different providers commissioned to provide different levels of care at different points in the patient's last year. It was hoped that the problems arising from this would be addressed under the new Home Care Model.

- Good End of Life Care ought to be part of the revalidation of GPs. The GP

Quality Outcomes Framework (QOF) does require GPs to have a register of Palliative Care patients and to meet them every three months. It was possible that these two requirements would be developed further for 2013/14.

- The decision on when to stop providing patients with food and drink was taken by clinicians and based on the individual circumstances of each patient. Health staff would not stop providing food and drink if it resulted in the patient suffering in any way.

7.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses to the questions raised; and

(b) requests:-

(i) that the business case for the new End of Life Care Home Care Model be referred to the Clinical Commissioning Group and the City Council's Cabinet for approval;

(ii) the Scrutiny Policy Officer to arrange a joint meeting of this Committee and the Children, Young People and Family Support Scrutiny and Policy Development Committee to discuss the issues regarding End of Life Care for children up to the age of 18;

(iii) that consideration be given to how the issues relating to the End of Life Care could be included in the revalidation process regarding GPs;

(iv) Kate Gleave to attend a future meeting of the Committee in 12 months to provide a further update on the new End of Life Care Home Care Model, including an update on local and national data; and

(v) the Council's Communications Service to look at how the Council could publicise the 'Talk About Death' campaign.

8. INTERMEDIATE CARE - PROGRESS ON NEW BUILD FACILITY

8.1 The Committee received a report of NHS Sheffield reviewing the position with regard to the planned intermediate care facility, identifying the factors influencing progress and containing a proposed timetable for reviewing the requirements for such a facility.

8.2 Tim Furness, Chief of Business, Planning and Partnerships, NHS Sheffield, presented the report.

8.3 In response to questions from Members of the Committee, Tim Furness stated that the figure of 120 beds had been suggested around five years ago, following analysis in terms of demand and cost-effectiveness. He also confirmed that, although discussions had been held with Council Planning Officers, a suitable site

for the facility had not yet been identified.

8.4 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses to the questions now raised; and

(b) requests the Scrutiny Policy Officer to facilitate discussions, as a matter of urgency, between Councillor Leigh Bramall, Cabinet Member for Business, Skills and Development, Planning officers and the Clinical Commissioning Group, together with any other Council officers who would be responsible for identifying a suitable site for the construction of the intermediate care facility.

9. GRENOSIDE GRANGE WEST WING

9.1 The Committee received a report from NHS Sheffield setting out the case for the decommissioning of Grenoside Grange West Wing, and seeking its views on the proposals.

9.2 Tim Furness, Chief of Business, Planning and Partnerships, NHS Sheffield Clinical Commissioning Group (CCG) presented the report and indicated that the NHS Sheffield CCG had identified, in the course of reviewing the effectiveness and efficiency of all services it commissioned, that the outcomes for people referred to Grenoside Grange West Wing could be improved, and subsequent savings made, by providing rehabilitation at home for those people who could benefit, and with interim care in a care home for those who need interim care rather than rehabilitation.

9.3 Members of the Committee and representatives of LINk raised questions and the following responses were provided:-

- People leaving West Wing would either return home, with rehabilitation, where appropriate, or would move to long-term care, as most patients currently do on discharge.

- NHS Sheffield CCG planned to consult LINk on the proposals following this meeting.

- The audit undertaken in October 2012 of patients in West Wing had shown that the care required could have been provided elsewhere at a significantly reduced cost. The comparisons had been made with an independent care home, providing a similar package of care, and which managed to get more people back home, at a cost considerably lower than at West Wing.

- The service was not meeting the needs of the client group it was originally intended for. Whilst it could not be confirmed where those people who were originally anticipating going to West Wing were being cared for, it was believed that they were receiving care elsewhere, from services such as Community Intermediate Care Services (CICS) or the Short Term Intervention Team (STIT), or other similar services.

- It was agreed that the decommissioning of West Wing could have a detrimental effect in terms of an increase in the length of a patient's stay in an acute hospital. Any increase would be likely to be for a much smaller length of time than the average time people spend on West Wing, so that people would overall get home sooner. It was agreed that the question needed further investigation before a decision could be made.

- It was not believed that the decommissioning of West Wing would have a detrimental effect on the other Wing at Grenoside (G1). Discussions had been held with the Care Trust on this issue and they had not raised any concerns in terms of finances or any other issues.

- There had been no discussions with the Care Trust regarding alternative use of the Ward, although it was likely that an alternative use for West Wing would be found.

