Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 28 March 2019 at 3.00 pm

A Committee Room at Sheffeld Town Hall

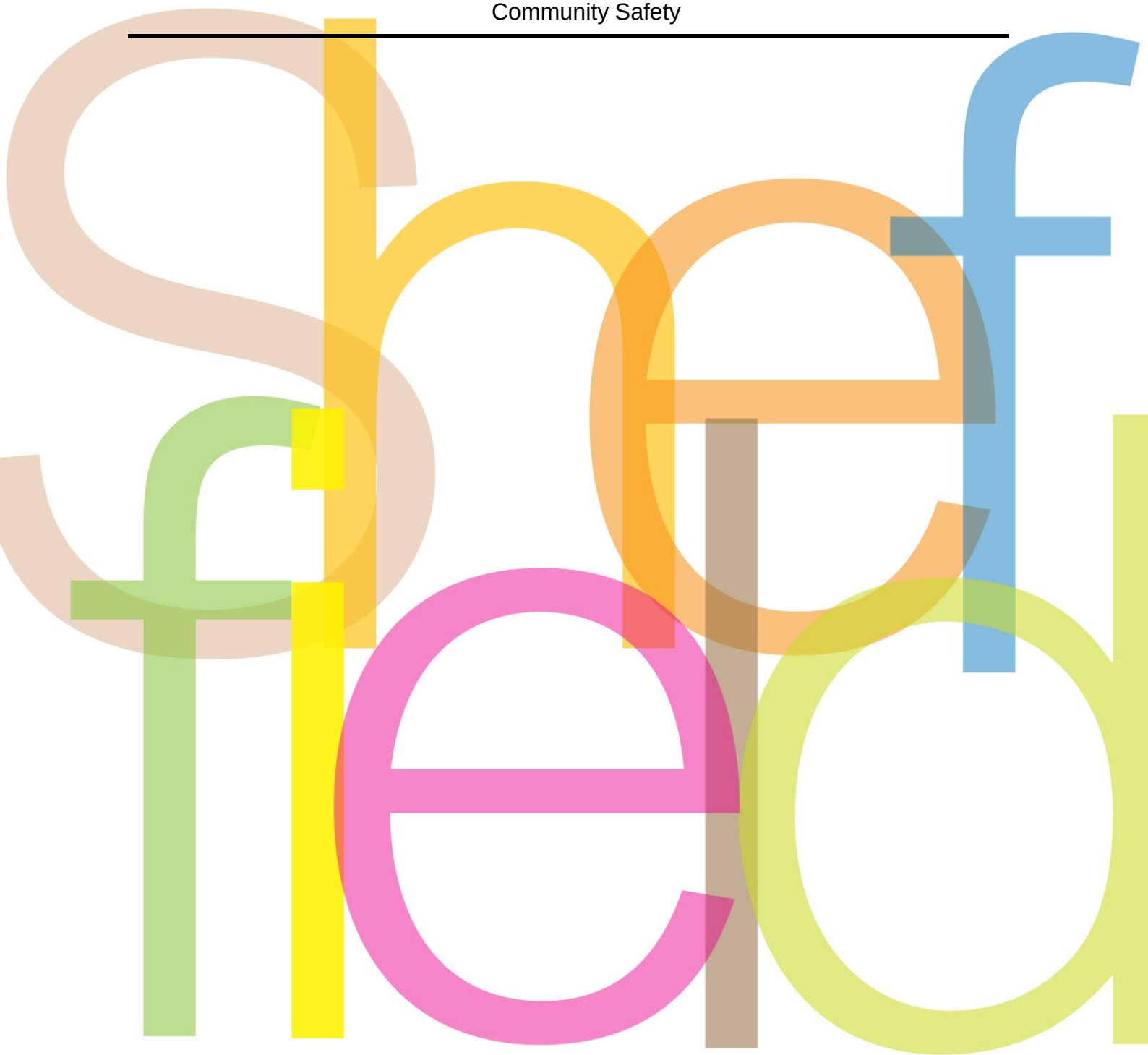
The Press and Public are Welcome to Attend

Membership

Councillor Chris Peace	Cabinet Member for Health and Social Care
Dr Tim Moorhead	Chair of the Clinical Commissioning Group
Dr Nikki Bates	Governing Body Member, Clinical Commissioning Group
Chief Superintendent Stuart Barton	South Yorkshire Police
Jayne Brown	Sheffield Health & Social Care Trust
Nicki Doherty	Director of Delivery Care out of Hospital, Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children and Young People
Greg Fell	Director of Public Health, Sheffield City Council
Phil Holmes	Director of Adult Services, Sheffield City Council
David Hughes	NHS Provider – Clinical Representative
Rebecca Joyce	NHS Sheffield Clinical Commissioning Group
Alison Knowles	Locality Director, NHS England
Jayne Ludlam	Executive Director, People Services Portfolio
Clare Mappin	The Burton Street Foundation
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group

Sheffield City Council

Laraine Manley	Executive Director, Place
John Mothersole	Chief Executive, Sheffield City Council
Judy Robinson	Chair, Healthwatch Sheffield
Maddy Ruff	Accountable Officer, Clinical Commissioning Group
Councillor Jim Steinke	Cabinet Member for Neighbourhoods and Community Safety



Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

Sheffield's Health and Wellbeing Board started to meet in shadow form in January 2012 and became a statutory group in April 2013. The Health and Social Care Act 2012 states that every local authority needs a Health and Wellbeing Board. It is a group of local GPs, local councillors, a representative of Sheffield citizens, and senior managers in the NHS and the local authority, all of whom seek to make local government and local health services better for local people. Its terms of reference sets out how it will operate.

Sheffield's Health and Wellbeing Board has a formal public meeting every three months as well as a range of public events held at least once a quarter.

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. http://www.sheffield.gov.uk/home/public-health/health-wellbeing-board

PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information please contact Jason Dietsch on 0114 273 4117 or email jason.dietsch@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

28 MARCH 2019

Order of Business

1. Apologies for Absence

2. Declarations of Interest (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting.

3. Public Questions
To receive any questions from members of the public.

4. Joint Health and Wellbeing Strategy (Pages 5 - 40)
Report of the Director of Public Health.

5. Care Quality Commission System Review - Action Plan Update (Pages 41 - 60)
Report of the Accountable Care Partnership Programme Director

6. Accountable Care Partnership Programme Directors Report (Pages 61 - 64)
Report of the Accountable Care Partnership Programme Director

7. Terms of Reference & Membership of the Board (Pages 65 - 74)
Report of the Director of Public Health

8. Minutes of the Previous Meeting (Pages 75 - 82)

9. Date and Time of Next Meeting
To confirm the date and time of the next meeting.

The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 27 June 2019 at 3.00 pm

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Audit and Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell, Director of Public Health
Date:	20th March 2019
Subject:	Joint Health & Wellbeing Strategy 2019-24
Author of Report:	Dan Spicer – 27 34554

Summary:

This paper sets out the background to and content of the Joint Health & Wellbeing Strategy to cover the period 2019-24. It also proposes a broad approach to implementation of the Strategy and asks the Board to provide a steer on how to proceed. Finally it asks the Board to formally agree the new Strategy in line with legislative requirements.

Questions for the Health and Wellbeing Board:

1. Do the Board agree with the broad approach to implementation described above?
2. Can the Board provide a steer on who should lead the implementation of the Strategy?

Recommendations for the Health and Wellbeing Board:

The Board are asked to formally agree the Joint Health & Wellbeing Strategy for the period 2019-24.

Background Papers:

- Joint Health & Wellbeing Strategy 2019-24
- 6th December 2019 Health & Wellbeing Board Paper – Draft Joint Health & Wellbeing Strategy 2019-24

What outcome(s) of the Joint Health and Wellbeing Strategy does this align with?

This paper asks the Board to agree a new Joint Health & Wellbeing Strategy for Sheffield, and thus supersedes the outcomes set out in the previous Strategy.

Who have you collaborated with in the writing of this paper?

Greg Fell – Director of Public Health, Sheffield City Council

Nicki Doherty – Director of Delivery, Care Outside of Hospital, NHS Sheffield CCG

Becky Joyce – Accountable Care Partnership Programme Director for Sheffield

Judy Robinson – Chair, Healthwatch Sheffield

Anthony Gore – Clinical Director for Care Outside of Hospital, NHS Sheffield CCG

Stuart Barton – District Commander for Sheffield, South Yorkshire Police

JOINT HEALTH & WELLBEING STRATEGY 2019-24

1.0 SUMMARY

1.1 This paper sets out the background to and content of the Joint Health & Wellbeing Strategy to cover the period 2019-24. It also proposes a broad approach to implementation of the Strategy and asks the Board to provide a steer on how to proceed. Finally it asks the Board to formally agree the new Strategy in line with legislative requirements.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 The Joint Health & Wellbeing Strategy is required by the Health & Social Care Act 2012, which also requires the Council and NHS to take it into account in their commissioning plans. It therefore provides a significant part of the framework within which services are designed and delivered locally.

2.2 The refreshed Strategy commits the Health & Wellbeing Board to focusing their attention on the challenge of reducing health inequalities in Sheffield, by addressing nine key determinants of health. Successful delivery of the Strategy will see major impacts on the lives of people living in Sheffield.

3.0 BACKGROUND

3.1 Under the 2012 Health & Social Care Act, Health & Wellbeing Boards are required to publish a Joint Health & Wellbeing Strategy for their area. The first of these for Sheffield ran from 2013 to 2018, so during 2018 the Health & Wellbeing Board dedicated time to developing its successor.

3.2 Early on in this process the following guiding principles emerged from the Board's discussions:

- It should be a strategic vision for improving the health and wellbeing of the population Sheffield, not just about NHS and social care services
- It should have a strong health inequalities focus
- It should consider both the long and short term
- It should aim to prevent poor outcomes rather than respond to them

4.0 THE STRATEGY

4.1 As agreed with the Board in previous discussions, work on the strategy has been iterative, involving a series of discussions with the Board to test the approach and develop content, and a range of discussions with partners to sense check this as it has

progressed. These discussions began with a Board workshop led by the Kings Fund and with broad representation from across the city, and have included specific engagement sessions with the Equality Hubs, the Fairness, Tackling Poverty & Social Exclusion Partnership Group, Social Landlords, and the Thriving Voluntary Sector Leadership Group, as well as ongoing discussions with stakeholders throughout the development process.

4.2 A first draft of the Strategy was also discussed by the Board at their December 2018 Public Meeting, with the Board providing a clear steer on how the Strategy should be developed at that meeting. The Board have continued to receive regular updates as work has progressed.

4.3 As a result of this work, the Strategy adopts a single headline target focused on reducing health inequalities:

We will close the gap in healthy life expectancy in Sheffield by improving the health and wellbeing of the poorest and most vulnerable the fastest

4.4 This is positioned as a 20-year vision to which the Board are committed.

4.5 As well as providing the headline focus of the Strategy, this will also provide the Board with the lens through which they examine all their business.

4.6 To address the commitment to considering both the long and short term, the Strategy is structured around the life course, and attempts to set out the key foundations to a healthy life. These are described in terms of ambitions for the population of Sheffield, across three stages of life:

4.7 **Starting Well**

- Every child achieves a level of development in their early years for the best start in life
- Every child is included in their education and can access their local school
- Every child and young person has a successful transition to independence

4.8 **Living Well**

- Everyone has access to a home that supports their health
- Everyone has a fulfilling occupation and the resources to support their needs
- Everyone can safely walk or cycle in their local area regardless of age or ability

4.9 **Ageing Well**

- Everyone has equitable access to care and support shaped around them
- Everyone has the level of meaningful social contact that they want
- Everyone lives the end of their life with dignity in the place of their choice

4.10 These ambitions are themselves significant commitments. The intention is that the work done over the period covered by the Strategy will serve to shift the trajectory the

city is on in each of these areas. When the time comes to review and refresh the Strategy, the question would be: are these still the right things to be focusing on, in service of the overarching vision of reducing health inequalities?

5.0 HOW DOES THIS COMPARE TO THE PREVIOUS STRATEGY?

5.1 As part of developing the refreshed Strategy, the Board have considered carefully what went well with the previous Strategy, and where there have been challenges.

5.2 The previous Strategy consisted of 10 principles (Valuing the people of Sheffield, Fairness and tackling inequality, Tackling the wider determinants of health, Evidence based commissioning, Partnership, Prevention and early intervention throughout life, Independence, Breaking the cycle, A health and wellbeing system designed and delivered with the people of Sheffield, and Quality and innovation) as the foundation on which to deliver five outcomes:

- Sheffield is a healthy & successful city;
- Health and wellbeing is improving;
- Health inequalities are reducing;
- People get the help and support they need and feel is right for them; and
- The health & wellbeing system is innovative, affordable and provides good value for money

5.3 These were underpinned by five proposed work programmes, covering:

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

5.4 A dashboard of indicators was produced to provide the Board with a broad understanding of the health and wellbeing of Sheffield's population.

5.5 Much of the broad intent behind the previous Strategy remains appropriate and so there is a degree of commonality across the two documents. However, there were some specific challenges in relation to delivery of the previous Strategy, along with changes in the overall context around health & wellbeing, that have led to some specific changes in direction:

- Health inequalities featured as one aspect of the previous Strategy, but it is now the central focus of the new one, and will be the lens through which the Board looks at everything that comes before it.

- The new Strategy is more clearly focused on the wider, social determinants of health, and on specific outcomes that we need to see an impact on to reduce health inequalities in Sheffield over the long term. These are defined in terms of things that impact on real lives, not as aspects of the system.
- With the national shift in approach to the NHS, and the emergence of the local Accountable Care Partnership, there are new structures in place to focus on delivering a more integrated health and care system in Sheffield. Where the previous Strategy went into some detail about the health and care system, the new Strategy restricts itself to setting a vision and strategic direction for the system that it expects the ACP to deliver, and against which the Health & Wellbeing Board will hold the ACP to account.
- Although the previous Strategy identified work programmes as part of its delivery plans, the reality is that resource restrictions mean these have not progressed as planned. The new Strategy takes a more realistic view of the Board's capacity to deliver directly, and positions implementation as the responsibility of the whole system, not just those around the Board table.
- The Board will maintain a dashboard of measures assessing the overall wellbeing of the Sheffield population, but these will be supplemented by bespoke measures against which they will assess progress against each of the nine ambitions. These will be designed alongside the delivery plans to be produced in partnership with the rest of the city.

6.0 IMPLEMENTATION

6.1 The Board does not have the direct resources to develop its own work programmes to deliver the Strategy, and successful delivery would in any case require the input and commitment of the whole city, not just the partners around the table.

6.2 Reflecting this, the Board's role in implementing the Strategy will be focused as follows:

- Convener – using its statutory role as the system leader for health and wellbeing in Sheffield to convene stakeholders and the public to agree what success looks like for each of the ambitions, and what needs to happen in the city to deliver. This process will see the development of action plans for each of the ambitions, leading to the second role for the Board;
- Accountability – using its democratic role to hold partners across the city to account for the commitments they have made in those action plans.

6.3 The aim of this is that, rather than the Strategy leading to specific programmes of work, it serves to shape the work that organisations in the city undertake, identifying gaps that need to be filled, blockages that need to be removed, partnerships that need to be developed, and investments that need to be maximised. This is about building wellbeing into all of the city's activity.

6.4 It is proposed that there are a number of key elements to delivering this work:

- **A major launch event**

  To give the Strategy the profile it needs, it is proposed that the Board sponsor a major launch event in the Summer of 2019.

