SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 26 June 2014

PRESENT: Dr Tim Moorhead (Chair), Clinical Commissioning Group

Ian Atkinson, Accountable Officer, Clinical Commissioning Group

Richard Armstrong, Interim Director of Commissioning, NHS England

Dr Nikki Bates, GP Governing Body Member, Sheffield Clinical Commissioning Group

Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families

Councillor Mazher Iqbal, Cabinet Member for Communities and Public Health

Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living

John Mothersole, Chief Executive, Sheffield City Council

Sue White, Chief Executive, Voluntary Action Sheffield

Dr Jeremy Wight, Director of Public Health

In Attendance

Tim Furness, Director of Business Planning & Partnerships, Sheffield Clinical Commissioning Group

Joe Fowler, Director of Commissioning, Sheffield City Council

Sue Greig, Consultant in Public Health, Sheffield City Council

Luke Morton, Programme Manager, Communities, Sheffield City Council

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Julie Dore, Professor Pam Enderby, Margaret Kitching, Jayne Ludlam, Laraine Manley, Dr Zak McMurray, Dr Ted Turner and Moira Wilson.

2. DECLARATIONS OF INTEREST

There were no declarations of interest from members of the Board.

3. PUBLIC QUESTIONS

3.1 Public Question Concerning Supported Living Services

Susan Highton asked a question concerning the proposal to look at alternative

providers of Supported Living, rather than these services remaining with the existing provider, the Sheffield Health and Social Care NHS Foundation Trust, which she stated, had a series of significant consequences, as follows:

- The cost of running down the service within the NHS are estimated in excess of £6M.

- The service users will not have a choice of service provider as suggested but rather will be told who has been chosen to provide the service for them.

- The current service provided by the NHS routinely has high dependency cases referred to it as other providers do not appear able or willing to take up these, with no NHS provision remaining who will pick up these high dependency cases.

- At meetings with service users' families and carers we have consistently been told they wish to remain with the NHS provider. Why has no thorough and full consultation been undertaken with them in advance of any changes?

- One proposal is to split the current service into several smaller contracts and these could include separate contracts for individual units on the same site. Currently, in busy times and emergencies NHS colleagues can call on other care workers providing the contract to assist in maintaining safe care provision. How will this work if 2 or more contractors are working across the same site.

Susan Highton stated that the budgetary pressures the City Council and the NHS have had and continue to face were understood, but this proposal involves high cost to the public purse and risk that with no proper alternative provision to fall back on, service users in crisis will be referred to hospital and then expensive out of city support as the only option available.

She asked why this proposal hasn't been referred to the appropriate Scrutiny Committee and a thorough and proper consultation carried out with service users, their families and carers.

Councillor Mary Lea, the Cabinet Member for Health, Care and Independent Living, responded to the questions. She said that the safety and wellbeing of service users was paramount. The Council had, over the past 3 years, increased the budget for services to people with learning disabilities, despite the context of funding cuts to the Council. The Council needed to ensure that it could deliver services in a cost effective way and make sure that people received the right care and were safe and well.

The Supported Living model for people with learning disabilities had general support and was considered the best model. It gave people independence and allowed them to make their own choices and was different to the service required in a residential care home.

The Health and Social Care NHS Foundation Trust had put itself forward as a potential service provider and there were also other supported living providers which had also put themselves forward. Approximately only 1 in 10 people in Sheffield in Supported Living settings were supported by the Health and Social Care NHS Foundation Trust.

The Council will work with residents in the 9 residential homes in order to select a provider and make sure there were high quality standards and that costs were reasonable. In similar processes within other care settings, residents had been engaged and independent advocacy had ensured that they had a say.

Financial pressures meant that the Council could not justify paying a high price for a service, if it was able to obtain services of an equivalent or higher quality from another provider.

Consultation had taken place with carers and service users.

Councillor Lea stated that she would provide a detailed response to the questions in writing.

