SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 11 December 2014

PRESENT: Councillor Julie Dore (in the Chair), Leader of the City Council
Dr Tim Moorhead (Co-Chair), Chair of the Sheffield Clinical Commissioning Group (CCG)
Dr Nikki Bates, Governing Body Member, Sheffield CCG
Maggie Campbell, Healthwatch Sheffield
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
Dr Zak McMurray, Clinical Director, Sheffield CCG
John Mothersole, Chief Executive, Sheffield City Council
Dr Jeremy Wight, Director of Public Health, Sheffield City Council

In attendance: Joe Fowler, Director Of Commissioning, Sheffield City Council
Tim Furness, Director Of Business Planning and Partnerships, Sheffield CCG
Steven Todd, Strategic Commissioning Manager, Sheffield City Council

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Ian Atkinson, Jayne Ludlam, Laraine Manley and Dr Ted Turner.

2. DECLARATIONS OF INTEREST

Dr Tim Moorhead declared a personal interest in the item numbered 7 on the agenda for this meeting (Pharmaceutical Needs Assessment for Sheffield 2015-18) on the grounds that his Practice dispenses medicines and this formed part of the income of the Practice.

3. PUBLIC QUESTIONS

Mr John Darwin asked a question concerning the role of the Mindfulness approach, particularly with regard to mental health. He stated that he had taught mindfulness for four years and it was clear that mindfulness based approaches had a role in relation to therapy and enhancing peoples' lives. There was no reference to this in the Mental Health Strategy papers as submitted to this meeting of the Board. He asked what role the Board saw with regard to mindfulness approaches, which were good for people and cost effective for the health service. He asked for the Board's comments. He commented that there were a growing number of courses relating to mindfulness, which were concerned with education, rather than theory and were relevant to everyone.

Councillor Julie Dore (Co-Chair of the Board) responded that the item on the agenda relating to Outcome 2 “Health and Wellbeing is Improving” included an action to promote a city wide approach to emotional wellbeing. The issue of mindfulness which Mr Darwin had raised was something which could be looked at within the emotional wellbeing theme and when the Board considered Outcome 2 later at this meeting. She said that she was not aware of other references to mindfulness within the Joint Health and Wellbeing Strategy.

Tim Furness stated that mindfulness approaches were not something which had been raised as part of the engagement concerning the *Sheffield Strategy for Mental Health* being developed by the Mental Health Partnership Board. There was still opportunity to incorporate the issue into the Strategy.

Councillor Jackie Drayton stated that emotional wellbeing was something which was linked to positive behaviours in parents and children.

Dr Nikki Bates stated that the IAPT (Improving Access to Psychological Therapies) team did use mindfulness based approaches and such approaches were also sometimes recommended by GPs in their consultations with patients.

4. UPDATE ON THE JOINT HEALTH AND WELLBEING STRATEGY: OUTCOME 2 - HEALTH AND WELLBEING IS IMPROVING

The Board considered a report of the Co-Chairs of the Board concerning the Health and Wellbeing Strategy: Outcome 2 – ‘Health and Wellbeing is Improving’. The report set out what had happened in relation to the 8 key actions over the past year and areas in which the Health and Wellbeing Board could make a difference.

The report was presented by Tim Furness, Director of Business Strategy and Partnerships, NHS Sheffield CCG.

Members of the Board discussed the two main themes of the ‘Health and Wellbeing is Improving’ outcome area, which were:

- emotional wellbeing; and
- living longer.

In discussing particular actions under each theme, the Board considered what progress had been made in the past year; the main issues and opportunities for the action and what the Board/ Members of the Board could do over the next year in relation to that action. A summary of the discussion is as follows:-

Emotional wellbeing

Action 2.1: Promote a city-wide approach to emotional wellbeing and mental health, focusing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.

With regard to the challenge to protect investment in emotional wellbeing, prevention and early intervention, the circumstances of reducing funding meant

that this may become more acute. However, the commissioning plans for mental and physical health aimed to increase investment and community activity and spend more on prevention.