- **Named individuals with responsibility to ensure work progresses on each ambition, who are accountable to the Board**

  In order to establish accountability, there need to be named individuals who are responsible for driving work forwards. It is also important that this work is owned by the Board and by all the organisations around the table. With this in mind, the following approach is proposed:

  1. A Strategic Lead to be identified to take responsibility for each of the Life Course Stages. This could be someone drawn from the Board, but does not have to be; what is important is that they are a topic expert and can command respect in the city and system.
  2. A Non-executive Lead to be identified to work with the Strategic Lead and provide oversight on behalf of the Board, on an ongoing basis. This person must be a Board member, and should ideally be from a different organisation to the Strategic Lead in order to maintain broad ownership of the Strategy.
  3. The Strategic Lead and Non-executive Lead should identify specific individuals to lead on the ambitions within their life course stage. This is not about these people doing the work: it is about making specific people for coordinating work and ensuring that it happens, and being a point of contact for the Board. These people should be drawn from the Board, but not just from the Board membership – their selection is also a mechanism to draw wider stakeholders into the work.

- **An implementation group to be responsible for the overall delivery**

  To ensure we retain a focus on the overall aim of reducing health inequalities, the Strategic Leads will also form an implementation group for the Strategy, alongside the Director of Public Health, with support from the Public Health Intelligence Team in relation to data and metrics, and secretariat support provided by officers supporting the Health & Wellbeing Board.

  A structure chart setting out how this would work in practice is included for information as an appendix to this paper.

- **A series of stakeholder workshops**

  A starting point for work on each of the ambitions should be a major stakeholder workshop, at which the ambition is discussed, work is undertaken to understand the system that exists around it, where pressure points, gaps and places to have impact exist, and crucially agree what good looks like. Critically, these are

positioned as open and frank listening exercises, where the whole system is invited to give their views on what is working well and what needs to change, and a collective view is developed on how to move forward.

These workshops would also agree how we will know that we are making progress, identifying for each ambition what data and intelligence will be reported. These workshops will be the starting point for work on each ambition, but the future direction beyond this would be developed by the named lead, working with a broad coalition of stakeholders with an interest in or responsibility for the ambition in question.

- **Supported engagement work**

  Healthwatch Sheffield are being funded through the Health & Wellbeing Board to deliver additional engagement work around the work of the Board, and there will be opportunities to shape this to support the work flowing from the initial workshops described above.

- **Use of Board time**

  The Strategy is reasonably well established in the Steering Group's approach to developing the Forward Plan for the Board, and this will need to continue. It is intended that the Forward Plan will establish a slot at every Board meeting to focus on one of the ambitions in the Strategy. Beyond this, discussions in meetings will need to be focused on drawing out links to the Strategy, at a minimum relating to the headline ambition around health inequalities, and ideally directly to one or more of the nine ambitions.

- **Revision of Board templates**

  To support this, we will revise templates and guidance that is provided for people producing papers and/or items for discussion at Board.

7.0 QUESTIONS FOR THE BOARD

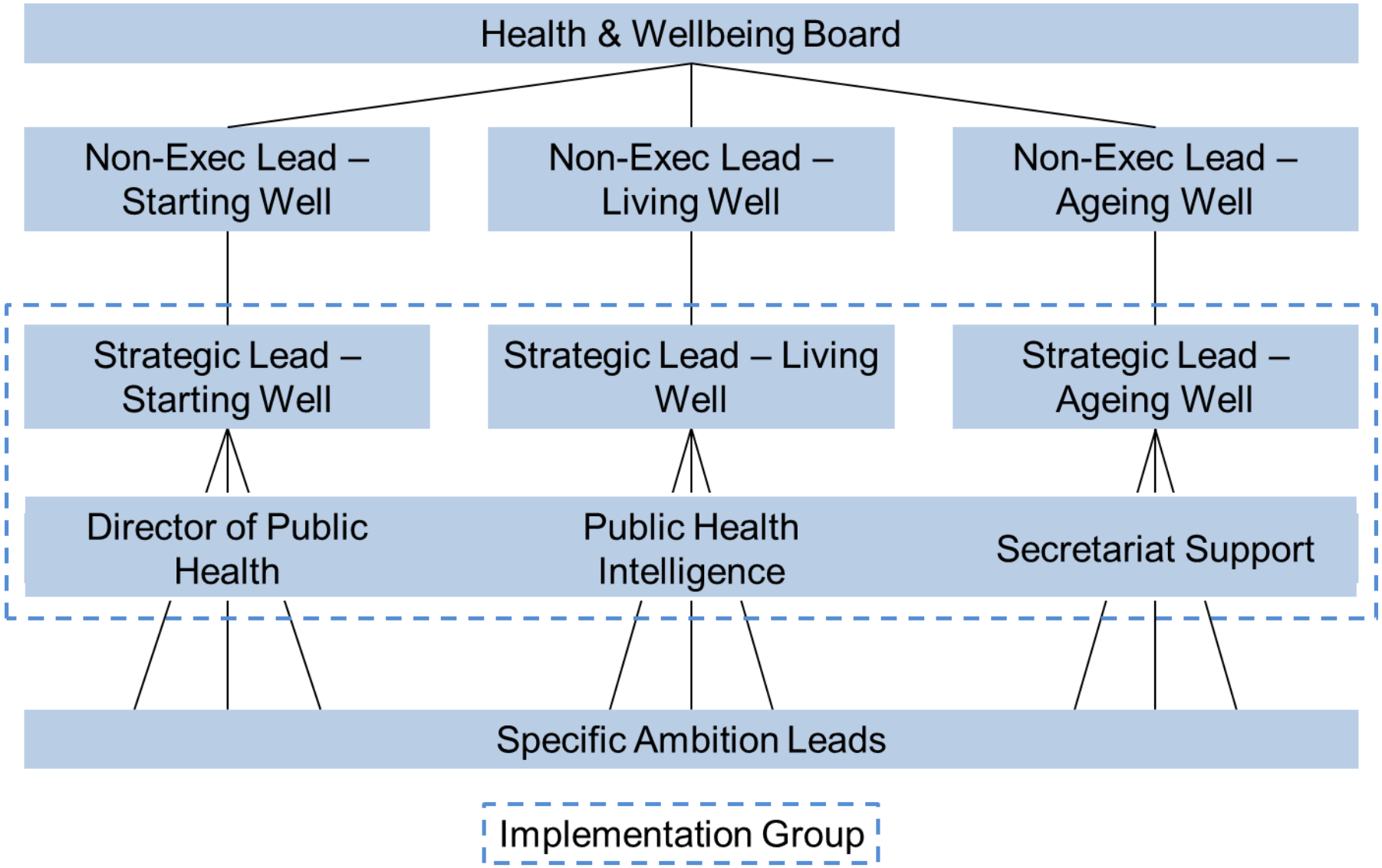
7.1 Do the Board agree with the broad approach to implementation described above?

7.2 Can the Board provide a steer on who should lead the implementation of the Strategy?

8.0 RECOMMENDATIONS

8.1 The Board are asked to formally agree the Joint Health & Wellbeing Strategy for the period 2019-24.

Appendix: Implementation Structure



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Sheffield Joint Health & Wellbeing Strategy

2019-2024

Contents

Foreword

Sheffield's Health & Wellbeing Board published its first Joint Health & Wellbeing Strategy in 2013. Much good work has been done to deliver on the aims of that Strategy, but in the context of continuing austerity we are seeing disproportionate impacts on the health of those in our city who are worst off.

We know too many people in Sheffield are struggling with poor health and wellbeing, and this is inequitably distributed across our city. We also know that most of the solutions are not to be found within NHS and social care services alone.

Our first Strategy covered the five years up to the end of 2018. Over the last 12 months the Board has substantially reviewed its approach and priorities for promoting health and wellbeing to ensure a wider range of perspectives are incorporated into its work, based on the evidence in Sheffield's Joint Strategic Needs Assessment. We have taken this broader approach into this updated Joint Health & Wellbeing Strategy, which will guide our work for the next five years up to 2024.

The ambitions set out within the Strategy do not represent the totality of our commitment to health and wellbeing. There is much going on in Sheffield already that is essential for improving the health of our population; for example, in the last two years Sheffield made major commitments to reducing smoking and improving access to healthy food. Existing work such as these are not formally part of this Strategy, but remain important and the Board is clear that they and other strategic commitments continue to be delivered on as part of our overall approach.

What this Strategy does do is reflect and reinforce the Board's overarching commitment to reducing, and one day eliminating, health inequalities in Sheffield.

Inequality is bad for everyone: places that suffer from greater inequalities have worse overall outcomes, across all population groups, areas and communities. This makes tackling inequality a whole population issue.

We already have a clear vision for tackling inequalities. In the report of the Sheffield Fairness Commission, published in early 2013, a vision was set out for "a city that is eventually free from damaging disparities in living conditions and life chances", along with an aspiration to be the fairest city in the country. In 2014 this was followed by the publication of our Health Inequalities Action Plan, and in 2015 by the Tackling Poverty Strategy. The actions and principles in that plan are still valid, based as they are on the recommendations of the Marmot Review and the Due North Report. This Strategy represents a continuing commitment to that vision, which remains widely accepted in our city.

Having the right Strategy is only the first step; what matters as much, if not more, is how we deliver it. There is a great deal we can learn from other places on this, in particular on how we can go about embedding our commitment to eliminating health inequalities in everything we do in Sheffield. For example, this could include incorporating wellbeing impacts in our budget decisions, so that they have parity with traditional economic considerations.

If we are to achieve our aim of improving health and wellbeing for everyone, and eventually eliminating health inequalities, every single sector, organisation and community has a role to play. We commit Sheffield's Health & Wellbeing Board to leading a whole city approach to delivering our Strategy.

Cllr Chris Peace & Dr Tim Moorhead, Co-Chairs, Sheffield Health & Wellbeing Board

Introduction: why health inequalities matter

We know that people in poorer parts of Sheffield live shorter lives and have worse health than those in more affluent areas. We also see similar disparities affecting groups with specific shared characteristics, such as people from BAME backgrounds, or people with learning disabilities. These differences and disparities are the health inequalities that exist in our city, and that we see as unacceptable.

It is not right that some people can expect to live a less healthy life because of who they are or where they live. Equally, vibrant and healthy communities produce skilled, happy and productive people, leading to a stronger economy, which benefits everyone.

Inequality is not simply bad for those who are most disadvantaged, it is bad for everyone. This is because in unequal societies, social cohesion is poor, skill levels are low, businesses find it difficult to start up and sustain themselves, support services struggle to meet the challenge of rising demand, and environments are often degraded. Inequality is linked to lower levels of educational attainment, social divides and poverty, which in turn affect everyone's futures because successful economies need skilled healthy people. Health inequalities waste human potential and are a burden on society.

Our goal

Healthy life expectancy is the best overall measure of both health and health inequalities, representing as it does the number of years someone can expect to live in good health. In Sheffield, the gap between the best and worst off is around 20 years. Our goal is therefore:

> ***We will close the gap in healthy life expectancy in Sheffield by improving the health and wellbeing of the poorest and most vulnerable the fastest***

We know this is a long term vision. We cannot expect to close this gap in 10 years, never mind the five years this strategy runs for. It follows from this that we have to think long term, about the things we can do now that will make a difference in 20 years time.

We do not shy away from recognising that this is a generational challenge. There are three components to achieving change on this scale: a long term vision; a medium term strategy; and short term actions. This strategy does the first two of these. It commits us to a vision of a city free from health inequalities, and it sets out ambitions to focus on over the next five years as the first steps to achieving that vision.

The third will follow the strategy. Since no one sector has all the answers to these difficult challenges it is important that people and communities are central to working with services and business to deliver this Strategy. We will convene the system around the ambitions in this Strategy to set out in detail what we are all going to do **together** to achieve them, developing action plans against which we will hold the system to account. We think this is the right approach to deliver our Strategy, and the right one for our city.

A Life Course Approach

We need to focus on the upstream factors, structures and conditions that influence and shape our opportunities for a healthy life, throughout life. The way to do this is to take a Life Course Approach where the emphasis is on healthy ageing from pre-birth through to the end of life and on the range of interventions that support that. This involves looking at the things that support healthy life, and how these change as people age.

We must recognise that most of the poor health experienced in later life is the result of what happened in earlier stages in life. If we do not try to prevent chronic conditions arising or delay their onset, we will always be managing or seeking to ameliorate them. From this point of view, a preventative approach from the beginning of life to death is our keystone.

Our approach to a healthy life is as follows:

- Starting Well – where we lay the foundations for a healthy life
- Living Well – where we ensure people have the opportunity to live a healthy life
- Ageing Well – where we consider the factors that help us age healthily throughout our lives

For each of these we identify three ambitions to focus on over the coming five years. These ambitions have been identified on the basis of local evidence of what is most likely to improve life chances and reduce inequalities, focusing on factors that will support people to be healthy from the start, rather than on intervening once they are unwell.

That is not to say that other activity that improves or protects health and wellbeing is not important. There is much excellent work delivered in Sheffield in this regard that remains vital, such as work around tobacco control, and health protection, to name just two. We remain committed to this work, and will continue to ensure it delivers for the people of Sheffield.

Continuing to deliver on these, and refocusing the city to ensure people are healthy from the start of their lives will mean we can make significant progress towards achieving healthier lives for all the people of Sheffield, and begin our journey towards eliminating health inequalities.

The rest of this Strategy sets out our specific ambitions that we ask the city to implement with us in more detail.

Plan on a Page

This Strategy sets out the Board's view of the critical foundations on which a healthier population, living longer lives, free from health inequalities will be based.

Health, and improvements in health, start from pregnancy and build throughout life to its end.

This life course approach is used to develop a set of ambitions for a healthier city that will make a difference both in the short term and the long term, and that serve to support and reinforce each other.

They can be seen as setting out the Sheffield view of the important elements of a healthy life lived to its fullest extent.

Our ambitions are that:

Starting Well

Children's earliest experiences are the key to their success as adults and the business case for investing in the early years is compelling. The evidence clearly demonstrates that promoting bonding and attachment and protecting babies' brain development provides the best start in life.

Evidence shows that children who do not achieve a good level of development by the age of four, and who continue to face challenges to their ongoing development, are less likely to have acquired the necessary vocational, social and health assets to transition successfully into healthy adulthood.

By addressing all types of childhood adversity and providing families and communities with the capacity, resources and support for children and young people to flourish, we are equipping them to lead healthy, fulfilling lives and to achieve their full potential.

Evidence from our Joint Strategic Needs Assessment suggests that the factors causing childhood adversity and disadvantage are increasing in Sheffield. For example:

- Over a quarter of children and young people are in or at risk of poverty or social exclusion, higher than for the overall population, with 5 wards where over half of children live in poverty;
- Adverse Childhood Experiences (ACEs: stressful experiences such as neglect or abuse), are also common, as they are elsewhere, and lead to long term health and other challenges. Almost half of adults are estimated to have had at least one adverse experience during their childhood;
- Childhood obesity rates are increasing, particularly in the most disadvantaged areas. Economic deprivation is a predictor of obesity and overweight prevalence in 4 to 5 year olds;
- 1 in 10 5-15 year olds have a clinically recognisable mental health disorder and a similar proportion of 0-3 year olds are thought to have a mental health problem. It is estimated that 15,000 Sheffield children and young people live with a parent with a mental health disorder;
- 2 out of 5 children experience insecure attachment, a risk factor for mental health.

