SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 31 March 2016

PRESENT: Councillors Julie Dore (Chair), Leader of the Council

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

Greg Fell, Director of Public Health, Sheffield City Council

Councillor Mazher Iqbal, Cabinet Member for Public Health and Equality

Alison Knowles, Locality Director, NHS England Yorkshire and the Humber

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

StJohn Livesey, Clinical Lead, NHS Sheffield Clinical Commissioning Group (CCG)

Jayne Ludlam, Executive Director, Children, Young People and Families, Sheffield City Council

Dr Andrew McGinty, Clinical Lead, NHS Sheffield CCG

Judy Robinson, Chair, Healthwatch Sheffield

Maddy Ruff, Accountable Officer, NHS Sheffield CCG
l

IN ATTENDANCE Sue Fiennes, Independent Chair, Sheffield Safeguarding Children Board and Safeguarding Adults Board

Richard Parrott, Strategic Commissioning Manager, Sheffield City Council

Peter Moore, Integrated Commissioning Programme Director, NHS Sheffield CCG/Sheffield City Council

.....

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Tim Moorhead, Dr Nikki Bates, Maggie Campbell, Laraine Manley, Dr Zak McMurray, John Mothersole and Dr Ted Turner.

2. DECLARATIONS OF INTEREST

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

3. PUBLIC QUESTIONS

3.1 Public Question Regarding Social Prescribing

Nicola Smith asked what the plans were in Sheffield as regards the introduction of social prescribing, so that people were best able to access support to stay well and have a lasting recovery if they had been unwell.

Dr St John Livesey responded that social prescribing was something which had to be made to work well and there was a good example of social prescribing working successfully in Rotherham. Third sector organisations were involved, through organisations such as Voluntary Action Sheffield. The Clinical Commissioning Group (CCG) and City Council lead on this matter was Peter Moore. This was part of the wider 'People Keeping Well' workstream and improving the co-ordination of referrals by primary care to services provided by the voluntary and community sector.

Councillor Mazher Iqbal stated that Voluntary Action Sheffield had hosted a Social Prescribing summit in 2015 and the Council was working with the CCG to produce a framework. A number of third sector organisations were part of the community wellbeing programme and it was acknowledged that there was need to improve the co-ordination of services.

Councillor Mary Lea said that social prescribing could be used to address the particular needs of individuals.

3.2 Public Questions Concerning People With Learning Disabilities and Employment

Adam Butcher asked how the Board would make sure that all members of the Learning Disabilities community and disabled community were able to gain employment, especially after a period out of the jobs market and how might they be supported with Work Capability Assessments undertaken by the Department for Work and Pensions.

Councillor Julie Dore stated that, in response to the Work Capability Assessments, local councillors did what they could to signpost people to help and the appeals process, in those cases when an individual believed an incorrect decision had been made or a decision was unfair.

Councillor Mazher Iqbal stated that the Council funded the Citizens' Advice Bureau, an organisation which collected data and carried out work in relation to benefits sanctions. There had also been a debate in Parliament concerning Work Capability Assessments in February 2016. Work was being done across Cabinet portfolios in relation to the re-design of support for people who had been away from the jobs market for a long period.

3.3 Public Questions Concerning the Better Care Fund

Mike Simpkin asked several questions relating to the following report submitted to the Board: *Sheffield's 2016/17 Draft Better Care Fund Submission,* as follows:

1) *In reference to governance*: How does the Board think its responsibilities and decision-making will be affected by the increasing number of sub-regional

structures appearing in the NHS, including the Working Together Partnerships, the new Testbed, and the Sustainability and Transformation Footprint for South Yorkshire and Bassetlaw?

2) What is the meaning of paragraph 8.1 in the Better Care Fund Draft Submission (p.27)? What is the accountability of the new Sheffield Transformation Board and to whom will it report?

3) Mr Simpkin stated that in reference to Para 4.2 of the report concerning a focus on those for whom there is the greatest opportunity for health outcomes improvement, there had been increasing concern that commissioning solely for health outcomes could be to the disadvantage of people with long term conditions for whom maintenance may be a more realistic ambition than improvement. He asked whether the Board was satisfied that the desired outcomes of the Better Care Fund reflect the full spectrum of patient need rather than organisational priorities and if they had been formulated with the full involvement of patients and service users.