The City did not have a strategy relating to suicide and a more focussed approach was required in that regard. This could be considered as part of the Strategy for Mental Health. There was also a link to transition from childrens to adults' services. The need for work to prevent suicides and promote awareness thereof and the transition from children's to adults' services were recognised in the report as submitted.

Action 2.2: Commission a needs-led response to support children and young people's emotional development to enable them to develop personal resilience and manage transition from childhood to adulthood.

There were no additions or further comments.

Action 2.3: Support the implementation of the new city Parenting Strategy which focuses on positive parenting and developing resilient families and communities so that all children have a stable and enriching environment in which they will thrive.

The relationship with parents and carers was vital and parents should be viewed as partners in parenting initiatives. Work was being done in early years to help develop positive parenting, which was being monitored.

It was not clear whether the ambition of the Strategy was to deal with immediate issues relating to parenting or whether it was intended to deal with breaking the cycle of where parenting breaks down.

There was a strategic programme for early prevention and intervention at the point of crisis to enable families to stay together and prevent children and young people from being brought into care. The Best Start work also included peer support and mentoring to help people before they reached a point of crisis. The strategy was intended to cover both early intervention and universal parenting concerns.

There were actions that individual schools, such Arbourthorne and Tinsley Primary schools were taking in targeting particular activities for the needs of children and families in their communities. This was best practice which could be shared. Arbourthrone Primary had used LAP (Local Area Partnership) funding and private sector funding to transform the former caretaker's house into a lifeskills centre, where young people could learn to look after themselves with activities such as cooking.

Under the 'issues and opportunities' heading on page 8 of the report, the first bullet point should be amended by the inclusion of the word "initiatives" after the words "The delivery of Parenting"**.**

Living Longer

Action 2.4: Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.

Whilst the Move More strategy was intended to encourage people to be more physically active, some people were not able to afford to participate in some physical activities as they were priced-out by the cost, for example, of gym membership.

The Move More strategy included physical activity which might not take place in a gym, such as gardening and dancing. However, the cost of gym memberships did need to be addressed. The chair of the food and physical activity Board, Dr Ollie Hart, had met with schools to try to use them to encourage young people into sport.

The addition of an action under section 3, page 10, as follows:-

To invite Graham Moore and Ollie Hart of the Food and Physical Activity Board to the next Health and Wellbeing Board strategy development meeting.

The Green Commission had heard evidence concerning the approach in Bristol to active travel and Calderdale also had an active travel planning mechanism to encourage walking and cycling. People might increase their physical activity by walking between tram or bus stops. It was also thought that people overestimated how long it took to walk to a destination.

The Board was not necessarily in a position to hold the city to account with regards physical activity, although it should consider how it was able to influence people to engage with the work relating to increasing physical activity. This included making sure that partner organisations were promoting increased physical activity.

The Learning Disabilities Partnership Board was also considering how physical activity might be promoted, including improving access to sports and health services and facilities.

Action 2.5: Implement an integrated approach to reducing levels of tobacco use through integrating work on: smoke-free environments; helping people to stop smoking; using mass media by reducing the promotion of tobacco; regulating tobacco products; reducing the affordability of tobacco; and substance misuse services.

A programme of tobacco control had been launched in April 2014. The introduction of smoke free spaces to protect children under 5 years from exposure to harmful tobacco smoke had been successful. A question was whether people who used electronic cigarettes viewed themselves as non-smokers. There had been a slight increase in the number of women smoking during pregnancy and this also needed to be addressed through the stop smoking relapse prevention service for pregnant women.

Tobacco was a major cause of early death and it was also a large cost to health and social care. It was noted that Greater Manchester Pensions Authority had taken a decision to dis-invest in tobacco. One of the actions for the Board was to ask the South Yorkshire Pensions Authority to review its investment in tobacco. The Board should state in writing that it would wish for the Pensions Authority to seriously consider dis-investment in tobacco and request the Pensions Authority to respond.