3.2 Public Question Concerning Governance of the Health and Wellbeing Board

John Kay asked whether there were opportunities to use the Foundation Trust model, which had been in place for some time, and apply it in the governance of the Health and Wellbeing Board, to promote resource-sharing and increase engagement with the Health and Social Care NHS Foundation Trust.

Tim Moorhead, the Co-Chair of the Board, responded to the question. He stated that the Board was a formal committee of the City Council and there were not separate arrangements in place for governance. The overarching role of the Board was to make sure it was satisfied that the respective organisations in the City were delivering, including the Clinical Commissioning Group, the City Council and providers of health and social care. There had already been several engagement events with patients, service users and the public in general. However, the membership model adopted by the Foundation Trust may have some aspects which were worth further consideration.

Ian Atkinson, Accountable Officer, Sheffield Clinical Commissioning Group (CCG), stated that it would be potentially sensible to see how the existing membership of an organisation like the Foundation Trust might be used by the Clinical Commissioning Group.

Sue White, Chief Executive, Voluntary Action Sheffield, stated that Healthwatch was the mechanism through which patient and public voice could be represented and there was a need to take stock of all the organisations in the City that performed such a role. Healthwatch had a place on the Health and Wellbeing Board, through which the views of patients and public could be brought to the Board's attention.

4. INTEGRATION OF HEALTH AND SOCIAL CARE AND THE BETTER CARE FUND

4.1 The Board received a presentation on the integration of Health and Social Care and the Better Care Fund from Joe Fowler, Director of Commissioning, Sheffield City Council and Tim Furness, Director of Business, Planning and Partnerships, Sheffield Clinical Commissioning Group.

4.2 There were four main areas for commissioning, namely: keeping people well in their local community; intermediate care; independent living solutions; and long-term high support and these were outlined in more detail in the presentation. The presentation also provided an update on progress and a summary of forthcoming activity.

4.3 Members of the Board made comments on the issues raised by the presentation, as follows:-

4.4 There were risks in pursuing greater integration of health and social care and also risks in not doing so. It was considered that by working together, there might be mitigation of risks and this may include learning from pilots and some recalibration. Some capacity to deal with potential risks would be created by the City's health and social care organisations working together.

4.5 Whilst there was not, as yet, definitive data, some of the available data on integration was beginning to support the view that investment in prevention and at community level does pay-off. An evidence and scale based approach was required.

4.6 The approach taken might vary according to the circumstances in a particular area. Each area was different and the infrastructure and capacity of the community, for example in terms of the voluntary and community sector, may vary.

4.7 Academic partners may be engaged in evaluating the process of integration to see whether it was leading to the desired/intended results.

4.8 The approach which was being adopted was ambitious and was also the right one, which in the long term would improve services. It was recognised that there were risks and that change in respect of ethos, culture and expectations would take time to implement. Resources were being brought together and each of the respective organisations had its own governance arrangements. It was noted that Sheffield had the lowest number of children and young people in care as a result of the investment in early intervention and prevention.

4.9 NHS England were connected with the co-commissioning and integration plans.

4.10 There had been national challenge about how effective the approach being adopted would be. However, it was considered the right thing to do and, in

Sheffield, such changes were taking place before the Better Care Fund.

4.11 **Resolved:** that the Board notes the presentation.

5. THE CARE ACT 2014

5.1 The Board received a presentation form Luke Morton, Programme Manager, Communities, Sheffield City Council, concerning the Care Act 2014, which set out in law reforms to care and support services and changes to the funding of those services.

5.2 The presentation set out the implications of the changes, which would be brought about by the Act, both for Sheffield and for the Health and Wellbeing Board in relation to areas including the principle of wellbeing, a person-centred approach, prevention, supporting people to stay independent, increased co-operation in health and social care and service integration. The aims of the Better Care Fund aligned with the principles of the Act as did the commissioning workstreams and the financial implications of the Care Act would impact upon pooled budgets.