Maddy Ruff stated that as part of planning and delivery of services, a broader footprint was being examined. The wider footprint of South Yorkshire and Bassetlaw had been covered by the Working Together Programme, although the footprint for the new Transformational Programme was not exactly the same. It was still relatively early in the process and the CCG and City Council were working with NHS England with regard to how plans would fit with the requirements of the Health and Wellbeing Board. Each CCG would produce a plan and the NHS and Sheffield City Council would work together, with that work being brought together through the Transforming Sheffield Programme Board. The governance arrangements relating to the Programme Board were being worked upon. It was positive that the commissioner and provider organisations were coming together to plan services.

Alison Knowles added that the basis of the footprint for NHS planning was the CCG, which was the accountable organisation for health services and a wider planning footprint was being looked at because of the savings required by the NHS to 2020. It was appropriate to have local planning in relation to primary care services, whereas, for some specialist services, such as stroke services, a wider planning footprint might be applicable.

Judy Robinson stated that there were good examples of working with the voluntary, community and faith sector.

Councillor Julie Dore stated that, in contrast to Manchester, Sheffield City Region chose not to deliver health and social care for the City region as a whole. The Health and Wellbeing Board would continue to look at its remit and focus in the light of emerging changes, including legislative change. With regards to Mr Simpkin's final question concerning patient need, Councillor Dore stated that the Board would consider that matter when it considered the *2016/17 Draft Better Care Fund Submission* later in the meeting.

3.4 Public Questions Concerning Adult Autism

Roger Guymer submitted questions in writing to the Board regarding the national strategy on adult autism as it affects Sheffield, as follows:

"1. I note that under Outcome 3 of your Sheffield's "Joint Health and Wellbeing Strategy - Report on Progress and Actions - September 2015", Health Needs Assessments are being undertaken or updated in relation to the following groups in Sheffield:

- Mental Health
- Learning Disabilities
- Carers
- Homeless
- Roma Slovak

Whilst I accept that attention to the needs of these various groups is commendable and highly desirable, why is there no mention of autism in Sheffield's Joint Health and Wellbeing Board's Strategy document or in the Board's Report on Progress and Actions of September 2015 (or, for that matter, in the Director of Public Health's 2015 report) when Sheffield's Joint Strategic Needs Assessment of 2013 says that *"There are as many as 6,000 adults with Autistic Spectrum Disorders (ASD) locally and we know this is the fastest growing area of 'primary need' in Sheffield"* ? And when the government's 2015 Statutory Guidance for Local Authorities and NHS organisations says that "*Health and Well-being Boards have a crucial role to play in overseeing implementation of the Adult Autism Strategy*" and that "*the Health and Well-being Board is central to ensuring the needs of people with autism are addressed locally*"?"

2. Why does Sheffield currently have no Autism Partnership Board when Sheffield does have a Learning Disability Partnership Board and a Mental Health Partnership Board, and when the Department of Health March 2015 Autism Statutory Guidance says that "*Local partners should already have a local autism partnership board in place, which brings together different organisations, services and stakeholders and adults with autism and their families to set a clear direction for improved services. Autism partnership boards have proved to be a highly effective means for stakeholders to shape and monitor local delivery of the strategy and statutory guidance. It is therefore essential for their partnership arrangements to be established in areas where they are not currently*"?

Councillor Julie Dore stated that responses would be given in writing to Mr Guymer, who was not in attendance at the meeting.

4. UPDATE FROM THE SAFEGUARDING BOARDS

The Board considered a report of the Independent Chair of the Safeguarding Children and Adults Boards, Sue Fiennes. The report provided an overview of Safeguarding activity in Sheffield and outlined priorities for 2016/17. The Annual Reports of the Safeguarding Children and Adults Boards for 2014-15 were appended to the report submitted to the Board.

The Board was asked to consider how Safeguarding related to the Board's current priorities and whether there were any developments the Board would want to see that would better align the work of the Safeguarding and Health and Wellbeing Boards.

Sue Fiennes stated that a governance review of the Safeguarding Adults Partnership had been completed and implemented in 2014/15. The leadership and governance of safeguarding was mature and enabled challenge and openness and there was a good basis for continuing improvement. It was also likely that the Child Death Overview panel would be taken out of the Safeguarding Board structure. With regard to adult safeguarding, Sheffield was at the forefront of issues concerning self-neglect and was well placed to develop this work. There were links between narrowing the health gap between communities in the City and keeping people safe. There was also recognition of diversity and the requirement to consider the needs of different communities and approach these in the appropriate way.

Members of the Board asked questions and made comments as summarised below:

It was important to make sure that as much as possible was being done in relation to safeguarding and it had to be a foremost priority to keep people safe.