In relation to the idea of a similar request to the pensions authority but relating to alcohol, there was a logic in tobacco being put first as it was the biggest single issue.

Action 2.6: Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.

Consideration would be given to the timetable and logistics in the preparation of a new alcohol strategy and approach to the commissioning of alcohol treatment and prevention services. Alcohol related admissions to hospital had increased in 2012-13. There was concern that the licensing rules were quite restrictive. Other local authorities used planning consents as a means of controlling the availability of cheap alcohol. The extent to which it may be possible to restrict the hours of the sale of alcohol would depend upon a strong case and would be subject to policy. These were issues which could be taken into account in the development of the new alcohol strategy. The involvement of the CCG in addition to the drug and alcohol co-ordination team (DACT) was endorsed and it was recognised that alcohol abuse had a cost to health services in terms of the treatment of in-patients.

Action 2.7: Commission a joint plan and integrated pathway across the city including schools and the commercial sector to act preventatively and with lower-tier interventions to tackle obesity, providing accessible information.

It was likely that the CCG would be tasked with commissioning tier 3 community obesity services, in the next year or two. This was, at present, a complicated pathway and it was likely the CCG would be given responsibility depending upon the financial resources that were available. There was concern that the Government approach was to use surgical procedures in relation to obesity and that the funding and targets to combat obesity would follow this approach and there would not be sufficient funding available to the CCG, which would be driven by the Government target. There was evidence to suggest that surgery was effective as a 'rescue' treatment for obesity and whilst it was expensive, it was cost effective. That did not mean that prevention shouldn't be undertaken. If the CCG had control of the entire obesity pathway, an integrated approach to obesity would then be possible. Family nutrition should be recognised in addition to improvements to school food. The Let's Change for Life programme included work in schools to improve nutrition.

The addition to the list of public health initiatives of a reference to community

initiatives concerning food under section 3, page 16 was suggested.

It was noted that there had been a report regarding the number of people in receipt of prescription medication, including statins. It was said that in certain cases, the equivalent benefit would be achieved from not taking the medication, but taking other action, for example doing more physical activity. The prescription of antacids was raised as a concern as they masked the problem of people eating the wrong types of food and drink. However, it was acknowledged that the medication did make people feel better.

Self-care was a minimal intervention approach, which encouraged people to look after themselves and could be relevant in helping people control their weight and general health.

An example was given of Devon CCG, which had decided to deny people operations until their BMI measured below 37. This was driven by cost and budget considerations and rationed access to elective operations and was also evidence of policy makers choosing which interventions they wished to use first.

There was a high incidence of women being prescribed anti-depressants and a question was asked as to whether there was a link to other conditions such as cardio vascular disease. In answer to which it was considered that in cases of severe depression, there was also a greater risk to physical health.

Action 2.8: Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.

There were no additional comments.

Outcome Indicators

The percentage of patients aged over 18 years with a new diagnosis of depression had increased from 6.93 in 2012-13 to 7.43 in 2013-14. This may be due to better diagnosis and treatment of patients with depression or there may in fact be a higher number of cases. Sheffield had a higher rate of depression than the national average, but the increase was in tandem with the national trend.

The Tackling Poverty Strategy consultation had shown that key workers and debt advisers had seen an increase in depression and mental ill health connected to poverty. Women were described as ‘shock absorbers’ in that they protected their families and the impact of poverty and debt may be a higher incidence of mental ill health. Research into child poverty had been undertaken by the Joseph Rowntree Trust indicating the importance of removing people from poverty and providing stable homes.

There was a need to understand for adults, in the same way as had been done for children and young people, the problems and solutions regarding access to services.

There was better diagnosis relating to mental ill-health and activity to reduce the

stigma around poor mental health. Other programmes such as the Move More initiative, which aimed to make people more active might also mean they had more opportunities to meet other people. Consideration also had to be given to prevention of mental ill health.

The Joint Strategic Needs Assessment provided evidence of where there was need and consideration was given to how services were provided to meet that need and identify which interventions would work and in relation to which area of need in the most cost effective way.