Emotional wellbeing and mental health in the early years and families is therefore a key priority. Children facing multiple risks such as being a victim of abuse, living in poverty or poor housing have a heightened risk of multiple and sustained childhood mental health difficulties. Protective factors such as social support and good quality of work and employment conditions can help buffer the impact of adverse conditions on poor mental and physical health.

Bad experiences in childhood can impact on health for the rest of an individual's life. That is why starting well is a priority. The 'Great Start in Life' early years' strategy provides vision and direction for our work and is directly informed by the Infant Mortality and Tobacco Control Strategies.

Our local Future in Mind Transformation plan for children and early years also reinforces the importance of attachment and bonding and the city's ambition to improve perinatal and infant mental health. The focus on school readiness and the development of an Inclusion Improvement Plan also shapes this work.

In making Sheffield an ACE-Aware City we will bring together partners from across all sectors to mitigate the impacts on our most vulnerable families and protect future generations.

Our ambitions for Starting Well

- Every child achieves a level of development in their early years for the best start in life
- Every child is included in their education and can access their local school
- Every child and young person has a successful transition to independence

Every child achieves a level of development in their early years for the best start in life

Children's experiences in their earliest years directly affect their lifelong health, wellbeing and life chances. All children need a supportive and nurturing environment and to be protected from harm - this begins in the antenatal period and should continue throughout childhood.

The Joint Strategic Needs Assessment shows the progress Sheffield has made in improving outcomes and reducing vulnerabilities for children and families: examples include the reduction in teenage conceptions and rates of sudden infant death. Significant inequalities remain within this, however, and these continue to widen. This is our biggest challenge.

We want all children in the city to have the best life chances and families to be empowered to provide healthy, stable and nurturing environments. We want to connect people to the right levels of support at the right time through universal and targeted prevention, early identification and early support. Local communities also play a vital role by offering family activities which promote child development and building parents' confidence, and offering peer support and volunteering opportunities which help build skills and can provide a pathway into employment.

Evidence shows that secure relationships with key adults and established routines in the first months of life are the best way to achieve good outcomes in adulthood. The First 1001 days All Parliamentary Group Report sets out a range of recommendations for re-focussing support around a baby's first two and a half years. These align with Sheffield's plans to develop prevention and collaborative action using both universal and targeted approaches in health care and other services.

Children's earliest experiences have an enormous influence on later life chances. A good start at home and in school will reduce the risk of exclusion, not being in employment, education and training and reduce the risks of loneliness and isolation. Poor maternal health increases the risk of birth complications, adverse mental health and the risk of ongoing problems in adult life. Supporting families to make healthy choices including diet and lifestyle provides the foundation for future health and wellbeing, reducing the risk of multiple long term illnesses and the need for healthcare in later life.

Inequalities in early learning, early achievement, health and wellbeing lead to poorer outcomes for children from disadvantaged homes. We are committed to helping all families get the support they need at the right time and in the right place to help reduce this gap. Children with speech and language and literacy needs should have prompt access to help in schools and nursery education settings.

By developing parents' confidence in their own skills and capabilities and improving access to advice and support through Family Centres, GP practices and other community settings, we can help families to: develop positive and fulfilling relationships with their children; reduce social isolation; and improve resilience, health and wellbeing.

Success will rely on continuing to build effective relationships with key partners in the Council, NHS, Schools, Communities, the Voluntary Sector, the Private Sector and with Parents and Carers.

In particular, strengthening communities by supporting informal groups to do what they do well - for example parent and baby drop-ins, or good neighbour schemes. By doing this confidence is built, social connections are strengthened, and the resilience of individuals, families and communities is enhanced so that people stay well even when faced with adverse circumstances.

Every child is included in their education and can access their local school

An approach to education that addresses the individual needs of each child will benefit everyone within a school community. The school-age population is growing and schools report that they are responding to more children with complex and challenging needs. The link between outcomes and exclusions is life-long and brings long term costs to individuals, communities and the state.

Needs must be identified early and met through high quality, flexible support provided within mainstream settings wherever possible. The Joint Strategic Needs Assessment highlights particularly high exclusion rates in certain communities including Roma, Eastern European and Traveller populations. Sheffield must be an inclusive city where all children and young people, including those with additional needs get the education, health, and care they need to achieve their potential and go on to make a positive contribution to society and lead a fulfilled adult life.

Evidence from the Institute for Public Policy Research illustrates that official exclusions have been rising for the past 3 years and are continuing to rise. Exclusions data are known to underestimate the school exclusion challenge. Although there are other less formal ways to exclude children from education they may still have the same consequences as a formal exclusion. Four priorities for development are identified:

- improving preventative support for young people with complex needs in mainstream schools
- improving the commissioning and oversight of alternative provision for excluded pupils
- increasing and then maintaining the supply of exceptional teachers and leaders into alternative provision
- developing an understanding of 'what works' in improving trajectories for excluded young people.

Children who have been excluded are at greater disadvantage across the life course. They are at greater risk of not being in education, employment or training after the age of 16, and of experiencing loneliness and isolation. Research shows that only 1% of excluded pupils get five good GCSEs, which directly affects their opportunities to access training and employment. Raising awareness of ACEs in the early years will help us to identify families where children are at a greater risk of exclusion.

There is a key connection between socio-economic disadvantage, exclusions and children with special educational needs and/or disability. This can create a cycle of poor health and social outcomes. More co-ordinated early help and targeted support within mainstream settings should lead to improved outcomes and enable all children to reach their full potential. Children and young people not accessing education may find it more difficult to have their health needs identified and met at an early stage.

Children with special educational needs and/or disability, or who are excluded from education are at greater risk of being marginalised or experiencing a mental health problem. This can in itself lead to antisocial behaviour, aggression and substance misuse problems. Meeting needs better at an earlier stage can help to reduce the risks of exclusion, and the negative consequences of being disconnected from a normal school or community environment.

No single organisation can achieve this vision independently. A strong partnership involving the Council, the NHS, LearnSheffield, schools and beyond is essential to create a service which is joined-up, responsive, understanding, fair, and consistent.

Every child and young person has a successful transition to independence

Development in early years and an inclusive education are in large part about setting young people up for success in later life, but we know that the transition from childhood to adult life can be difficult for many. Standing on your own two feet for the first time is a challenge for anyone, and people who have already experienced a disrupted or disadvantaged childhood can find this more difficult than most.

Young people who fall out of education and employment can experience a range of negative outcomes with costs for both individuals and wider society. The case for identifying young people at risk of not being involved in education, employment or training after the age of 16 and developing a range of local actions designed to improve their life chances as a whole is clear.

By strengthening young people's resilience, enhancing educational attainment and building social and emotional skills, they will have a greater opportunity to achieve their full potential and make a positive and rewarding contribution within the community. This in turn will bring positive consequences for their own children by breaking the damaging cycle of deprivation and disadvantage within families.

Research on improving outcomes for young people at risk of these adverse outcomes conducted in Newcastle recommended that a hierarchy of risk should be used to identify the young people with the highest probability of experiencing multiple poor life outcomes. Services should be designed to identify these risk indicators (including those relating to their wider family), and early action taken.

Young people in this group are also vulnerable to a range of poor outcomes in later life, resulting in significant inequality. Looked after children, those with a history of social care involvement and children with disabilities are at particular risk. They are more likely to present as homeless, claim housing benefit, become involved with police, become pregnant at a young age, and are 50% more likely to have a prescription for depression and anxiety, and 1.6-2.5 times more likely to experience poor physical health.

By intervening early it is possible to help build self-esteem and resilience, improve attainment and increase the employment prospects of disadvantaged young people. Our ambition for early development will help address this, particularly where there are difficult family circumstances or children are identified as facing ACEs. Positive engagement with school is also a key protective factor and so our ambition for an inclusive education system will contribute to this too. There should be a focus on providing tailored support for vulnerable young people at key transition points to maximise their life chances and break the cycle of deprivation.

The Council and Sheffield NHS must work together to find ways to jointly commission services including a therapeutic element for young people and/or their families. Social, emotional and mental health issues are increasingly a barrier for young people progressing in education and employment post 16. This work must include health partners, schools, employers and providers of careers advice and the voluntary sector, and is not just about services for young people: it is also about links with and transitions to adult services. Where young people are receiving support from public services, the transition to adult services represents yet another challenge, and one that is currently harder than it needs to be.

In addition, some of this work needs different approaches to the conventional commissioner/provider or services/recipients of services models. An asset based approach values the capacity and skills of people and communities and sees citizens as co-producers of health and well-being not just as recipients of services. It is fundamental to place based strategies.

Living Well

Positive early experiences are vital for children so they are ready to learn, ready for school and given the best possible start in life. What happens in our younger years affects our social circumstances, physical and emotional health as we move into adulthood, a time in our lives when generally we are looking to find meaning and satisfaction through relationships, family life and work.

Those who are most at risk of poor health usually have least access to health-enhancing living and working conditions such as decent housing, a fulfilling occupation and a safe environment. Having access to a warm, comfortable place to live; our work and financial situation; and staying active make a difference to our chances of remaining healthy and well during this time of life and into older adulthood, as well as playing a material role in the development of the next generation.

People with mental illness are more likely to have higher rates of: poverty; homelessness; incarceration; social isolation; and unemployment. Their needs tend to be more complex and urgent including issues such as finances and debt, essential services, housing, employment and the welfare system. Stable, good quality and rewarding employment is protective for health and can be a vital element of recovery from mental health problems. Stable and appropriate housing is another important part of the recovery pathway and can reduce the need for inpatient care.

In Sheffield, people living in the most deprived areas or who have limited choice over where they live, due to low income, lack of available work or disability, are more likely to find themselves in circumstances that have a harmful impact on their health and wellbeing. This can lead to people being cut off from important aspects of life, and a widening of health inequalities in the city.

There are already a number of strategies for Sheffield that set out to improve access to the living and working conditions and environments that support health and wellbeing, such as the Council's Housing Strategy, Economic Strategy, Transport Strategy, and the city's Food, Tobacco Control, and MoveMore strategies, to name just a few.

Designing and providing services that are accessible and enhance people's health are an essential part of preventing health inequalities. This is not just the role of the NHS or the Council. To make a difference, we need to work together across the public and voluntary sector to advocate for health promotion to be considered in strategies for housing, the economy, the NHS, transport and the local environment, and we need to put communities at the heart of decision-making to influence the choices made to improve the places where they live.

The contribution of citizens, users and families to improving health outcomes is central to co-production. It values what works well in an area, it sees the potential of people's knowledge and moves away from a deficit approach to recognising the assets people already have and can contribute to their neighbourhood.

In order to deliver public services with an equal and reciprocal relationship between professionals and people using services, as outlined above, new thinking and training will be required as well as a targeted commitment to work differently.

Our ambitions for Living Well

- Everyone has access to a home that supports their health
- Everyone has a fulfilling occupation and resources to support their needs
- Everyone can safely walk or cycle in their local area regardless of age or ability

Everyone has access to a home that supports their health

No-one in Sheffield should live in a home that damages their health.

Cold housing is a risk to health and those with the poorest health live in the coldest homes. People living in cold homes are far more likely to suffer from illnesses such as asthma, 'flu and bronchitis and it can increase the risk of a heart attack or stroke. In Sheffield, around 5,500 owner-occupied and private rented properties across the city are classed as having an excess cold hazard due to a mix of financial hardship and poor property conditions. 12% of households are living in fuel poverty as a result of low income, high fuel prices and homes which are expensive to heat and run. This contributes to winter deaths, cold-related illnesses, unplanned admissions to hospital and delayed discharge, particularly in older adults. Children in poor housing are more likely to have mental health problems, contract meningitis, have respiratory problems, experience long-term ill health, disability, slow physical growth and delayed cognitive development, giving them a much poorer start in life.

The current shortage of affordable housing is the greatest threat to health for many people if they become homeless or are forced to wait for new homes in unsuitable conditions or in places away from their social networks. There is little competition at the more affordable end of the private rented sector, which can offer poor housing conditions where vulnerable people find it impossible to ensure basic maintenance of the property. Overcrowding is also detrimental to health, in particular mental health. The shortage of affordable housing means a lack of properties for families in the social and private rented sectors. The city needs more affordable homes than are currently being built, in particular for households unable to afford market price. This could include first time buyers on a low income; families seeking homes across all tenure types; vulnerable groups who need accessible or supported accommodation; or people affected by changes in the benefits system.

Home improvements can significantly improve social functioning as well as physical and emotional wellbeing. For example, adequate heating systems improve asthma and reduce the number of days off school. Some private rented homes in the city have a hazard that could pose a serious threat to the health or safety of people living in or visiting the home. It is estimated that the removal of all hazards could provide £13.5 million annual savings to society, including £5.4 million savings to the NHS in Sheffield.

This is not just about the quality and affordability of the bricks and mortar; we also know that homelessness is tied to some of the most significant health inequalities in our city, with homeless people having significantly shorter life expectancy than the rest of the population. Homelessness and tenancy failure can affect all groups: however, some groups are more vulnerable than others including young people, older people, people with mental health issues, people with drug and alcohol problems, people leaving hospital, care leavers, people released from prison, and former members of the armed forces.

In Sheffield, support is focused on preventing people from becoming homeless and helping people to resettle after a period of homelessness. Although homelessness in Sheffield has reduced in recent years, there was an increase in homeless acceptances in 2016-17. In addition, an estimated 9,200 households are likely to be adversely affected by ongoing welfare reforms including the introduction of Universal Credit in Sheffield from November 2018. We need to make sure we have the right type, amount and quality of accommodation to take account of any changes in need.

Everyone has a fulfilling occupation and the resources to support their needs

We know that one of the keys to a happy, healthy and fulfilling life in adulthood is being able to lead the life you want to. Fulfilment means something different to everyone, but having a constructive, meaningful and productive daily life is vital, whether through learning, caring, volunteering, or conventional paid work.

For most people, a good job or volunteering opportunity can significantly improve their life by offering security, rights, personal development, career progression, a supportive environment and a fair income. Equally, being unemployed or unable to work, because of caring responsibilities for example, can restrict people's health and quality of life. We must do all we can to support people who are able and want to find a fulfilling occupation, whether in a paid job or a voluntary role. For children and young people to be prepared for work, they need access to education, training and employment as this will improve their long-term life chances and help them to make a positive contribution to their community and the economy.

Many people find work is important for their mental wellbeing and helps them feel good about themselves, although sometimes problems at work can be a cause of stress. In Sheffield, over half of the people claiming out of work benefits are affected by mental health problems. If people have been out of work for a while, they are likely to need support when they feel ready to return. This could be through rebuilding their self-confidence through voluntary work, a phased return to work, or working with an employer to put in place reasonable adjustments to help them stay in work. As well as supporting people to return to work, preventing others from becoming long-term unemployed or having to leave work due to mental illness is part of maintaining a healthy population.

Work should be a way out of poverty. However, even though the number of households where nobody is working has declined and the employment rate is up, the number of people struggling to make ends meet has increased. Across Sheffield, there are people with multiple jobs, who are in and out of insecure, low hour, temporary employment and struggling to afford even life's basics. In-work poverty is increasing with over half of households in poverty now having someone that is in work. Three-quarters of adults in working families in poverty are themselves working, with female employees as the single largest category in this group. We must also recognise that for many people, a bad job is worse for their health than no job.

For people a long way from the labour market, the contribution of intermediate labour market interventions to develop employability by acting as a bridge between unemployment and work, such as supported employment projects for those with intermittent mental or physical health problems, is particularly important.