There was a balance required of proactive and reactive approaches and the question was asked as to how this might be done better. In response, the Board was informed that as regards adult safeguarding, the Safe in Sheffield scheme had been well received by people with disabilities and a positive programme of prevention had been created. If progress was made in relation to health and wellbeing programmes, for example therapeutic support and suicide pathways, this might help to realise a more balanced approach.

As regards what needed to happen in order to make a difference, there was a significant challenge in relation to available resources and other approaches were being looked at. In relation to emotional wellbeing, resources could be pooled to provide support to people in need.

There was a need to train and support people who were the eyes and ears of the Board and respective organisations in relation to safeguarding, be they in services which required them to visit people's homes or other services such as licensing. They should be able to help recognise signs of issues relating to safeguarding and exemplar training was available to enable and support people in such roles to do so. Training should also be available for elected members.

The health gap was something that was recognised by the Board and the changing nature of the City's population and requirement for proactive measures in relation to safeguarding was also something to which the Board would need to give its attention.

Members thanked Sue Fiennes for her work for adults and children in respect of safeguarding and it was recognised that as Independent Chair, she had held

organisations to account, including the Council and health trusts in the City, and had provided challenge. There were initiatives including the Safe in Sheffield initiative that could contribute to adult safeguarding and helping people to keep well in the future.

The Health and Wellbeing Board needed to be able to respond quickly to new and emerging issues and policy changes. For example, the implications for safeguarding of the decision to make primary schools become academies. At present, local authorities had responsibility for the safeguarding of vulnerable children at primary school age.

Councillor Julie Dore, on behalf of the Board, expressed the Health and Wellbeing Board's best wishes and thanks and appreciation for the work that Sue Fiennes had contributed to safeguarding, especially in the most recent few years in relation to Child Sexual Exploitation and with regard to individual safeguarding cases.

RESOLVED: That the Health and Wellbeing Board:-

1. Endorses and supports the work of the Safeguarding Boards in Sheffield; and

2. Commits to continuing to work with the Safeguarding Boards to protect people at risk.

5. HEALTH AND WELLBEING PLANS FOR SHEFFIELD IN 2016/17

The Board considered a report of the Director of Commissioning, Sheffield City Council and Director of Health Care Reform, NHS Sheffield Clinical Commissioning Group, concerning Health and Wellbeing Plans for Sheffield in 2016/17. The report was presented by Richard Parrott, Strategic Commissioning Manager, Sheffield City Council.

The report outlined plans for 2016/17, based around 5 main actions and how the Health and Wellbeing Board and its partners would work together to address them. These were as follows:-

Action 1: Over 2016/17, the Health and Wellbeing Board will continue to communicate and engage with Sheffield people and organisations to ensure that the vision and plans we have are the right ones.

Action 2: The Health and Wellbeing Board will ensure that the JSNA will be fully refreshed and revised in 2016/17.

Action 3: Once the JSNA has been refreshed and revised, in 2016/17 the Health and Wellbeing Board will take the lead, with partners, in revising the Joint Health and Wellbeing Strategy.

Action 4: In 2016/17, the Health and Wellbeing Board will continue to ensure that the plans of the Board's main organisations – Sheffield City Council, NHS Sheffield Clinical Commissioning Group, NHS England, Healthwatch Sheffield – are coordinated and coherent.

Action 5: In 2016/17, the Health and Wellbeing Board will take a proactive and

assertive approach to ensure that partner organisations make progress with tackling health inequalities, transforming the health and care system, and delivering better outcomes for Sheffield people.

The Board was asked to consider the following issues:

- Does the Health and Wellbeing Board support the priorities proposed by the commissioning organisations?
- Are there areas for greater joint working between the organisations on the Health and Wellbeing Board (and others) in 2016/17?
- Does the Health and Wellbeing Board approve of the five actions outlined in the report?
- What role is there for Healthwatch Sheffield over the coming year in assisting with the implementation of these plans and ensuring that Sheffield people are appropriately involved, communicated with and engaged?

Members of the Board asked questions and commented upon the matters relevant to this item, as summarised below:-

Whilst tackling health inequalities was identified as a concern for the Board, the Commissioning Plans as appended to the report, did not say how inequalities would be addressed. The Director of Health Annual Report 2015 indicated that there had been little improvement in relation to health inequalities over the past 10 to 15 years. In response to this point, the Board was informed that there was a focus on reducing health inequalities and this was evident for particular groups, including people with learning disabilities. However, this might be made more explicit within the plans from Sheffield City Council and NHS Sheffield Clinical Commissioning Group (CCG).