5.3 Consultation on draft regulations and guidance had begun on 6 June and would close on 15 August 2014.

5.4 Members of the Board commented upon the matters raised in the presentation, as summarised below:

5.5 In relation to standards of care set out in the Act and in terms of ensuring standards and possible rights of appeal, there was potential redress through the local authority, the Ombudsman and through Judicial Review. Case law would inform future judgements in circumstances where there were appeals or challenges to decisions.

5.6 It was confirmed that the implementation project group, which was in place to deliver change, included representation from other services including children's and adults' services, to make sure implications of the changes brought about by the Act were properly considered, for example the transition from childhood to adulthood.

5.7 **Resolved:** that the Board notes the presentation.

6. THE CHILDREN AND FAMILIES ACT 2014

6.1 The Board received a presentation from Sue Greig, Consultant in Public Health, Children, Young People and Families, concerning the Children and Families Act 2014, which would come into force in September 2014. The main aspects of the Act related to adoption, children in care and contact, family justice, Special Educational Needs, childcare reform and the welfare of children. It also included measures such as the rights of parents to request flexible working patterns and partner leave (for example to attend antenatal classes) and adoption leave and reinforced the office of the Children's Commissioner.

6.2 Key Issues for Health and Wellbeing Board Partners arising from the Act were joint accountability across health, education and social care for assessing and responding to children's needs, for example Education, Health and Care Plans; support for young carers, including in relation to their mental and emotional health needs as well as practical/social support; and support in school for children with medical conditions.

6.3 The Board commented on issues arising from the presentation, as follows:-

6.4 It was envisaged that integration would result in better outcomes for less, whilst there would be some cost associated with change. For example, there was the potential for reducing duplication and streamlining systems and greater efficiency.

6.5 Whilst it was disappointing that the City had not been successful in its 'best start' bid to the Lottery Fund, there had also been some transformational change as part of the preparations for the Lottery bid. The process had opened dialogue and there was most certainly commitment and momentum in this regard. In fact, the process was now not tied into the more prescriptive aspects of the Lottery bid. There were some indications of how external support might be obtained; and consideration was being given as to where effort would be focussed. The strategy group was meeting to look at potential opportunities.

6.6 Some work relating to children and young people which addressed issues within the Act was already happening. For example, the creation of a Head of Virtual School for Looked After Children. In Sheffield, opportunities had been created for young people in care, who might previously have left care at age 18, which the Act had now sought to address in law. The challenge was with regard to transition from child to adult services and in seeing a person in the context of their whole life and not simply a child or adult.

6.7 The Care Act and the Children and Families Act shared a policy backbone and local authorities and partner organisations were encouraged to identify an individual's ongoing need and to avoid implementing the two Acts in isolation of one another.

6.8 **Resolved:** that the Board notes the presentation.

7. HEALTH INEQUALITIES PLAN

7.1 The Board considered a report of the Leader of Sheffield City Council and the Chair of NHS Sheffield Clinical Commissioning Group concerning the Health Inequalities Action Plan. The report sought approval to the plan, which was designed to implement the actions identified in the Health and Wellbeing Strategy during the financial years 2014/15 to 2016/17.

7.2 Dr Jeremy Wight, Director of Public Health, introduced the report and stated that the plan was work in progress, which was subject to adaptation and change. Engagement events had been held, which looked at what the Health and

Wellbeing Board could do to tackle health inequalities. The plan would be subject to an annual report of progress.

7.3 The Board was asked to consider several areas, including the identification of leads and reporting mechanisms relating to the actions identified in the Strategy and included in the plan; the identified priority tasks; and the measures of impact. The Board was also asked to consider the addition of the action proposed at paragraph 3.10 in the report to the Health and Wellbeing Strategy and to the plan, which was to promote health literacy and early engagement with health services in disadvantaged communities.