Families with children are most likely to be locked in poverty despite being in work, especially lone parents, and in-work poverty is associated with poorer mental health. Because of rising costs and the increasing gap between income and the cost of a minimum acceptable standard of living, low income workers and families are less likely to manage when unforeseen costs hit. In this situation, choices become more restricted – cut back, go without or borrow – leading to further financial problems and detrimental effects on health.

This is not just about getting people into any job or working more hours, which is not possible for some workers. We need to work with employers to create more and better paid jobs with fair contracts. The Sheffield Fair Employer Charter includes the aspiration for employers to exceed the recognised living wage. Longer term, we need to ensure that people have the right training to get on once in work and the opportunity to earn more to improve their living standards and reduce the need for welfare.

Everyone can safely walk or cycle in their local area regardless of age or ability

A physically active lifestyle reduces the risk of cardiovascular disease, diabetes, obesity, osteoporosis and colon or breast cancer, improves mental wellbeing and, in older adults, increases functional capacities. In Sheffield two in every three of those aged 19 and over are physically active. However, one adult in four is classed as physically inactive compared with one in five nationally. Of the Core Cities, we have the second highest percentage of regular walkers with just over half of the 16-plus population walking at least five times a week, but conversely the lowest percentage of regular cyclists with only around 2% of the 16-plus population cycling at least three times a week. Despite the many parks in the city, use of green and open spaces for health and exercise is slightly lower than the national average.

Active travel, such as walking or cycling to school, work or the shops, provides people with daily physical activity and is a sustainable way of getting around the local community. Good street design and lighting can make places easier, safer and more pleasant to move around which can encourage walking and cycling. Road safety has a direct impact on health inequalities so lower speed limits reinforced by other traffic calming measures in local areas can reduce the risk of injury or death for pedestrians making it safer to walk or cycle in their neighbourhood. Providing or designing-in safe, direct walking and cycling routes within a neighbourhood can help people get to work, school or college, as well as recreational facilities, green and open spaces which can have a positive effect on physical and mental health.

More active travel will also help reduce pollution and improve the air we breathe. Poor air quality results in more respiratory conditions such as asthma, higher levels of physical inactivity and higher levels of mortality. In addition, noise pollution such as the noise from traffic is also associated with poorer mental wellbeing and greater levels of stress. People living on lower incomes are more likely to live in high traffic areas and urban centres which discourage walking and cycling so are affected disproportionately.

Walking and cycling is the most likely way that children and adults can achieve increased levels of physical activity. The physical health benefits associated with regular walking include reduced risk of coronary heart disease, cancer, stroke and type 2 diabetes. People living closer to green space are likely to be more physically active than those who do not.

Safe, clean and walkable local environments improve social connections within neighbourhoods, offering places for people to meet and children to play, with resulting benefits to mental and physical well-being. People are more likely to use green space if they think it is safe, well-maintained and easy to reach.

Walking and cycling can help to improve an individual's mental wellbeing including concentration, decision-making and enjoyment of normal daily activities. It can help reduce the feeling of being constantly under pressure. Greater proximity to green space has been associated with lower prevalence of a number of diseases, reduced premature mortality and improved mental health and wellbeing. For some outcomes, particularly mental health, the effect has been shown to be greater for those on lower incomes, demonstrating the potential of access to green space to reduce health inequalities.

Neighbourhoods with safe walking and cycling as standard will contribute to improving air quality, improving poor health, strengthening communities and promoting healthier lifestyles for all.

Ageing Well

Ageing well is something that happens throughout our lives, not just in old age: Starting and Living Well contribute as much if not more to ageing well as anything that happens later in life. Despite this, older age is too often viewed as a societal 'burden', with phrases like 'the demographic time bomb' evoking images of an inevitable, overwhelming and impending health and social care crisis. This sees things incorrectly: the problem is not that older people are a burden, it is that too often we leave ageing well too late in life.

For some people, later life can be marked by disability, dependency and inequality rather than offering opportunities to continue leading a healthy and active life. The experience of later life is therefore deeply divided, especially along the lines of social class, relative deprivation, gender and ethnicity. These factors are strongly associated with the socio-economic conditions that shape earlier life, for example ACEs, low income, or lack of supportive social networks.

Long term ill health tends to be associated with later life and, as a result of population ageing, the need for health services is increasingly shifting from short-term, curative treatment to managing long-term conditions. However the distribution of NHS resources remains focused on the former. The good news is that many of these conditions are preventable or at least can be delayed, through delivering on the ambitions set out above, and by better shaping care and support around people and what matters to them.

Ageing Well is more than a stage in the life course, it is in itself an expression of inequalities in health: not everyone in Sheffield has the opportunity to age well. Our work on health inequalities in Sheffield over the past two decades, documented by successive reports from the Director of Public Health and the Sheffield Fairness Commission, has shown that later life is where health inequalities become most extreme. This can be most starkly seen through older people living isolated lives, with poor mental wellbeing.

For this reason, the Council is developing the concept of a Sheffield Healthy Lifespan, setting a target for all residents of a number of years lived free from chronic ill-health. Whilst the details are yet to be finalised, this target would be a bold step towards eradicating health inequalities in Sheffield and setting an example to other parts of the country.

Our understanding of a healthy life must also include how it ends. Too often, we see people unable to live their last days and weeks where they want to, with their loved ones, and with the support they all need, both at that time and in bereavement. We should see a good end as being as important as a good start.

Our ambitions for Ageing Well

- Everyone has equitable access to care and support shaped around them
- Everyone has the level of meaningful social contact that they want
- Everyone lives the end of their life with dignity in the place of their choice

Everyone has equitable access to care and support shaped around them

It is a common misconception that the ageing population is responsible for inexorable increases in demand for health and social care services. This is not the case: many older people live fully independent lives and the increase in demand for services far outweighs the increase in the number of older people.

The demand is, in fact, due to increasing numbers of people living with one or more long term conditions, and at younger ages. Currently, almost two-fifths of the population in Sheffield has at least one long term condition and almost one-fifth have two or more. The most common conditions are high blood pressure, depression and diabetes. Whilst the prevalence of long term conditions tends to increase with age, this does not mean that age is specifically responsible; indeed many people in this situation are of working age.

Multiple chronic illness has a devastating impact on health and wellbeing outcomes for individuals, is in danger of overwhelming the health and social care system and has a detrimental economic impact on the city when people of working age are rendered unable to work.

Long-term ill health is more common in deprived areas, starts at a younger age and is more likely to include mental health conditions. There is a 15 year gap in the onset of multiple illnesses between the most and least deprived people in Sheffield.

Depression is the second most common condition found in people with chronic conditions, present in two out of every five people. Not only is depression more likely in individuals with a physical long term condition, but the presence of depression makes taking steps to maintain good physical health even harder. Our ambition is therefore to delay and prevent multiple chronic illness, as well as ameliorating the effects.

A key starting point is to understand that a health system designed around hospitals treating people with single episodes of ill-health is not the best response to this challenge. A highly specialised, disease specific approach is not appropriate for people with multiple long-term conditions. Focusing on disease markers for one illness can have a detrimental effect on another and pharmacological interventions can interact with each other producing unpredictable and difficult to manage side-effects. This can end up being a worse experience than the symptoms of the diseases.

A whole population, person-centred approach must be taken to understand what is most important to any given person and how they may be enabled to care for their own health and live a meaningful life within the confines of their illness. This must be done at the community level and we must shift resources accordingly. Primary and community care has for too long been underfunded relative to the rest of the NHS, and this needs to change. The Accountable Care Partnership will be a key partner in delivering on this ambition, but it will be the work of the whole system to truly make it a reality.

Improved outcomes due to the prevention or delay of long-term ill health could be seen as the culmination of all the ambitions related to starting and developing and living and working well. Prevention of multiple chronic illness is everyone's business and must engage all ages across the life course.

Everyone has the level of meaningful social contact that they want

Evidence from the National Loneliness Strategy demonstrates the importance of meaningful social contact and the role it can play in underpinning a healthy and happy life.

Loneliness and social isolation are linked, but are not the same. One way of describing the distinction between the two is that you can be lonely in a crowded room, but you will not be socially isolated. Beyond this, evidence tells us that the most negative impacts happen when these are severe and enduring.

They can affect anyone of any age, and the relationship with health and wellbeing is strong: they have an impact on mortality that is comparable to obesity or smoking, are associated with raised risk of coronary heart disease and stroke, increase the risk of high blood pressure, and are associated with a higher risk of the onset of disability. They affect our mental health and are linked to cognitive decline, increased risk of dementia and depression and risk of suicide.

There is no miracle cure to reduce loneliness; we are all unique as are the factors behind loneliness. We need to focus on identifying the risk factors and taking a person centred, asset based approach to encouraging greater social contact and stronger community networks. Reducing loneliness and social isolation across the life course will improve the health and wellbeing of the whole population. It is estimated that around half of all loneliness experienced is linked to inherited factors and the other half to socio-economic factors. This is good news because it means the risk can be modified, not least because of the strong connections to the other areas set out in this Strategy:

- supportive early development sets us up with the social skills and empathy to sustain relationships;
- an inclusive education offers the opportunity to develop social bonds;
- a fulfilling occupation and resources to live on provide the opportunity to participate in a range of activities and more broadly in the community;
- walkable spaces in communities make it easier for people to mix and maintain relationships;
- loneliness and isolation are linked to a range of long term conditions; and
- people with good social networks are more likely to end their lives in dignity and independence.

Loneliness can be felt by people of all ages, but the likelihood of experiencing loneliness increases with age and there is evidence that ethnic minority elders may be amongst the loneliest. Friendship and loneliness are often significant contributors to young people's self-esteem and emotional wellbeing. Schools participating in our local Healthy Minds Framework model have identified that friendship and loneliness are the significant self-reported issues impacting on emotional wellbeing and mental health for young people. Men and women also respond differently to loneliness and social isolation with older women more likely to admit to feeling lonely. Perhaps not surprisingly, people who live alone are more likely to say they feel lonely and, in particular, this is the case for people who are widowed and living alone. Gay men and lesbians may also be at greater risk of becoming lonely and isolated as they age. The risk of loneliness in Sheffield is inequitably distributed across the city, with greater risk focused around areas of deprivation.

Everyone has an opportunity to make a difference to this, from services incorporating an understanding of risk factors into their delivery, commissioners focusing on the development of assets at the community and individual level to sustain relationships, to voluntary and community organisations working to build and develop links within and between communities. Targeted measures to tackle loneliness by supporting small community organisations, valuing and resourcing volunteering and linking into the intelligence and know-how of the voluntary sector will be pivotal.

Everyone lives the end of their life with dignity in the place of their choice

On average, 14 people die every day in Sheffield. End of life care has a profound effect on individuals, families and friends and staff. It can be a very positive and meaningful experience, wherever someone dies. But delivery of a consistent experience and standard of care that is personalised and responsive to people's needs is not yet the case in Sheffield.

Experience and standards vary according to the type of illness someone has, their personal characteristics and where they live. In Sheffield 7% of people have three or more hospital admissions in the last three months of life. Whilst Sheffield does not perform the worst on this measure, it is by no means the best, and a similar situation exists with regard to access to palliative care services. Evidence tells us that people who receive early palliative support require less specialist care at the end of their life, have better quality of life, experience better mental health, and actually live longer as a result.

Whilst it is said that we are all equal in death, sadly that cannot yet be said for the circumstances in which we die. People living in more affluent areas are more likely to die at home than those living in deprived areas; this is both worse for them, and more costly to provide.

Whilst frailty and chronic diseases such as coronary heart disease are the biggest killers, most people receiving hospice services in particular will have a diagnosis of cancer. Older people, those from black and minority ethnic groups, lesbian, gay, bisexual and transgender people, homeless people or people in secure or detained settings, people with dementia, a learning disability or mental health condition can all experience barriers to good quality care at the end of their life.

Good quality, personalised care at the end of life is the responsibility of the health and care system and the wider community. In order to achieve our ambition of ensuring everyone in Sheffield lives the end of their life with dignity in the place of their choice, we need to embed the six End of Life Care ambitions:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

We also need to consider those who are left behind. This relates both to the immediate aftermath of someone's death, such as in relation to funeral costs which can be a major source of difficulty for many people, and to the need for support and help that families have in dealing with the longer term effects of bereavement.

A good end to life should be seen as being as important as a good start, and there is a role for all partners and communities in delivering this.

Delivering on our ambitions

As we said in the introduction, our ultimate goal of reducing the gap in healthy life expectancy is a generational mission. This Strategy is focused on the foundations for achieving that goal, that are each major ambitions in themselves. It does not make many specific commitments about precisely what we need to do to achieve them, and deliberately so.

The ambitions set out in this Strategy are intentionally stretching, and we cannot pre-judge all the activity that will be necessary to achieve them. Reaching our ambitions will require not just the insight, commitment and action of the partners around the Health & Wellbeing Board, but that of all partners and stakeholders across Sheffield. In producing this Strategy, the Board commits to focusing its attention on these ambitions, using its time and resources to challenge the system in Sheffield to agree together what needs to change to get there, and then work together to do just that.

The Board's role in this will be to convene those conversations, to challenge the system to develop action plans, and then to hold all partners in Sheffield to account for delivering on the commitments they make. We will use already scheduled Board meetings for this, and run additional events wherever necessary to ensure the development of these plans is as inclusive as possible.

Through this work we will establish:

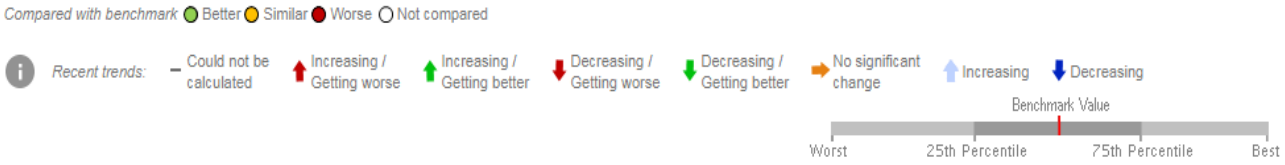
- A set of action plans, developed with and owned by all stakeholders, setting out clearly what we need to do in Sheffield to deliver on our ambitions; and
- A set of measures, tied to and developed alongside those action plans, that the Board will use to ascertain whether the necessary change and progress is being delivered.
- An active programme of engagement (with partners in the voluntary and community sector, including Healthwatch) to enable the assets and energy of communities and citizens to be central to this Strategy.

To support this work and ensure it is focused correctly, we will engage on an ongoing basis across the city on the question of what it is to be healthy in Sheffield, feeding what we hear back from the people of Sheffield into our thinking and the work that flows from this Strategy.

Beyond this, the Board will use its position as a statutory committee of the local authority to advocate for change wherever necessary, both within the Sheffield system and upwards to central government.

Outcome measures

The Board will continue to monitor the overall health and wellbeing of Sheffield, but this represents an assessment of health rather than an assessment of the success of this strategy. The following indicators are taken from the Marmot Review and are based on the wider determinants of health and wellbeing across the life course whilst providing context and direction for tackling health inequalities.