It would be useful to identify a smaller number of priorities, on which effort could be directed and in relation to which progress could be made. Further discussion would take place with the Director of Public Health. It was also questioned as to whether the City Council and CCG plans were truly ambitious and bold rather than operational. The Board were informed that the appendix to the report brought together plans of both organisations and did represent a step forward.

The CCG in Liverpool for example had decided to contribute funding for physical activity, which could be allocated to programmes or initiatives involving physical activity. There were also areas of public health and inequalities which could be considered by having bold and ambitious plans. Community projects might be extended, where these had achieved good results, and other jointly delivered activity could also be considered.

Reducing health inequalities was a priority for the Board and should be a thread through the various aspects of its work, but it should also be explicit in asking questions about health inequalities in each decision that was made.

In refreshing plans for the CCG, health inequalities were one of the main priorities and the CCG was working jointly with the City Council. The CCG faced significant

challenges as regards its financial position and it was important to prioritise the use of resources. Physical activity and smoking cessation were two areas which made a difference to health.

Community assets could be considered alongside other resources and systems. Healthwatch Sheffield was keen to work with the City Council and the CCG on such issues. The recognition of people as potential assets as well as organisations was important and could also be included as part of the Joint Strategic Needs Assessment (JSNA). The People Keeping Well plan included the building of social capital and self-care.

People suffering with mental ill health and those with learning disabilities were known to have a comparatively shorter life expectancy and the City Council and CCG were in a position to try to address these issues together. However, new additional resources were not available. There was a role for social workers and health workers in referring people to services such as smoking cessation services.

It was important to get things right for children in their early years, which would set the conditions for later in life. Young Commissioners had been trained so they could participate in the process of discussing tenders and it was hoped that young people would continue to be engaged and they would have a voice in the commissioning of services. The CCG and City Council plans were evolving and would change where appropriate, with items being added or taken away.

RESOLVED: That:

1. the Health and Wellbeing Board supports and endorses the plans set out in this document and the actions proposed for the Board; and

2. Health and Wellbeing Board members and the Board's organisations commit to working together in an integrated way over the coming year.

6. UPDATE FROM THE JSNA

The Board considered a report of the Director of Public Health concerning the Joint Strategic Needs Assessment (JSNA), which set out the main findings of a review of the Sheffield JSNA conducted earlier in 2016 based on stakeholder interviews and literature. The report outlined actions, a timeline and resources required to develop an up to date JSNA by October 2016.

It was proposed to combine production of an up to date JSNA summary report with that of the 2016 Director of Public Health report, focused on the key actions and interventions that would improve outcomes and reduce health inequalities. The full redesign of the JSNA would then be developed as a phased programme of work starting later in the year.

Greg Fell, the Director of Public Health, stated that the JSNA had been defined

differently by different local authorities. It was important that the document was both joint and focussed on need, rather than demand. There was also a duty to produce a Director of Public Health Annual Report. Public Health England produced data packs and ward and neighbourhood profiles which would help to inform this work. During the review, stakeholders had expressed concerns regarding organisations working in silos between organisations and within them and in relation to age groups. There was also a desire to increase emphasis on prevention.

The Board was asked to consider the following questions:

- Is the proposal to combine the JSNA with this year's DPH report acceptable?
- Is the timescale of April to October 2016 acceptable?
- Are there any nominations for the editorial group?
- Is the broad approach to the report (i.e. based on starting well; living well; ageing well) acceptable?
- Are there any specific questions the report should seek to answer?

Members of the Board commented and asked questions on the matters raised by the report, as summarised below:-

Changes in the health of the population were gradual and it was accepted that for this year, an interim summary JSNA could be combined with the Director of Public Health's Annual Report. The timescale of April to October 2016 was agreed. The interim Director of Public Health had engaged with stakeholders as part of the JSNA review. An editorial group would be established to oversee this work. It was important to consider how data could be used to inform decisions on spending to bring about health improvement.

There were other issues which should also be considered in the report relating to all age mental and emotional health and wellbeing and young people's health. It was clarified that the Director of Public Report would continue to be produced annually.

RESOLVED: That the Health and Wellbeing Board:

1. Agrees the approach to developing a combined report as set out in section 4 of the report submitted;
2. Agrees the key actions and timescale set out in section 4 of the report; and
3. Requests the final report for approval in October 2016.

7. UPDATE FROM THE CHILDREN'S HEALTH AND WELLBEING BOARD

The Board considered a report of the Executive Director, Children, Young People and Families, Sheffield City Council, the Chief Officer, NHS Sheffield Clinical Commissioning Group and the Cabinet Member for Children, Young People and

Families, Sheffield City Council. The report provided an update on activity of the Children's Health and Wellbeing Partnership Board and an overview of the Children's Health and Wellbeing Board work stream priorities and outlined the current work programme.