The weight management contract was to be put out to tender and a question was how this linked with other aspects of a healthy lifestyle, such as food and an individual’s journey mapped out in order to build a clear pathway.

The Board needed to make sure there was a market before it made investment. Learning should take place from, for example, the retail sector in order to overcome problems such as the inverse care law, where availability of care was often inverse to needs of the population. Such learning might be applied to the work on stopping smoking.

Thought had been given to the most cost effective methods of prevention and national and international research had been taken into account and interventions based accordingly. However, some approaches were found not to be delivering. Thought was being given to how people accessed services and how intervention might be made most effective. Interventions needed to be targeted to particular communities where they were most needed.

The same people may be in each indicator area and there may be many interventions into one household, which would require a holistic approach to dealing with the causes of health conditions, such as alcohol consumption and smoking, in that household. The estimated prevalence of smoking for 2011 (19.5%) was thought to be unrealistic as it was out of line with the estimates for 2010 and 2012 (which were 23.8% and 23.2% respectively). The indicator for the proportion of 10 to 11 year olds overweight or obese was more or less static over 3 years. The indicators for alcohol related admissions to hospital and breastfeeding of babies at 6 to 8 weeks were worsening. Nonetheless, Sheffield was comparatively good in terms of the rate of breastfeeding. Activity to increase breastfeeding was targeted at particular communities.

Issues relating to poverty and inequality were reoccurring concerns throughout the outcome, which also had connections with the City’s Health Inequalities Action Plan.

Resolved: that the Health and Wellbeing Board:

1. Actively supports the recommendations made under each action in the report as submitted, subject to the following additions having discussed report in some depth:

   Action 2.3:

Under the 'issues and opportunities' heading on page 8 of the report, the first bullet point should be amended by the inclusion of the word "initiatives" after the words "The delivery of Parenting"**.**

- The delivery of Parenting **initiatives** in Sheffield is well established. There is now an opportunity to develop targeted programmes and projects that respond to local need. We also have an opportunity to consider the marketing and promotion of parenting programmes to ensure the service is accessible to families from all backgrounds.

Action 2.4:
The addition of an action under section 3, page 10, as follows:-

- To invite Graham Moore and Ollie Hart of the Food and Physical Activity Board to the next Health and Wellbeing Board strategy development meeting.

Action 2.7:
The addition to the list of public health initiatives of a reference to community initiatives concerning food under section 3, page 16.

- Support public health initiatives that indirectly contribute to the agenda, for example, 20mph areas, playing out schemes, including regular road closures to allow for active play, improvements to school food, ensuring that public sector catering provides healthy and sustainable food; **and community initiatives concerning food** etc.

2. Supports the ongoing programme of needs assessment.

3. Requests another update on this outcome in December 2015.

5. UPDATE ON THE INTEGRATED COMMISSIONING PROGRAMME (BETTER CARE FUND)

The Board considered a report of the Director of Business Planning and Partnerships, NHS Sheffield CCG and the Director of Commissioning, Sheffield City Council, concerning the progress of the Integrated Commissioning Programme (Better Care Fund).

Joe Fowler, the Director of Commissioning, Sheffield City Council, introduced the report, stating that the Clinical Commissioning Group and the City Council had agreed to establish a pooled budget in 2015/16 to cover four key areas of work and with the aim of improving service user experience and outcomes and making the best decisions concerning the use of the available resource. He outlined the key developments relating to the 4 following areas:-

- Keeping People Well in their Community
- Independent Living Solutions
- Active support and Recovery
- Long Term High Support

The governance for the pooled budget would require the alignment of Clinical Commissioning Group and City Council decision making.

Resolved: that the Health and Wellbeing Board notes progress and confirms its support for the establishment of integrated commissioning and a pooled budget, as set out in the report, as submitted.