Indicator	Period	Sheffield			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Healthy life expectancy at birth (Female)	2014 - 16	–	-	57.5	61.5	63.9	54.6		71.1
Healthy life expectancy at birth (Male)	2014 - 16	–	-	60.4	61.3	63.3	54.3		69.9
Life expectancy at birth (Female)	2014 - 16	–	-	82.6	82.4	83.1	79.4		86.8
Life expectancy at birth (Male)	2014 - 16	–	-	79.0	78.7	79.5	74.2		83.7
Inequality in life expectancy at birth (Female)	2014 - 16	–	-	8.6	-	-	-	-	-
Inequality in life expectancy at birth (Male)	2014 - 16	–	-	9.9	-	-	-	-	-
People reporting low life satisfaction	2016/17	–	-	5.2%	5.1%	4.5%	-	*Insufficient number of values for a spine chart*	-
School readiness: Good level of development at age 5	2016/17	↑	4,578	69.8%	68.8%	70.7%	60.9%		78.9%
School readiness: Good level of development at age 5 with free school meal status	2016/17	↑	817	55.1%	53.2%	56.0%	43.9%		70.7%
GCSE achieved 5A*-C including English & Maths	2015/16	–	2,879	54.0%	55.9%	57.8%	44.8%		74.6%
GCSE achieved 5A*-C including English & Maths with free school meal status	2014/15	–	247	27.6%	28.5%	33.3%	20.5%		60.0%
19-24 year olds not in education, employment or training	2017	–	-	-	13.3%	13.2%	-	*Insufficient number of values for a spine chart*	-
Unemployment	2017	–	17,200	6.0%	5.0%	4.4%	10.3%		1.7%
Long term claimants of Jobseeker's Allowance	2017	↓	2,522	6.6*	4.7*	3.5*	13.3		0.7
Individuals not reaching the Minimum Income Standard	2013/14 - 15/16	–	-	-	31.9%	30.3%	-	*Insufficient number of values for a spine chart*	-
Work-related illness	2014/15 - 16/17	–	-	-	4490	3980	-	*Insufficient number of values for a spine chart*	-
Fuel poverty	2016	↑	28,658	12.2%	12.1%	11.1%	17.0%		6.5%
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	–	-	15.3%	17.5%	17.9%	5.1%		36.9%

As noted above, just as the actions to deliver on our ambitions must be developed with the system, so must the success measures. We will work with the rest of the Sheffield system to develop robust approaches to judging whether we have achieved our ambitions, and commit to publishing regular updates on our progress against them.

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	6th December 2018
Subject:	Background Paper **-** Draft Joint Health & Wellbeing Strategy 2019-24
Author of Report:	Dan Spicer, 0114 273 4554

Summary:

This paper sets out the draft refreshed Joint Health & Wellbeing Strategy to cover the period 2019-23, and asks the Board to advise on its future development ahead of its planned agreement at the Board's March public meeting.

Questions for the Health and Wellbeing Board:

1. Are the board content with the specific wording of each ambition statement?
2. Are the board content with the development of the substance underpinning the ambitions?
3. Do the Board feel the strategy properly addresses mental health and wellbeing, and healthy communities, and other issues that cut across the life course?
4. Are the Board content with the proposed approach to implementation and measurement?

Recommendations for the Health and Wellbeing Board:

- That the Board formally agree the wording of the proposed ambitions
- That the Board commit to further engagement and development of the strategy for agreement at the March meeting

Background Papers:

- Draft Health & Wellbeing Strategy 2019-23

What outcome(s) of the Joint Health and Wellbeing Strategy does this align with?

N/A

Who have you collaborated with in the writing of this paper?

Health & Wellbeing Strategy Editorial Group

DRAFT JOINT HEALTH & WELLBEING STRATEGY 2019-23

1.0 SUMMARY

1.1 This paper sets out the draft refreshed Joint Health & Wellbeing Strategy to cover the period 2019-23, and asks the Board to advise on its future development ahead of its planned agreement at the Board's March public meeting.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 The Joint Health & Wellbeing Strategy represents the Health & Wellbeing Board's considered view on the best strategic approach to improving the health and wellbeing of Sheffield's population. Once approved it will frame and drive the Board's work, and be the lens through which it examines and holds accountable the health and wellbeing system in the city.

3.0 THE WORK SO FAR

3.1 In September, the Health & Wellbeing Board received a paper setting out a proposed approach to developing a refreshed Joint Health & Wellbeing Strategy for Sheffield. This paper set out an approach that:

- Focused on reducing health inequalities across the city by improving the health of the most deprived the fastest;
- Used a life course to describe a set of 9 ambitions that if delivered would lay the foundations for that reduction; and
- Would describe the ambitions but not the delivery mechanisms, with these to be developed in partnership with the rest of the city following publication of the Strategy.

3.2 The paper also set out an approach to producing the Strategy that was guided by the Board, but actively engaged with the rest of Sheffield to test and refine the content. To this end it was agreed that the Board would receive an initial rough draft of the Strategy at its October Strategy Development session, with a public first draft to be produced for its December public meeting, based on feedback from the Board and from broader engagement. This paper introduces that updated draft.

4.0 THE DRAFT STRATEGY

4.1 As agreed at the Board's September meeting, the Strategy sets out a generational target of reducing health inequalities in Sheffield, described as committing to:

Closing the gap in healthy life expectancy in Sheffield by improving the health and wellbeing of the poorest and most vulnerable the fastest

4.2 This is described as generational because there is an acceptance that such a goal cannot be achieved within the life of the Strategy; it is a 20-year vision, not a five year vision.

4.3 The Strategy describes the Board's view of the critical foundations that must be laid for achieving this vision. These reflect those discussed at the Board's September meeting, but have been developed and refined further through engagement with board members and a range of stakeholders across Sheffield.

4.4 These foundations are set out as ambitions for the city, and broken into three Life Course stages. The ambitions are that:

Starting & Developing Well

- Every child in Sheffield achieves the level of development needed in their early years to provide the foundation for a healthy life
- Every child is included in their education and can access their local school
- Every young person in Sheffield is equipped to be successful in the next stage of their life

Living & Working Well

- Everyone in Sheffield has access to a home that supports their health
- Everyone in Sheffield has a fulfilling occupation and the resources to support their needs
- Everyone in Sheffield can safely walk or cycle in their local area regardless of age or ability

Ageing & Dying Well

- A decisive shift of resources from acute hospital settings to preventative primary and community settings
- Everyone in Sheffield has the level of meaningful social contact that they want
- Everyone in Sheffield lives the end of their life with dignity in the place of their choice

4.5 It is important to recognise that this document remains a draft, and is expected to develop further between now and its intended agreement in March. Officers will continue to engage with stakeholders in the system as part of this process, seeking to ensure broad buy-in to the Strategy.

5.0 DELIVERING THE STRATEGY

5.1 As proposed in the September paper, the Strategy does not go into detail on how these ambitions are to be achieved. The intention of the Strategy is to develop a city position on the critical things that matter for improving the health of the population and reducing health inequalities. Designing the required activity to achieve these is the business of all partners in Sheffield, not just those around the Health & Wellbeing Board table; it is proposed that the role of the Board be to convene and lead the development of these plans.

5.2 Similarly, there is no attempt to set out specific measures for assessing success. This is not to say that these are not important: they clearly are. However, discussions with a range of stakeholders have suggested that determining success measures ahead of agreeing activity would have the affect of skewing those discussions, focusing them on what we intend to measure, not necessarily what needs to be done.

5.3 To this end, it is proposed that following its agreement, the Board should make the Strategy the driving force behind its work, with a programme of work from March 2019 onwards to develop action plans, and a commitment to challenge the rest of the system on their contribution to reducing health inequalities and to meeting the ambitions in the Strategy.

5.4 With this in mind, it would be helpful for the Board to confirm the precise wording of the ambitions to aid development of the Strategy towards its intended agreement in March, either along the lines set out in the current draft, or in agreed amended versions.

6.0 QUESTIONS FOR THE BOARD

6.1 Are the board content with the specific wording of each ambition statement?

6.2 Are the board content with the development of the substance underpinning the ambitions?

6.3 Do the Board feel the strategy properly addresses mental health and wellbeing, and healthy communities, and other issues that cut across the life course?

6.4 Are the Board content with the proposed approach to implementation and measurement?

7.0 RECOMMENDATIONS

7.1 That the Board formally agree the wording of the proposed ambitions

7.2 That the Board commit to further engagement and development of the strategy for agreement at the March meeting

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HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Rebecca Joyce, ACP Programme Director
Date:	Thursday 28 March
Subject:	Quarterly Update Against the Care Quality Commission Local System Review
Author of Report:	Rebecca Joyce, ACP Programme Director

Summary:

This report aims to provide an update on progress against the Care Quality commission (CQC) Local System Review submitted in July 2018.

This is the third quarterly update of progress. An earlier version of the report was by the Health and Well-Being Board on 31/1/2019 and Accountable Care Partnership (ACP) Board on 27/2/2019. It has been considered by various partner boards through February and March.

Alongside system ownership through the ACP, each organisation has identified an executive lead for their organisation. That individual is responsible for ensuring actions for each partner are appropriately governed within organisations.

Questions for the Health and Wellbeing Board:

Health and Well-Being Board are asked to consider whether this provides sufficient assurance on progress against the CQC Local System Review Action Plan.

Recommendations for the Health and Wellbeing Board:

We need to be sure this action plan is a vehicle for change, rather than a process we move through. In particular this requires bold action to tackle the areas of concern outlined.

HWB Board are asked to debate the points outlined and:

- Note the areas of good practice

- Outline any further points they wish the ACP to consider relating to how they are addressing the areas of concern.

Background Papers:

In 2018, Sheffield was one of twenty areas chosen by CQC for a Local Area Review because performance was not as good as many other parts of the country on a number of measures, including delayed transfers of care.

The action plan focuses on improving and accelerating progress on the following themes:

- A way of working that is built around acknowledging and improving older people's views and experiences and which drives a citywide vision (sections 1 and 2 of the action plan).

- A shared citywide workforce strategy to support front-line staff in delivering this vision and in particular further develops multi-agency working (sections 3 and 4 of the action plan).

- Developing clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for our Voluntary, Community and Faith sector (sections 5 and 6 of the action plan).

- A meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability (sections 7 and 8 of the action plan).

- A strong system focus on enabling the right support from the right person in the right place at the right time, to give the best possible experience (section 9 of the plan, covering the Why Not Home Why Not Today Work)

The CQC have indicated their intention to return to care economies to review whether their recommendations have been implemented and care has improved.

Two appendices accompany this report:

Appendix 1 – Line by line progress report against CQC LSR Action Plan
Appendix 2 - Why Not Home Why Not Today Dashboard

The original report from the CQC can be found here:

https://www.cqc.org.uk/news/releases/sheffield-cqc-publishes-its-review-how-local-health-social-care-systems-work-together

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What outcome(s) of the Joint Health and Wellbeing Strategy does this align with?

- This paper fits with the "Ageing Well" chapter of the refreshed Health and Well-Being Strategy

Who have you collaborated with in the writing of this paper?

- Members from all 7 partners of the ACP, responsible for individuals actions within the action plan

Quarterly Update on Progress Against the CQC Local System Review – Health and Well-Being Board

1.0 SUMMARY

This report aims to provide an update on progress against the CQC Local System Review submitted in July 2018.

An earlier version of the report was by the Health and Well-Being Board on 31/1/2019 and ACP Board on 27/2/2019. It has been considered by various partner boards through February and March.

Alongside system ownership through the EDG, each organisation has identified a director lead for their organisation. That individual is responsible for ensuring actions for each partner are appropriately governed within organisations

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

In 2018, Sheffield was one of twenty areas chosen by CQC for a Local Area Review because performance was not as good as many other parts of the country on a number of measures, including delayed transfers of care.

The report highlighted that the experience older people receive in the care system in Sheffield could be improved. All partners have accepted the recommendations of the report and are working collaboratively to make improvements.

3.0 MAIN BODY OF THE REPORT

3.1 The action plan focuses on improving and accelerating progress on the following themes:

A. A way of working that is built around acknowledging and improving older people's views and experiences and which drives a citywide vision (sections 1 and 2 of the action plan).

B. A shared citywide workforce strategy to support front-line staff in delivering this vision and in particular further develops multi-agency working (sections 3 and 4 of the action plan).

C. Developing clearer governance arrangements to ensure stronger joint-working between organisations and greater involvement for our Voluntary, Community and Faith sector (sections 5 and 6 of the action plan).

D. A meaningful shift to prevention at scale, supported by clear commissioning arrangements and digital interoperability (sections 7 and 8 of the action plan).

E. A strong system focus on enabling the right support from the right person in the right place at the right time, to give the best possible experience (section 9 of the plan, covering the Why Not Home Why Not Today Work)

3.2 The CQC have indicated their intention to return to care economies to review whether their recommendations have been implemented and care has improved.

Two appendices accompany this report:

Appendix 1 – Line by line progress report against CQC LSR Action Plan
Appendix 2 - Why Not Home Why Not Today Dashboard

The summary below outlines where good progress is being made, and areas of the action plan which require further focus.

3.3 Areas of the Plan Progressing Well

A. The system has achieved significant improvement on DTOC through close collaborative working and efforts of all parties comprising the Why Not Home Why Not Today group. The Why Not Home Why Not Today Board look at a wide set of metrics, to track their progress, a short summary is shown in Appendix 2. The charts show improvement with DTOC performance both in terms of delayed patient and delayed day volumes. Chart 1 in Appendix 2 demonstrates volumes of delayed days are now only marginally above the NHS England target of 3.5% of beds being occupied by DTOCs. DTOC actual numbers are at 55 (as at 18.3.2019), above the 45 NHS England target but with plans to bring down these increases to below 45, a position sustained from mid-December to end of January. Slight increases have continued to be effectively managed to ensure lower numbers than the same period last year. Additional system wide patient experience data (via the Healthwatch ACP work) will be built into this report, building on the patient stories shared by clinicians. Workforce metrics will also be incorporated as the workforce strategy work further develops.

B. The efforts to develop a system wide workforce strategy with staff and patients are developing well. Partners have come together in a Steering Group, working with GE Finnamore. Good progress is being made, 2 large scale workshops with patients and staff were held in December and January. Next Steps

   - Modelling of Band 2 (or equivalent) staff and using the WRAPT workforce modelling tools to do some projections for the future.

   - All partners are working together to develop the strategy for the April deadline.

C. Patient experience leads are coming together across the system to take a more holistic view of the user experience through our system. Practical actions have been implemented, supported by Healthwatch now working 3 days into the ACP. Actions taken include: a patient panel has been recruited to for the ACP, a number of workshops have been held with service users and the public and a process of “semi structured interviews” are commencing to get whole system service user view on an

ongoing basis. All of this will inform the city wide ACP strategy, the workforce strategy for Older People and the changes to the system care model that we have committed to within the CQC action plan.

D. All governance actions are now completed – including clarification of role of ACP with Health and Wellbeing Board & decision around an independent chair.

3.4 Areas of Concern

The key areas of concern considered by the ACP Board in February 2019 are:

A. Whilst good progress has been made on DTOC (see all tasks under section 9 of the action plan) the ACP Board needs to consider confidence levels on sustainability. At EDG in January the CCG, STH and SCC CEOs acknowledged there was a greater degree of confidence in the sustainability of DTOC improvement linking back to key pieces of work such as utilising off site beds since the Robert Hadfield wing closure and good liaison with the private sector. A 2 page summary has been developed outlining a shared system understanding behind the improvement. It was recognised that Easter may represent the next significant challenge and CEO and COO leaders plan to pay close attention to this position.