Jayne Ludlam, the Executive Director, Children, Young People and Families, introduced the report and stated that in the development of the Sheffield Children's Health and Wellbeing Programme Blueprint, the Partnership Board had reviewed the JSNA, public health profiles and variation in child health outcomes. The Partnership Board priorities were outlined and these workstreams were each led by an Executive Member of the Board.

Health and Wellbeing Board members would be given opportunity to hear how work on the Emotional Wellbeing and Mental Health work stream was progressing during the discussion forum which was to take place at the end of the Health and Wellbeing Board Meeting. The Board was asked whether it was in agreement with the priorities and workstreams which the Children's Health and Wellbeing Partnership Board had identified.

It was noted that the engagement and support of Sheffield Healthwatch and Young Healthwatch as regards priorities had been beneficial.

RESOLVED: That the Board:

1. Notes the work of the Children's Health and Wellbeing Partnership Board, the identification of the Board priorities and named Board sponsors;

2. Notes the development of the Children's Health and Wellbeing Programme (2015- 2020) Blueprint document;

3. Notes the impending review of governance structures and boards that exist across Children and Young People's services; and

4. Requests a future update and description of activity/progress from each of the work streams (and to note that the Emotional Wellbeing and Mental Health work stream will be providing an update on progress in the discussion forum at the end of the meeting on 31st March 2016).

8. UPDATE ON THE BETTER CARE FUND

The Board considered a report of the Chief Officer, NHS Sheffield Clinical Commissioning Group and the Executive Director Communities, Sheffield City Council. The report sought approval to Sheffield's 2016/17 Draft Better Care Fund Submission and the delegation of final approval of the Better Care Fund submission to the lead executive officers in the Council and the Clinical Commissioning Group. The draft submission for Sheffield's Better Care Fund 2016/17 was appended to the report. Peter Moore, NHS Sheffield Clinical Commissioning Group/Sheffield City Council, presented the report.

The Board was asked to consider the following questions:

- Is the Health and Wellbeing Board satisfied that these plans will help to progress the Board's ambition to transform the health and care landscape, reduce health inequalities and deliver better outcomes for Sheffield people?
- Where might there be further opportunities for integration and joint working?

Members of the Board asked questions and made comments, as summarised below:-

In the plans for the second year of the Better Care Fund, the report indicated that the planned pooled budget of £282m included current expenditure on four areas of need, focusing on those at risk of hospital admission and those for whom there is the greatest opportunity for health outcomes improvement. It was questioned whether attention was also being given to long term conditions and in response, the Board was informed that in relation to long term conditions, helping people with such conditions to maintain their health was important. A doctor's job was to see to people who were ill and dealing with those with long term conditions was a relatively new addition, which required a realignment of structures. There was a 20 year gap in people keeping well between people in the most and least deprived sections of the population. It was important that the ongoing care (which was one of four key areas in 2016/17) was provided to those with long term conditions.

Whilst adults were the main focus of the Better Care Fund, there was also an earlier indication that children and young people would be considered. For example, the target of reducing emergency admissions was focussed only on adults. In response it was agreed that this was a fair challenge, which should be given further consideration. A joined-up approach was required for a number of areas and it was important to make sure there was prevention activity at an early stage. A children's delivery board was to be established. There had also been discussion regarding the integration of activity relating to the Better Care Fund and children's services, especially with regard to the development of services in neighbourhoods. However, it was acknowledged that, at present, children and young people were an omission in relation to the Better Care Fund submission.

Other observations were made including that the 'need' statement did not follow through on actions and there was not an evaluation regarding outcomes; and that the Better Care Fund did not actually represent new money, although it was not the only financial resource for health and social care.

A question was asked as to whether health assessments were available for young people.

It was acknowledged that there were organisational, professional and cultural boundaries and some matters were affected by such boundaries. A flexible workforce was needed.

A question was asked as to whether there had been high level discussion regarding the Better Care Fund which had included the Executive Director, Children, Young People and Families.

RESOLVED: That the Health and Wellbeing Board:

1. Formally approves these plans;
2. Delegates final approval of the Better Care Fund submission to the lead executive officers in the Council and the Clinical Commissioning Group (CCG); and
3. Receives an update on progress at its September 2016 public meeting.

9. MINUTES OF THE PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Health and Wellbeing Board held on 24 September 2015 be approved as a correct record.

Note: At the conclusion of the meeting, a discussion forum took place concerning children and young people's wellbeing and mental health.