6. SHEFFIELD STRATEGY FOR MENTAL HEALTH

The Board considered a report of the Director of Business Planning and Partnerships, NHS Sheffield CCG (and Chair of the Mental Health Partnership Board) concerning the draft Sheffield Strategy for Mental Health. The Mental Health Partnership Board had developed the draft Strategy, which covered the promotion of good mental health and treatment and care for people with mental health problems. The Health and Wellbeing Board was asked to comment upon the principles and priorities in the Strategy and to consider whether it would inform and guide the provision of appropriate mental health service provision over the next 5 years.

Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield CCG (and Chair of the Mental Health Partnership Board) presented the report. Stephen Todd, Strategic Commissioning Manager, Sheffield City Council (with responsibility for Adult Mental Health) was also present.

Members of the Board commented and asked questions, as follows:-

The South Yorkshire Police and Sheffield Health and Social Care Foundation Trust had established a Street Triage pilot to improve joint working in cases of mental health crisis and which was funded by the CCG. It was hoped that this would continue.

Some issues had begun to be identified during the development of the Strategy which would require further consideration by commissioners. These included:

- What people had said about mental health services and how they should change including “Whether care plans still existed?” and “The system makes me feel a nuisance”.
- The relationship between primary care and secondary care.
- Treating people as a whole person and undertaking treatment in partnership with the patient.

The estimated prevalence of psychosis amongst adults aged over 16 in Sheffield

of 50 per 1000 adults was thought to be a life-time prevalence, rather than the number at any one time.

The vision and aims set out in section 7 of the report should be amended so that the sentence “Helping to make Sheffield a place that supports and improves the mental health of all its people” was listed as the first item.

Whilst prevention was a priority, it was not emphasised within the draft Strategy. The prevention of early death of people with psychiatric illness was important and most deaths were caused by smoking related diseases. The Health and Social Care Foundation Trust had decided not to tolerate smoking by employees or patients.

The draft Strategy did not include an action plan. However, the Mental Health Partnership Board would ask all providers and commissioning organisations to respond to the Strategy and to state what, in positive terms, they will do to achieve the Strategy’s aims. An action plan would be developed following this process.

Mindfulness approaches should be included in the strategy outcomes.

The inclusion of transitions in the Strategy was positive. There were several recent developments which might be included, which would ensure the Strategy was up to date. These included the Select Health Committee report on Child and Adolescent services of 5 November 2014; the recommendations of the Health Scrutiny Committee relating to Mental Health; the consideration by the Children’s Trust Executive Board regarding mental health; and capturing young people’s views at the workshop.

Young people suffering a mental health crisis might be taken into custody, which was the wrong place for them and action was needed for the 16 to 25 age group in particular. One school had a pilot scheme, whereby specialist mental health work had taken place.

The Strategy document was not explicit about the age range which it covered. Issues concerning transition and connections needed to be highlighted. It was also considered that it would be beneficial to hold a joint meeting of the Children and Young People and Adult Mental Health Boards.

Adults in mental health crisis were also taken into custody. In cases of crisis, a person might be detained and taken to a place of safety.

Work to develop a care pathway and packages in mental health services brought with it challenges. This aimed to create an outcome based contract and pay for people in ‘clusters’ of care on the basis of need. The challenge was a financial one in that the new process could create cost pressures, and a technical one, as it was important to define outcomes in a way that could be robustly measured.

There was an attempt to focus on individual need and also examine how personal health budgets might apply to mental health.

It was clarified that the action plans would identify what was going to be done with regard to each priority.

Resolved: That the Board endorses the work of the Mental Health Partnership Board in developing the Sheffield Mental Health Strategy and supports the work of the Mental Health Partnership Board in finalising and publishing this Strategy.

7. PHARMACEUTICAL NEEDS ASSESSMENT FOR SHEFFIELD 2015-18

The Board considered a report of the Director of Public Health concerning the Pharmaceutical Needs Assessment (PNA) for Sheffield 2015-18. The Pharmaceutical Needs Assessment provided a framework to allow the strategic development and commissioning of pharmaceutical services to help meet the needs of the local population. The report provided an introduction to the PNA and presented key findings and the draft PNA was appended to the report.