B. There is considerable ambition around the implementation of new models of care, following the move towards integrated commissioning (see tasks references 7.1 – 7.4 in the plan). In the CQC plan we have committed to an end of March deadline for agreeing recommendations for the new model of care and being ready to mobilise by April 2019. This includes scaling up successful pilots etc. This timescale is very ambitious and risks not being achieved. There are several actions we need to agree

    - Bringing provider and commissioner discussions together on new models of care for Frailty/ Older People/ “Patients at Risk of Admission” – EDG agreed it should explicitly confirm next steps to bringing these conversations together & reaching decisions). This discussion took place on 25/2/2019 at EDG and is being further built upon.

    - We then will need to quickly make decisions on resourcing implementation and acting quickly to mobilise these models for winter 19/20.

    - The larger strategic commitment to joint commissioning across CCG and SCC is also cited in the action plan (reference 8.2).

C. Whilst the workforce strategy for Older People is going well, we are not yet set up to be confident on the delivery of an integrated workforce strategy. CEOs have committed to consider both leadership and capacity arrangements for this across the system.

D. In the plan we committed to reviewing digital inter-operability in the city. This business case is underway, but will require commitment from all partners and needs close ACP Executive Delivery Group (EDG) attention. EDG in January agreed to develop a proposal outlining what a broader digital workstream needs to look like, with digital leadership for the ACP to be fully considered. There is a particular

challenge on how we mobilise these cross system digital developments, alongside often significant internal operational digital agendas.

E. We committed to a new relationship with the voluntary sector in our action plan (see tasks 5.1-5.3). We agreed to consider how to “enable the VCF to have capacity to provide strategic leadership to the ACP and be a full partner”. We have not reached agreement on what this looks like.

3.0 RECOMMENDATIONS

We need to be sure this action plan is a vehicle for change, rather than a process we move through. In particular this requires bold action to tackle the areas of concern outlined. HWB Board are asked to debate the points outlined and:

3.1 Note the areas of good practice

3.2 Outline any further points they wish EDG to consider relating to how they are addressing the areas of concern.

CQC Local Services Review Action Plan
Produced by Becky Joyce
Dated: 25.1.2019

Appendix 1

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
1	**CQCLSR18.19-01**	**A Shared City Wide Vision**	**A Shared city wide vision for older peoples care, developed and shared between service users, carers and families, the wider population and frontline staff across the NHS, Council and voluntary sector**										
1.1	CQCLSR18.19-02	1.1 Vision for Older People Across the City	Articulate, share and develop the vision for older people across the city and hold a series of workshops to further develop this and a level delivery plan to support the work.	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Rebecca Joyce ACP	25/1/2019 5 public and staff workshops planned 28/1/2019 - 8/2/2019. Developing overall strategy, Older People one of 5 key priorities. Further staff and partner events being organised. Older People workforce workshops completed - links to changing care model/ overall strategy. 31/10/2018 - Progress Since July - Good. Plan agreed and workshops to be delivered in Jan 2019 as part of wider ACP vision/plan development. 25/09/2018 - The approach will be discussed and agreed
2	**CQCLSR18.19-03**	**Ensuring Older Peoples Views and Experiences become integral to our approach**	**Improvement in self-reported satisfaction from older people and family carers in receipt of health or social care support**										
2.1	CQCLSR18.19-04	2.1 Develop a Comprehensive Approach to becoming Person Centred City	Working with communities and system representatives to develop a comphrehensive appraoch to becoming a Person Centred city across our health and care system across Sheffield. This will focus on "What Matters to ME" and bring together linked work such as Health Conversations, For Petes Sake, and the Alzheimers society - This is Me tool to identify the personalised needs of older people	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Nicki Doherty, CCG/ Jane Ginniver, ACP / Susan Hird SCC	Jan 19: Good strategic support for embedding Person Centred care throughout Older People's workforce strategy. Not yet developed into a system wide plan. Has been built into Liminal Leadership approach. Remains pockets of good practice, not yet systematic approach. No clear plan yet determined. As part of workforce strategy delivery plan, capacity to take this forward needs to be determined.
2.1.1.	CQCLSR18.19-05	2.1.1 Strategic Agreement	Strategic Agreement to scaling up work and a tangible plan at July 2018 EDG	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Nicki Doherty, CCG/ Jane Ginniver, ACP / Susan Hird SCC	Jan 19: Strategic commitment secured. Growing good practice - plan required.
2.1.2	CQCLSR18.19-06	2.1.2 Developing Joined Up Training Plans	Developing joined up training plans to scale up this work and techniques	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Workforce Group	25.1.2019 Older People workforce strategy workshops completed. Joined up trained key theme. Strategy to be developed by April. Implementation plan will be critical - need clear vehicle to deliver plan.
2.1.3	CQCLSR18.19-07	2.1.3 Working in partnership with the voluntary sector	Working in partnership with the voluntary sector to benefit from their considerable expertise in this area	Task	0 Days	01/10/2018	31/12/2018			Open	Green	Rebecca Joyce ACP	25.1.2019 VAS now part of the ACP. Part of all work, VAS colleagues member of the workforce steering group. Review what recommendation is.

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
2.2	CQCLSR18.19-08	2.2 Individual Patient Case Studies & Review end to end studies	Take a set of individual patient case studies and review end to end experience of our health and care system. Consider what could be better and does our action plan sufficiently address these cases and agree any additional actions.	Task	6 Months	01/10/2018	31/12/2018			Open	Green	Sue Butler, STH	25.1.2019 "Listen and learn" semi-structured conversations with patients planned to gather whole pathway experience, all partners supporting this approach. 31/10/2018 - Group Met. Individual cases being reviewed across organisations. Action plan to commence from end of December in line with commitments described 25/09/2018 - Meeting to be set up end of October 18. Action plan to commence from end of December in line with commitments described. Accountable by Executive Delivery Grp Patient experience leads taking forward
2.3	CQCLSR18.19-09	2.3 Implement an approach to engagement	Agree and implement an approach to engagement and co-design with Health watch and voluntary sector that builds on good examples within the city (ie Test beds, MASK) and build capacity and capability across local health and care services to effectively involve local people	Task	0 Days	01/07/2018	30/09/2018	31/10/2019		Open	Green	Rebecca Joyce ACP, Margaret Kilner, Healthwatch	25.1.2019 Laura Cook from Healthwatch working 3 days into the ACP team. Public engagement events taken place for improving Older People's Experience in Care. Advisory Panel of patients recruited with first meeting February. "Listen and Learn" structured interviews taking place Jan/ Feb. Healthwatch agreeing with partners approach to generating approach to capturing "holistic" experience. Work being connected into WNHWNT work.
2.4	CQCLSR18.19-10	2.4 Develop Regular Mechanisms	Develop regular mechanism to systematically share and learn continuously from older peoples end to end feedback as part of our evaluation and monitoring mechanism in relation to capturing and responding to system wide patient experience. This will be facilitated by vibrant quality improvement approaches across the system	Task	0 Days	01/10/2018	31/12/2018			Open	Green	Rebecca Joyce ACP, Margaret Kilner, Healthwatch	Jan: See above - advisory group and ongoing semi-structured interviews. 31/10/2018 - Group Met. Individual cases being reviewed across organisation. Action plan to commence from end of December in line with commitments described 25/09/2018 - Meeting to be set up by end of Oct 18. Action plan to commence end of Dec 18 in line with commitments described. Patient Experience Leads taking forward. Accountable by Exec Delivery Group
2.5	CQCLSR18.19-11	2.5 System Theme Feedback	Ensure system themes from older peoples feedback is shared with and built into training and development plans for our workforce to ensure a tailored and responsive approach	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Workforce Group	25.1.2019 All feedback to be brought into the workforce strategy process. Patients involved directly in this work. 31/10/2018 - Will emerge through 12 week workforce strategy plan Accountable body: Workforce ACP Workstream 25/09/2018 - Feedback into workforce training plan limited. Accountable by Workforce ACP work stream
3	**CQCLSR18.19-12**	**Develop a Joined Up City-Wide Strategy for the Workforce**	**A joined up approach to ensure that Sheffield is an attractive place to work in health and care. A Joined up approach to tackling some of the shared recruitment and retention challenges with the older peoples workforce. A Joint approach to improving quality so that staff working across health and care have the tools they need put "What Matters to You" into action. A Joined up vibrant training programme to support and**										
3.1	CQCLSR18.19-13	3.1 Establishment of a Workforce Oversight Group	Establishment of a workforce oversight group to steer the development of a strategy to be co-designed with frontline staff across the city.	Task	0 Days	01/10/2018	31/12/2108			Open	Green	Workforce Group	5/1/2019 Group steering 12 week process. 2 co-design workshops completed, rich outputs for strategy. 31/10/2018 - Plan for approach agreed and now mobilising. 1st system wide workshop 18th December. Each partner is providing leadership capacity to support delivery alongside consultancy 25/09/2018 - Consultancy Commission Issued. GE Finnamore to provide support. Details of mobilisation awaited, due 4.9.18. Steering Group meeting planned for late Sept. Plan for approach agreed in principle.
3.2	CQCLSR18.19-14	3.2 Analysis of Workforce Data and Planning of Engagement Workshops	Analysis of workforce data and planning of engagement workshops	Task	0 Days	01/10/2018	31/12/2018			Open	Green	Workforce Group	25/1/2019 - data collected from partners. Workforce modelling with data commencing, focusing on Band 2 level staff across system (carers/ support workers etc). 31/10/2018 - Plan for approach agreed and now mobilising. 1st system wide workshop 18th December. Each partner is providing leadership capacity to support delivery alongside consultancy 25/09/2018 - Consultancy Commission Issued. GE Finnamore to provide support. Details of mobilisation awaited, due 4.9.18. Steering Group meeting planned for late Sept. Plan for approach agreed in principle.

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
3.3	CQCLSR18.19-15	3.3 Workshops to Develop Strategy Using Data Input	Workshops to develop strategy using data, input of front line staff and views of local older people	Task	0 Days	01/10/2018	31/12/2018			Open	Green	Workforce Group	25/1/2011 9 -2 workshops completed December and January. All outputs to be brought together into single strategic approach. 31/10/2018 - Plan for approach agreed and now mobilising. 1st system wide workshop 18th December. Each partner is providing leadership capacity to support delivery alongside consultancy 25/09/2018 - Consultancy Commission Issued. GE Finnamore to provide support. Details of mobilisation awaited, due 4.9.18. Steering Group meeting planned for late Sept. Plan for approach agreed in principle.
3.4	CQCLSR18.19-16	3.4 Publication of overall city wide strategy for workforce	Publication of overall city-wide strategy for workforce, with a focus on older people that is co-designed and connects the front line and the strategic vision. This needs to incorporate the private sector, voluntary and community sector as well as the statutory organisations. We will involve unions across Sheffield in the approach	Task	0 Days	01/01/2019	31/03/2019			Open	Green	Workforce Group	25/1/2019 - see above. On track for April draft. 31/10/2018 - Plan for approach agreed and now mobilising. 1st system wide workshop 18th December. Each partner is providing leadership capacity to support delivery alongside consultancy 25/09/2018 - Consultancy Commission Issued. GE Finnamore to provide support. Details of mobilisation awaited, due 4.9.18. Steering Group meeting planned for late Sept. Plan for approach agreed in principle.
3.5	CQCLSR18.19-17	3.5 Key Work Force Initiatives identified in the Place Based Plan	Progress the key workforce initiatives identified in the Place Based Plan	Task	0 Days	01/10/2018	31/03/2019			Open	Amber	Workforce Group	25/1/2019 No Further Update31/10/2018 - Progress since July: Part of Wider Workforce Strategy Work - will be part of workforce strategy plan. Capacity: SCC Business Partner work to Mark Bennett, HR OD Director 25/09/2018 - Plan work on this as part of workforce strategy. Arrangements for Steering group agreed, Strat Dev Proposal exp from Finnamore 4.9.18. Capacity SCC Bus Partner, wking with Mark Bennett HR OD Director
3.6	CQCLSR18.19-18	3.6 Embed a Training Module on Person Centred Care	Work with provider, voluntary and education partners to embed a training module on person centred care as part of the What Matters to You initiative	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Nicki Doherty, CCG/ Jane Ginniver, ACP / Susan Hird SCC	25/1/2019 - implementation plan still needs to be determined - needs to be worked into strategy implementation approach. 31/10/2018 - No update from last time 25/09/2018 - Person Centred Training to be part of overall Person Centred Care Plan. Part of overall person centred proposal to be developed following EDG discussion. Capacity PC team, Susan Hird and colleagues
4	**CQCLSR18.19-19**	**A City Wide Organisational Development Approach**	**Improved multi-agency working for older people.** **Improved pathways and communication between different services and parts of the systems.** **More seamless care for older people** **High job satisfaction**										
4.1	CQCLSR18.19-20	4.1 Develop Organisation Development Interventions	Develop organisation development interventions to support and improve multi-agency working between frontline inter-agency teams	Task	0 Days	01/10/2018	31/12/2018			Open	Green	Maddy Ruff, CCG	25/1/2019: Neighbourhood based "liminal leadership" cohort 2 to commence March. Promote MDT working. 1/10/2018 - Progress since July: Plan agreed at EDG on 9th Oct. OD Workstream now mobilising plan to commence Jan 2019. ACP Wide plan but will incorporate Older People Focus. 25/09/2018 - OD Workstream refining plan for discussion at EDG Oct 18. ACP Dep Director to commence 17/09 OD Capacity will need to be released from each organisation to support. Accountable: Exec Del. Group
4.2	CQCLSR18.19-21	4.2 Develop Improved System Leadership Behaviours	Develop improved system leadership behaviours and attitudes at all levels to develop collective leadership approaches across the city. First stage will to be build q plan as agreed by Organisational Development ACP workstream . This will build on the Liminal Leadership pilot delivered in Q1 2018/19	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Maddy Ruff, CCG	25/1/2019 - "Leading Sheffield" work commencing. Other work for tiers of leadership need to be developed. 31/10/2018 - Progress since July - Plan agreed at EDG on 9th October. OD Workstream now mobilising plan to commence Jan 2019. ACP wide plan but will incorporate Older People focus. 25/09/2018 - OD Workstream refining plan for discussion at EDG Oct 18. ACP Dep Director to commence 17/09 OD Capacity will need to be released from each organisation to support. Accountable: Exec Del. Group