- As indicated in the report now submitted, approximately 40 patients a year were discharged from West Wing, with approximately six patients being discharged home. This was around half the number of patients discharged home from the independent care home, which had been used as a comparison as part of the audit undertaken in October 2012. The outcomes, particularly regarding how patients were discharged, were considerably better within the independent sector.

- It was possible that patients had been discharged from West Wing when they were not ready to leave. The majority of patients were discharged into care homes and were generally well enough to do so.

9.4 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the responses to the questions raised; and

(b) requests that the issues now raised as part of the question and answer session be referred to the Clinical Commissioning Group, for consideration as part of the consultation.

10. 'HOW DID WE DO?' - SHEFFIELD'S LOCAL ACCOUNT OF ADULT SOCIAL CARE SERVICES 2012

10.1 The Committee received a report of the Executive Director, Communities Portfolio, on Sheffield's first Local Account of Adult Social Care Services.

10.2 Howard Middleton, Development Manager, Planning and Performance, Communities, introduced the report and referred to the booklet 'How Did We Do?' – Sheffield's Adult Social Care Service 2012, which had been circulated prior to the meeting, stating that the booklet was still in draft form, and welcomed Members' comments on its format and contents prior to final print in December, 2012.

10.3 Mr Middleton stated that from this year, all Councils must produce a Local Account of how their Adult Social Care and Support Services were performing, which would comprise an annual report to the public, providing information on the performance of such services, together with details on priorities and outcomes. The need to produce a Local Account had come about following the Department of Health's framework for Adult Social Care, published in 2011, which confirmed the intention to open up information on Adult Social Care and to make available more information on what Councils achieved for local people.

10.4 Members of the Committee and representatives of LINk raised questions and the following responses were provided:-

- There were approximately 20 people on the Readers Group, who had helped to shape the contents of the booklet and Howard Middleton had met individually with members of the Group to discuss the contents in more detail.

- The draft booklet had also been tabled at the Quality Live event which had been commissioned by the Service Improvement Forum, and at which approximately 70 people had attended.

- Though the report is essentially the Council's account of adult social care performance, councils across the region had agreed some common features for future editions, including providing the opportunity for HealthWatch to be included in its production.

- It was acknowledged that there were no pictures of older people on the front of the booklet, and arrangements would be made to ensure an older person was featured on one of the small photographs on the front page.

- It was appreciated that some people may consider that details of negative issues, such as areas of poor performance, were 'hidden' in the booklet, so future editions would focus on how such issues had been addressed.

- Whilst one of the case studies featured someone with a learning disability in employment, it was acknowledged that the report could make a better link between this personal story and general progress on supporting people with learning disabilities into employment.

- Whilst the booklet was considered to be reasonably easy to read, consideration would be given to producing an "easy read" version to make sure the booklet was accessible for all.

- In terms of the contents appearing too general, officers would look at including specific themes or focuses in future editions.

- Contact would be made with the Sheffield Institute for the Blind in terms of including the contents of the booklet on their Talking News.

10.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, the contents of the draft booklet 'How Did We Do?' now circulated, and the responses to the questions raised;

(b) requests that the issues now raised in terms of the contents of the booklet, as part of the question and answer session, be referred to Howard Middleton, for consideration in the final print in December 2012; and

(c) agrees to include early consideration of items for the 2013 report, as part of its Work Programme.

11. WORK PROGRAMME AND CABINET FORWARD PLAN

11.1 The Scrutiny Policy Officer submitted a report containing the draft Work Programme for the Committee, together with the latest version of the Cabinet Forward Plan.

11.2 Arising therefrom, Emily Standbrook-Shaw reported that (a) a report on the 'Right First Time' programme was scheduled to be submitted to the Committee's meeting to be held in January 2013 and (b) she would hopefully be arranging a meeting of the Nutrition and Hydration in Hospitals Working Group in December 2012, and raised the issue as to whether a representative from the Sheffield Children's Hospital should be included on the Working Group.

11.3 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, together with the additional information now reported; and

(b) agrees that the Sheffield Children's Hospital should not be represented on the Nutrition and Hydration in Hospitals Working Group on the basis that the Working Group should focus mainly on the needs and requirements of older people, but that the Hospital should be given an opportunity to have an input to the work of the Working Group through a desktop review.

12. DATE OF NEXT MEETING

12.1 It was noted that the next meeting of the Committee would be held on Wednesday, 16th January 2013, at 10.00 am, in the Town Hall.