Dr Jeremy Wight, the Director of Public Health, presented the report. The duty to produce a PNA was placed on Health and Wellbeing Boards by the Health and Social Care Act 2012. The first Assessment was to be produced by 1st April 2015 and in accordance with the National Health Service (NHS) (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

The PNA concluded that Sheffield was well served by pharmacies and dispensing doctors. There were good links with other NHS services. Nonetheless, it was recognised that there was potential to develop this much further, particularly in the context of developing integrated primary care services. Local pharmacies were already contributing extensively to raising awareness and understanding of health risks.

There was likely to be increased demographic and cost pressures from patients with long-term conditions and the PNA acknowledged pharmacy's continuing role in helping to meet that need. It found that further development of the public health role of pharmacy and commissioning of relevant services could secure additional improvements in health. Known future other developments were unlikely to generate a significant level of need or demand for additional pharmaceutical provision over the next 5 years.

A question was whether there were aspects of pharmacy provision of which more could be made such as developing a role in contributing to messages about the help and support which was available to people.

Resolved: that the Health and Wellbeing Board, having sought assurances that the PNA has been produced in line with the 2013 regulations; that relevant needs and services have been assessed and gaps, as appropriate, identified; and the PNA is on track to be published by 1 April 2015, notes that the final version of the Pharmaceutical Needs Assessment will be submitted to the Board for approval in March 2015.

8. BRIEFING ON PREPAREDNESS FOR WINTER AND THE EBOLA VIRUS

The Board considered a report of the Co-Chairs of the Board which provided a briefing on preparedness for winter and the Ebola Virus. The report summarised issues relating to preparedness for winter for health and social care services. This included national resilience funding to provide additional resources to target admissions avoidance and to streamline the admissions process with major providers of healthcare. There were also some complimentary projects that were often community based, which aimed to keep people well and reduce the demand on GPs and hospitals. Additional funds specifically focused on achieving the 4-hour Accident and Emergency target had been allocated to Sheffield Teaching and Sheffield Children's Hospitals by NHS England.

The Surge Planning Group, a sub-group of the System Resilience Group, had been established to facilitate knowledge of winter plans and understanding of interdependencies across the system by the respective health and social care organisations.

In respect of social care, there was a joint business continuity plan between the City Council, Sheffield Teaching Hospitals Primary and Community Services and Sheffield Health and Social Care Trust and Continuing Health Care to support existing service users and vulnerable people. Care homes had individual contingency plans in the event of an enforced emergency closure or evacuation. In relation to prevention and early intervention, Community Support Workers would liaise with GPs to identify vulnerable people and if necessary, refer them to support. The Workers would also manage a network of volunteers to support frail and vulnerable older people with no access to formal or family support. The report outlined other aspects of winter preparedness relating to social care.

The report also provided a briefing on the Ebola Virus outbreak in West Africa. Sheffield CCG and the Foundation Trusts had taken part in an exercise to test the preparedness of health services and partners for dealing with a case of Ebola and the wider consequences for communities. The Royal Hallamshire Hospital Infectious Diseases department was one of the 4 High Level Isolation Centres across the country that could, if required, receive a case of Ebola. South Yorkshire Local Resilience Forum had discussed Ebola preparedness and Public Health England had produced information and guidance.

Resolved: that the Health and Wellbeing Board receives the report and thanks those, especially volunteers, who will support the frail and unwell over the winter period.

9. MINUTES OF THE PREVIOUS MEETING

Resolved: that the minutes of the meeting held on 25 September 2014 be approved as a correct record, subject to the following amendments:

Page 3 Paragraph 5.2, second to last bullet point: to amend the sentence "The Council had established a Green Commission to look at how the cost of energy could be reduced" so that it read "The Council had established a Green

Commission, the remit of which included fuel poverty and the cost of energy”.

Page 5 Paragraph 6.7. Part 2 of the Resolution be amended after the words “service users” so as to replace the word “to” with the word “and”.