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
4.3	CQCLSR18.19-22	4.3 A Single Quality Improvement Approach	Working towards a single quality improvement approach across health and social care	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Mark Bennett SCC, Jane Ginniver ACP, Maddy Desforges VAS	25/1/2019 SCC and VCSE have committed to this but not yet happening. 31/10/2018 - Progress since July: Singe Q1 approach - Discussions commenced with SCC and VCSE. Plan - Ongoing discussions. 25/09/2018 - Single Q1 approach- awaiting update from SCC/MCA. Need clarity on next steps. Capacity Person Centred Team. Accountable: Exec Delivery Group
4.4	CQCLSR18.19-23	4.4 Build on System Wide Improvement Programmes	Build on and accelerate specific system wide improvement programmes for pathways within the ACP requiring improvement including: A Continuing healthcare processes B End of Life Care	Task	0 Days	01/07/2018	30/09/2018			Open	Amber	Chief Nurses	25/1/2019 - Good progress on CHC - shared values and behaviours agreed and improvement programme. EOL??? 31/10/2018 - Progress since July: System Wide EOL Work. CCG leading work to refresh current actions and address CQC concerns 25/09/2018 - Good progress on CHC work across SCC/SCCG. Joint Training, SOP delivered. System Wide EOL not yet defined. Case for change considered Oct for overall prog. of work. Disc re shared budget ongoing
4.5	CQCLSR18.19-24	4.5 Develop a Learning Culture	With the first step a process that shares and reviews incidents, risks complaints and patient, family and carer experience across the system and routinely undertakes joined up system wide analyses and investigations, including root cause analysis where appropriate	Task	0 Days	01/07/2018	30/09/2018			Open	Green	Sue Butler, STH	25/1/2019 - complaint reviewed on whole system basis and commitment to continuing this approach on trial basis - then intend to roll out. Learning shared with team. 31/10/2018 - Progress since July - please refer to 2.2 and 2.4 updates. Plan: Experience and governance leads now meeting across the system 25/09/2018 - Will be incorporated into overall plan for patient exp. to be ready Jan 18. Capacity Patient Exp/Governance leads. Accountable Body, Sue Butler co-ordinating/Exec Delivery Group
5	**CQCLSR18.19-25**	**Strengthening our Strategic Partnership**	**strengthening our strategic partnership with the voluntary community and faith sectors to provide more seamless joint working for older people**	**Milestone**	**0 Days**	**01/04/2018**	**31/12/2018**						
5.1	CQCLSR18.19-26	5.1 Define New Strategic Working Relationship with VCF	Define new strategic working relationship with voluntary, community and faith (VCF) sector and consider how we create a mind set shift to this relationship across the city	Task	0 Days	01/07/2018	31/12/2018			Open	Green	Cllr Chris Peace, Tim Moorhead, ACP Board Chairs	25/1/2019 - Further consolidation of relationship throughout system required on ongoing basis. 31/10/2018 - Progress since July: Good progress VCSE confirmed as 7th member, strategic discussion at ACP Board. Strategic discussion between Chair & CEO of VAS and CEO of EDG & Prog Director took place 24.9.18 25/09/2018 - good progress, VCSE confirmed as 7th member, strategic disc at ACP Board. Strat disc. between chair and CEO of VAS and CEO of EDG and Prog Director planned 24/09
5.2	CQCLSR18.19-27	5.2 Recognise the Contribution of the VCF	Recognise the contribution of the VCF to health and care across the city through formal invitation to be a 7th formal member of the ACP	Task	0 Days	01/04/2018	30/06/2018			Closed	Green	Cllr Chris Peace, Tim Moorhead, ACP Board Chairs	25/1/2019 - Action Closed. 31/10/2018 - No changes since last update 25/09/2018 - progress good - VCSE confirmed as 7th member, strategic disc at ACP Board. Strat disc. between chair and CEO of VAS and CEO of EDG and Prog. Director planned for 24/9/18

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
5.3	CQCLSR18.19-28	5.3 How the ACP will enable the VCF to have the capacity to provide strategic leadership to the ACP	Develop a clear plan about how this will be different and how the ACP will enable the VCF to have capacity to provide strategic leadership to the ACP and be a full partner	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Maddy Desforges, VAS, Rebecca Joyce, ACP	25/1/2019 - Plan presented at December EDG but conclusions not drawn about next steps. Ongoing. 31/10/2018 - Progress since July: Get update from Maddy Desforges. Plan: EDG considering full proposal Dec 18. CEO discussions wiht VAS CEO through Nov to develop outline proposal 25/09/2018 - Get update from Maddy Desforges. Meatier discussion required to understand how this will be different - deadline TBA. Accountable Exec Delivery Group
6	**CQCLSR18.19-29**	**Strengthening our Supporting Governance**	**Strengthening our Supporting Governance to turn vision into timely action:** **Review how housing links into services for older people at operational and strategic level.** **Clear definition of key respective roles for health and well-being board (understanding needs and driving priorities at city -wide level). ACP driving actions to help achieve those priorities.** **Overview and Scrutiny committee ensuring accountability to local people both to work in**							**Open**			
6.2	CQCLSR18.19-31	6.2 Six Monthly Monitoring of Partnership Delivery	Establishment of 6 monthly monitoring of partnership delivery at overview and scrutiny committee	Task	0 days	01/04/2018	30/06/2018			Closed	Green	Rebecca Joyce, ACP	25/1/2019 ACP first appearance at Scrutiny took place January 2019. Review cycle established. 31/10/2018 - No changes since last update 25/09/2018 - scrutiny planned by ACP Board
6.3	CQCLSR18.19-32	6.3 Review relationship & operation of Health and Wellbeing Board & ACP	Review relationship and operation of health and well being board and ACP This will include: Active review of practice by other Health and Well-Being boards and review of membership	Task	0 Days	01/10/2018	31/12/2018	30/11/2018		Closed	Green	Cllr Chris Peace, Tim Moorhead, ACP Board Chairs	31/10/2018 - Progress since July: Options appraisal to be considered at Oct HWB & ACP Board. Plan: Agreed option to be implemented thereafter 25/09/2018 - Agreed options appraisal. plan options appraisal by end of November 18 by ACP Director/Director of public health
6.4	CQCLSR18.19-33	6.4 Review and Strengthening of Relationships	Review and strengthening of relationship with housing in operational, governance and strategic inter-agency working for older people	Task	0 Days	01/07/2018	30/09/2018			Open	Amber	Phil Holmes SCC	25/1/2019 - 25/1/2019 - . Closer relationships housing/ ASC leading to better delivery of equipment adaptations - operational. Joint development of supported housing focusing on key schemes where health, housing and care can be better aligned. Adlington more sheltered independent living as new model of Homecare currently being developed. L 31/10/2018 - No changes since last update in July. Plan: Working in SCC to delivery a joined up approach to housing and social care to deliver a more targeted & effective approach to housing older people 25/09/2018 - SCC Directors meeting agreed commitment to housing/prevention closer working 03.09.18. Planned disc in Oct on short & long term actions to avoid admission & expediate discharge
6.5	CQCLSR18.19-34	6.5 ACP Delivery Plan	A clear programme ACP delivery plan with milestones informed by the plans for each of the work streams. This will require the partnerships to identify and secure the resource to co-ordinate, communicate and drive each of the programmes	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Rebecca Joyce ACP	25/1/2019 - Overall plan developing, will be drafted for April following public and staff consultation process currently taking place. 31/10/2018 - Progress Since July: Overall plan agreed at October EDG 25/09/2018 - Overall Plan: Some progress. Plan - refreshed expected 18/19. Capacity: ACP Team

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
7	**CQCLSR18.19-35**	**Scaling up pilots, into sustanable, large scale change to ensure a meaningful shift to prevention**	**Focusing available resources on the support that has most impact for local people in helping them stay safe and well and preventing avoidable deterioration**										
7.1	CQCLSR18.19-36	7.1 Agree priorities for any short term funding (winter pressures)	Agree priorities for any short term funding available to alleviate winter pressures	Task	0 Days	01/07/2018	30/09/2018			Closed	Green		25/1/2019 - Plan agreed and operational 31/10/2018 - Progress since July: Winter Funding Priorities. Plan: Set of agreements made. Plan for additional social care funding being determined for add. commitments (discussion Oct 18) 25/09/2018 - Winter Funding Priorities. Identify whether resource available. Meetings w/c 03.9.18 to progress. Capacity B Hughes/N Doherty (CCG) Dawn Walton & John Doyle (SCC) Accountable: EDG
7.2	CQCLSR18.19-37	7.2 Evaluate successful pilots and assess scale up	Evaluate successful pilots and assess scale up and implement on a city wide basis. This will include a review of Better Care Fund Schemes	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Nicki Doherty, CCG	25/1/2019 - Commissioning & providers discussion underway re longer term new care model. Needs bringing together to ensure shared conclusions & approach. 31/10/2018 - Progress since July: BCF reviewed at EMG. Plan: Evaluation ongoing through EMG being led by BCF Manager. Overall action behind plan 25/09/2018 - BCF reviewed at EMG. EMG 05.09.18 Evaluation of BCF Schemes Capacity. B Hughes/N Doherty CCG, Dawn Walton & John Doyle SCC
7.3	CQCLSR18.19-38	7.3 Longer Term System Reshaping	Make recommendations about longer term system reshaping of investment priorities to develop new models of care and support (ie facilitated through the Sheffield Outcomes Fund etc)	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	EDG	25.1.2019 - See above. Commissioner and provider discussions taking place on specific proposals. Needs to be brought together joint system approach. 31/10/2018 - No update on progress. Plan: Will be part of forthcoming commissioning round. Overall action behind plan. 25/09/2018 - Work commenced but needs greater pace and commitment to move into tangible actions/decision. To include BCF/Non elective plan (CCG/STH), SOF- timescale = risk. Accountable EMG/STH/SCCG
7.4	CQCLSR18.19-39	7.4 New Models of care for mobilisation	Mobilisation of new models of care and support through collaborative working which focus on multi -disciplinary multi-agency working and single inter-disciplinary care planning and records. These models must approach both the physical and mental health and well-being of older people building on approaches such as IAPT and other models across the city	Task	0 Days	01/01/2019	31/03/2019			Open	Amber	Commissioning Directors SCC, SCCG	25/1/2019 - urgency to ensure decisions & actions to mobilise new model of care. This timescale is pressing challenging now. 31/10/2018 - No updates on progress 25/09/2018 - New models of care for mobilisation. Plan: progress on integrated commissioning models and what we want need to be clear about priorities for early mobilisation
8	**CQCLSR18.19-40**	**Review key supporting Strat & Funct Enablers to improve Effectiveness**	**Review key supporting Strat & Funct Enablers to improve Effectiveness focusing available resources on the support that has most impact for local people in helping them stay safe and well, and preventing avoidable deterioration.** **More seamless joint working for older people**										

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
8.1	CQCLSR18.19-41	8.1 Review of Digital Inter-Operability	Review of digital inter-operability and ability to share care information across boundaries	Task	0 Days	01/07/2018	30/09/2018			Open	Amber	Sheffiedl CIOs	25/1/2019 Business case being developed. Needs higher profile, shared digital leadership for city to accelerate city wide approach 31/10/2018 - Progress since July: Sheff approach being defined. Part of wider ICS wk. Plan: ICT Directors met Oct 18. Part of ICS approach to implement integrated care record & flow. Full consideration Dec EDG 26/09/2018 - Digital inter-operability. Broad plan discussed but not yet embedded across Sheff. Leadership workstream not identified. Meeting planned of Digital Leads Sept 2018 to agree way forward.
8.2	CQCLSR18.19-42	8.2 Work towards a Joint Commissioning Strategy	Work towards a joint commissioning strategy across health and social care that includes a commitment to creating stability in the parts of the market that we wish to develop and strengthen as part of our new models of care.	Task	0 Days	01/07/2018	31/03/2019			Open	Amber	Maddy Ruff, CCG, John Mothersole, SCC	25/1/2019 Formal discussions on joint commissioning taking place between Cabinet and Governing Body. Discussions still ongoing. 31/10/2018 - Plan: Details of governance arrangements being confirmed on track for April 2019. 26/09/2018 - Progress made - to be fed back October EDG. Good progress on draft model on integrated commissioning, being consulted on via formal bodies in Sept 18. Capacity: B Hughes/N Doherty
9	**CQCLSR18.19-43**	**Ensure Flow & Best Use of System Capacity**	**Ensure Flow & Best Use of System Capacity so older people get timely support from the right person in the right place.**										
9.1	CQCLSR18.19-44	9.1 Ensure that the voice of the older person is heard	Ensure that the voice of the older person and those who care for them in their home is heard and listened to relation to getting them home. This will help to provide the right support and minimise the risk of the provision of non-value adding interventions which introduce waste and do not benefit the individual	Task	0 Days	01/07/2018	30/09/2018			Open	Green	Sue Butler, STH	25.1.2119 - see 2.2, 2.3, 2.4. Good progress. 31/12/2018 - Progress since July: see 2.2, 2.3, 2.4 co-ordination of patient experience across the system plus 2.3 wider work with strategic and operational partner to strengthen approach in ACP as a whole 26/09/2018 - Plan: Overall plan to be mobilised in October. Capcity: Partner Support and Funds for Partner. Accountable body: UEC
9.2	CQCLSR18.19-45	9.2 Refresh of Independent Sector Homecare	Refresh of independent Sector Homecare "Primary Providers"	Task	0 Days	01/10/2018	31/12/2018			Open	Amber	Phil Holmes SCC	25.1.2019 - Reorganisd primary home care provision to ensure greater provision for the city. Incentive schemes introduced to increase capacity in periods of peak demand mobilised and helping pts leave hosp quickly. 26/09/2018 - 9.2-9.4 Series of actions taking place, co-ordinated by Phil Holmes Capacity: Phil Holmes and team Accountable: UEC
9.3	CQCLSR18.19-46	9.3 Development of Outcome based Independent Sector Homecare	Development of outcome-based independent sector home care	Task	0 Days	01/01/2018	31/03/2018			Open	Green	Phil Holmes SCC	25/1/2019 - be clear about locality model in city by March for new home care model with implementation by Oct. 26/9/18 9.2-9.4 Series of actions taking place, co-ordinated by Phil Holmes Capacity: Phil Holmes and team Accountable: UEC
9.4	CQCLSR18.19-47	9.4 Joint Commissioning and Quality Assurance of Homecare and Care Homes between Council and CCG	Joint Commissioning and quality assurance of homecare and care homes between Council and CCG	Task	0 Days	01/01/2018	31/03/2018			Open	Amber	Mandy Philbin, CCG, Phil Holmes, SCC	25/1/2019 - workstreams and project leads agreed. Aims to deliver consistent approach to quality to communication with providers to sustainable funding across NHS and SCC funded models. 26/09/2018 - 9.2-9.4 Series of actions taking place, co-ordinated by Phil Holmes Capacity: Phil Holmes and team Accountable: UEC