7.4 Members of the Board made comments on the matters contained in the report and accompanying Health Inequalities Plan, summarised as follows:-

7.5 The Clinical Commissioning Group (CCG) should take the lead in relation to actions 3.4 (Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.) and 3.7 (Commission disease-specific interventions, including a programme to improve the physical health of the severely mentally ill or those with a learning disability).

7.6 The engagement events had been positive and Healthwatch would work with public health colleagues to identify what was and what was not working well. The plan had been changed in light of the engagement events, which included the addition of the action to increase health literacy. Further engagement events would be welcomed.

7.7 The work relating to children with complex needs, special educational needs and disabilities would require more development and would be connected with action relating to children's mental health, emotional wellbeing and resilience.

7.8 NHS England had ambitions to improve public health services and were keen to work with the Clinical Commissioning Group in relation to implementation in Sheffield through the CCG and the local authority.

7.9 The Health Inequalities Action Plan represented progress and was core business of the Health and Wellbeing Board.

7.10 Health inequalities were a consequence of the inequalities in society at large and the Action Plan included measures to help mitigate those wider inequalities but would also require long term change.

7.11 The identified leads for each action would be notified that they would be responsible for delivery and to report on actions allocated to them.

7.12 **Resolved** that the Board:

1. Formally approves the Health Inequalities Action Plan, whilst accepting that further work is required on the detail;

2. Approves the addition of the action 3.10 to the Health and Wellbeing Strategy and to the Plan, which was to promote health literacy and early engagement with health services in disadvantaged communities;

3. Requests the identified lead individuals and relevant Groups and/or Boards to implement the Plan; and

4. Requests an annual report on progress.

8. HEALTHWATCH SHEFFIELD ANNUAL REPORT

8.1 The Board received a presentation concerning the Healthwatch Sheffield Annual Report from Sue White, Chief Executive, Voluntary Action Sheffield and acting Chief Officer Healthwatch Sheffield. The Annual Report would be launched on 16 July 2014.

8.2 The presentation outlined the role and reach of Healthwatch Sheffield with regard to engagement, gathering peoples' views and providing information and advice. Healthwatch also had a role in raising awareness and influencing and improving services. Reports and recommendations had been produced for the CCG Group Select Committee inquiry; concerns over a specialist care provider had led to an escalation of concerns to the Care Quality Commission; and consultation had been undertaken in relation to the Adult Social Care Review.

8.3 Challenges for Healthwatch included resources and capacity and concerned how collectively the organisations represented on the Health and Wellbeing Board could make the most of the various means of listening and involving people.

8.4 Members of the Board commented and raised matters arising from the presentation, as summarised below:-

8.5 The 100,000 people 'reached' referred to information on websites, and media including newspapers and radio stations and the figure was an estimate of the number of listeners or readership of a particular publication and included dialogue events.

8.6 Those groups which were considered to be hard to reach were contacted through existing networks of organisations, for example, Sheffield carers' organisations, the Black and Minority Ethnic (BME) Network and a community event with members of the Roma community. It was also requested that young persons' groups including the young carers' group were included in such activity.

8.7 The former Chief Officer of Healthwatch had left in April 2014 and the organisation was considering whether the post would be replaced or not in the new structure. Interim arrangements were in place. The situation would be kept under review.

8.8 It was recognised that Healthwatch had to continue to be effective and also maintain an independent voice and that it might need support in that regard. This

might include learning from elsewhere in the country.

8.9 The health and social care system was undergoing significant change and this also needed to be reflected in the work of Healthwatch, which was listening to people with regard to the effect of decisions relating to change on patients and the public.

8.10 **Resolved:** that the Board notes the presentation concerning the Healthwatch Annual Report 2013/14.

9. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the Board held on 27 March 2014 were approved as a correct record.

10. DATE AND TIME OF NEXT MEETING

The next meeting of the Board would take place on Thursday 25 September 2014 at 2.00pm.