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
9.5	CQCLSR18.19-48	9.5 Agreement and Joint Commissioning of Non-home None-acute Bed Capacity	Agreement and joint commissioning of non-home, non acute bed capacity	Task	0 Days	01/07/2018	30/09/2018			Open	Green	STH/ SCCG	25.1.2019 Intermediate beds commissioned and working well, with good flow. Jointly managed across community team at STH/ Social Care 31/10/2018 - Progress since July: Refreshed commissioning approach across SCC/SCCG - still being discussed 26/09/2018 - No update at time of report although progress being made. Plan TBC, Capacity TBC,
9.6	CQCLSR18.19-49	9.6 Gold Level Board Rounds on all wards with high DTOC levels	Gold Level Board Rounds on all wards with high DTOC levels	Task	0 Days	01/07/2018	30/09/2018			Open	Amber	Jennifer Hill, STH	25.1.2019 Largely in place, some risks around maintaining during operational pressures linked to Hadfield. 31/10/2018 - All 16 DTOC wards now have GOLD boards round in place (final work with MSK - still some silver). All others achieved. Sustained implementation of gold board rounds by Dec 18 26/09/2018 - Plan: To move onto plan for every patient to further build on this work Capacity: STH Service Improvement Team Accountable: WNHWNT - overall accountable body UEC
9.7	CQCLSR18.19-50	9.7 Roll out across STH of the SAFER patient flow bundle	Continued roll-out across STH of the 'SAFER' patient flow budnle (which incorporates daily senior medical review. All patients having a planned discharge datge, flow of patients beginning early in the day and all patients with a long length or stay being frequently reviewed). All these actions are of vital importance in ensuring that patients receive timely and safe care in the most appropriate location	Task	0 Days	01/07/2018	30/09/2018			Open	Green	Jennifer Hill, STH	25.1.2019 Roll out continuing, additional support from STH Organisational Development team during winter period. 31/10/2018 - Plan: Metrics demonstrate impact on length of stay. Ongoing implementation. Team considering how to scale up faster. 26/09/2018 - SAFER work progressing well - linked closelly with Board Round Work. Plan: Ongoing implementation. Team considering how to scale up faster. Capacity: STH Service Imp. Team linked to WNHWNT
9.8	CQCLSR18.19-51	9.8 Initial Evaluation of 'Red to Green' work	Initial evaluation of RED to Green work to speed hospital decision making and discharge actions	Task	0 Days	01/07/2018	30/09/2018			Open	Green	Jennifer Hill, STH	25.1.2019 Roll out continuing, additional support from STH Organisational Development team during winter period. 31/10/2018 - Ongoing roll out of red to green pilot to all GSM and MAPS wards by end of Oct. Sustained implementation of red to green in GSM, MAPS and MSK by Dec 18. 26/09/2018 - Evaluation successful. Measured impact on internal delays. Still further work to build on . Red to green pilot completed (informed by ECIST guidance) 5 wards including high priority areas.
9.9	CQCLSR18.19-52	9.9 Physio and OT Assessment in Acute Setting within 24 hrs	Physio and OT assessment in acute setting within 24 hours	Task	0 Days	01/08/2018	30/09/2018			Open	Green	Jennifer Hill, STH	25/1/2019 - HIghlight report outlines over 95% compliance with targets for therapy to support timely discharge. 31/10/2018 - KPIs for all metrics established. Programme plan reports good progress against plan at end of October but amber for impact. All ongoing work. 26/09/2018 - Plan: Ongoing work Therapy service improvement piece of work commenced Aug 18 (focusing on effective work between TOC/therapists/ward MDT), plus some work on therapy care assessment and tool.
9.10	CQCLSR18.19-53	9.10 Therapy Core Assessment and Triage Tool Roll Out	Therapy core assessment and triage tool rolled out to all wards	Task	0 Days	03/09/2018	30/09/2018			Open	Green	Jennifer Hill, STH	25/1/2019 - see above - all therapy actions as part of Hospital Complete project on track. 31/10/2018 - KPIs for all metrics established. Programme plan reports good progress against plan at end of October but amber for impact. All ongoing work 26/09/2018 - Plan: Ongoing work see 9.9
9.11	CQCLSR18.19-54	9.11 Streamlined handover from hospital and community to single point of access	Streamlined handover from hospital and community to single point of access for community services	Task	0 Days	03/09/2018	30/09/2018			Open			25/1/2019 no update available at time of writing. 31/10/2018 - no updates since last report 26/09/2018 - Single Point of Access - Programme of work ongoing Plan: Detailed next steps TBC Capacity: SR Accountable body: UEC

WBS	ID	Task Name	Description	Type	Duration	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	RAG	Lead Person(s)	Task Updates
9.12	CQCLSR18.19-55	9.12 Integration of Active Recover Services	Integration of Active Recovery Services provided by council and STH: common assessment, trusted assessors, single rostering system	Task	0 Days	03/09/2018	31/12/2018			Open		STH and SCC Leads	31/10/2018 - no further updates 26/09/2018 - Integration of active recovery services - programme of working ongoing. Plan: detailed next steps TBC. Capacity: STH Operations Director, CCA and Head of Access & Prevention SCC

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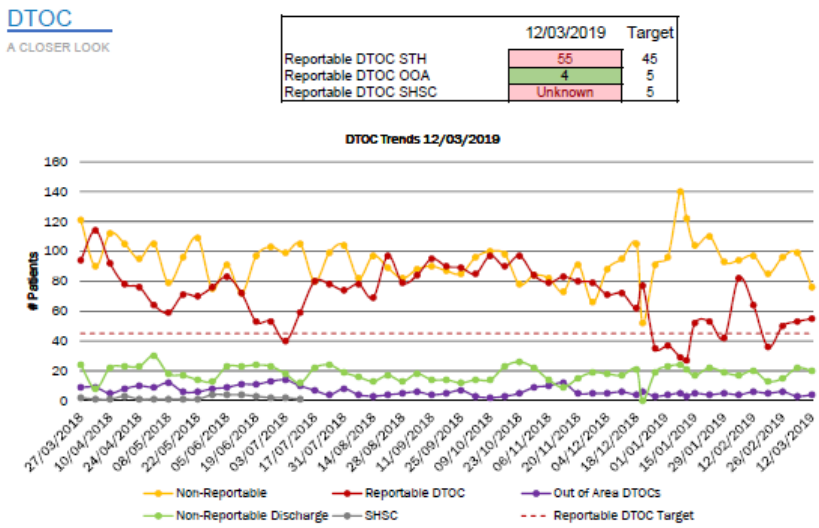
Appendix 2

CQC Report: Why Not Home Why Not Today Metrics

Core metrics

- DTOC performance in early March continues to show significant improvement in terms of delayed patient and delayed day volumes, maintaining improvement over the last 12 months. Slight increases have continued to be effectively managed to ensure lower numbers than the same period last year overall.

Chart 1



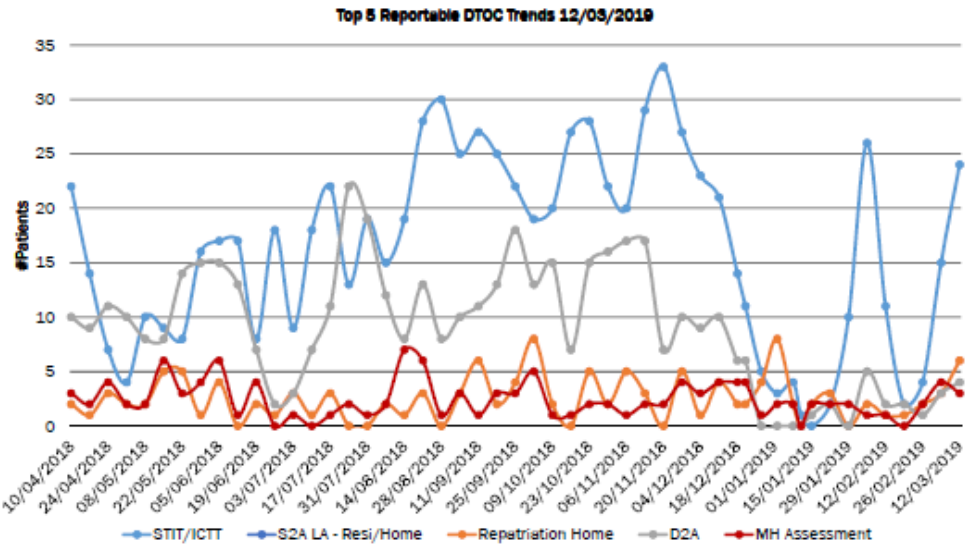
The March 2019 data shows month-on-month improvement since October 2018 with volumes of delayed days now only marginally above the NHS England target of 3.5% (maximum) of beds being occupied by DTOCs.

Weekly reports ensure more focused attention of all delays and focus upon 'delayed patients'. These reports allow a more immediate appreciation of performance and provide more granular data which show in Chart 2, as per Chart 1, continuing decreases in delay volumes, with a particularly sharp decrease during late December and early January. An increase in early February has been quickly addressed.

Chart 2

DTOC

A CLOSER LOOK



Trend analysis, shows much reduced queues within the Route 2 delay categories. However, a significant peak in demand for STIT/ICTT can be seen in early February and early March.

Route 2 Capacity Flexibility

Flexibility now provided by the Offsite Community Beds (OCBs) with the increased demand for Route 2 catered for via dovetailing STIT and OCB capacity to ensure delays are quickly tackled. Moreover, the OCBs and Intermediate Care Beds (ICBs) are now managed in tandem, teeming and ladling bed capacity between the two in order to provide a rapid response to changing demand patterns.

This flexible approach is co-ordinated via the weekly system 'Flow' meeting and informed by the daily TASK meetings.

Patient Experience

It is the intent of this report to include regular information on patient experience across the system. This is underdevelopment. At present this report includes feedback from clinicians during the why not home why not today board, to give an indication of how services are focusing on avoiding admission and discharge.

A patient story about successful admission avoidance**.**

- Patient was an 80 year old woman, who was living alone
- History of chest problems including having part of her lung removed in 2017 due to cancer
- Had input from community nursing team and also help from her daughters
- HCA attending the patient noticed she was short of breath- HCA phoned the community matron who was comfortable that the patient could wait for an hour until she could go to her home to make an assessment.
- As a result no ambulance was called

- The community matron attended and ruled out a serious cause of shortness of breath
- Shortness of breath attributed to the fact that the patient was anxious and had been rushing around
- The community matron did identify that the patient was struggling (issues with weight loss and relationship with family)
- The community matron arranged to visit again when family was there
- The result was that the patient was referred to breathing space, the matron also spoke to the patient's GP who made referrals to the community pharmacist and the Community Mental Health team and the patient was also given advice on diet and exercise.

Reflections:

- The HCA was skilled to recognise the potential problem, consider the appropriate escalation and the potential impact that this could have for the patient
- The community matron was easily contactable by phone
- Expertise of the matron – looking at the whole of the patients' needs
- Good relationship between HCA and Community Matron and also with the patient and family (Trust and Confidence)
- Feedback from IF, SL and HK that this sort of situation does happen routinely in the community- some feeling that had the patient presented at the GP or ED then connecting back out would have been more challenging
- Reflection that the outcome of this story could have been different depending on how the situation is presented in terms of when and to who
- Area to develop identified - all of those working with people in the community (including social workers) need to know the options available to them as alternatives to ringing an ambulance.
- It was recognised that trust, confidence and relationships take time to build
- Agreed to link into the Organisational Development work happening in neighbourhoods

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Sheffield Children's NHS Foundation Trust
Sheffield Clinical Commissioning Group
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

Programme Director Report

For Partner Boards

Sheffield Accountable Care Partnership (ACP)

For Health & Wellbeing Board on March 29th 2019

Author(s)	**Rebecca Joyce**
Sponsor	**Cllr Chris Peace, Cabinet Member for Health and Social Care, SCC and Dr Tim Moorhead (Joint Chairs of the ACP Board and HWB Board)**

1. Purpose

a. To provide headlines from the progress of the Accountable Care Programme.
b. To provide an overview of ACP Programme Activities.

2. Introduction / Background

A short written overview of the Programme activities is provided by the Programme Director for the purpose of each partner board.

3. Is your report for Approval / Consideration / Noting

For noting

4. Recommendations / Action Required by Accountable Care Partnership

See attached actions within the report.

5. Other Headings

N/A

Are there any Resource Implications (including Financial, Staffing etc.)?

N/A

Programme Director Report

Health & Wellbeing Board Meeting, March 29th 2019

1. Strategic Update

a) The 'Shaping Sheffield: The Plan' workshops took place late January/ early February as part of the staff and public consultation to feed into an action plan, which will outline the work of the Sheffield Accountable Care Partnership for the next 5 years. This action plan will provide tangible outcomes to focus on our agreed aims and priorities. Over 300 staff and members of the public attended across the ACP partner organisations. The events focused on the 5 priorities for 19/20. Key themes from these workshops included:

Workforce: staff capability to work differently and the capacity to implement new ways of working, morale and culture, leadership and management capabilities, empowering and listening to staff were all raised multiple times across the 5 workshops. A strong message from the smoking and obesity & physical activity groups in particular, was around maximising the opportunity to focus on supporting staff across the system in stopping smoking and becoming more physically active.

Funding: there was a strong call for integrated commissioning and an investment in prevention activities, including support for the voluntary sector. The issue of short term funding and concerns around the short-term thinking this promotes was raised multiple times.

Person-centred approaches: incorporating flexibility to tailor approaches and support as appropriate at the individual and community levels, addressing issues around access and lack of awareness and using co-production techniques to ensure that care models and future plans have the public at their centre.

Integrated working: a lot of references to silo working and 'inward looking' practices, with a call for more holistic, better-coordinated services. Co-location was cited numerous times, along with the need for digital interoperability and the development of trust between organisations.

Full feedback will be shared with delegates and other stakeholders.

b) The ACP team are working with colleagues a draft Shaping Sheffield: The Plan for the end of April. This will bring the work together into a more coherent whole, acknowledging that the overall fit is not yet transparent. This will be supported by refreshed delivery plans. Each partner executive team will meet with the ACP team through April to feedback on the draft plan and ensure a set of shared goals. A system dashboard to measure progress has been agreed and will track progress.

2. Delivery

a) MH & LD and Children's and Maternity workstreams held a **joint programme** workshop on 7 December 2018 around developing an **all age mental health care model.** The workshop was an excellent event with very high levels of engagement from all stakeholders. Joint governance arrangements across the progammes are now being discussed.

b) EDG and ACP Board at their February meetings considered a summary of proposals to establish a **Joint Commissioning Committee** between Sheffield City Council (SCC) and the Clinical Commissioning Group (CCG). The paper summarised proposals for a joint commissioning plan, and identified the priority areas for commissioning new preventative services that will seek to reduce inequalities, increase the capacity of community based services and reduce demand on acute services. ACP partners were fully supportive of the plan.

c) The **new models of care for multi-morbidity / admission prevention** was supported in principle by all ACP partners and work will now commence on mobilising this. This will underpin the joint commissioning priority of "frailty".

d) The **Quarterly CQC Local System Review** update was considered by Board, with good progress noted. All partners should be considering this report within their agreed internal governance routes.

e) November EDG supported greater ownership from the ACP on next steps relating to **urgent primary care,** following the CCG consultation between September 2017 and January 2018. There is a question as to whether this is CCG led or ACP owned. Current workshops are taking place across the system to understand the problem, and consider the next steps in light of this. This will return to EDG in April.

f) **Organisational Development** – The Leading Sheffield Cohort 2 (formerly known as Liminal Leadership) commences in March and NHS Leadership Academy funds have been secured for a Shadow Board.

g) **Integrated Care Record and Digital Agenda:** The Integrated Care Record project remains at Amber/Red status. Whilst it is acknowledged that there are busy operational organisational digital agendas, Sheffield is losing pace on the system wide agenda compared to a number of other care economies. Kevin Connolley, CIO at SCH, has offered to prepare a proposal outlining what a digital workstream could look like on behalf of the CIOs.

Cross-Cutting Risks

A set of high level programme risks are taken from the highlight reports:

Risk	**Mitigation**
UEC have raised the risk of operational pressures impeding transformation work.	Review of links between transformation and performance aspects of workstream taking place
Primary care workforce as a key risk to deliver the ambition of the primary care workstream. More broadly, whilst we are developing some integrated workforce approaches, we are not yet set up to mobilise workforce strategy effectively across the system.	Team linking with SY Workforce Hub and LWAB on this issue. CEOs have agreed to review this theme through their monthly private meetings.

Project/ programme management support to help drive programmes forward identified as risk in a number of programmes (MH & LD- for dementia, psychiatric decision unit, neighbourhood health and wellbeing service).	Overall, this risk has reduced with the appointment of a number of posts, but risk still apparent and is slowing progress in some areas. We need to start re-shaping some of our collective resource in line with ACP priorities in order to accelerate the system wide work
System digital transformation is a key risk of the programme and we do not currently have system wide capacity or dedicated leadership working on this adequately.	CEOs have committed to getting underneath this as a priority. Whist it is acknowledged that there are significant organisational operational digital agendas, Sheffield is losing pace on the system wide agenda compared to a number of other care economies.

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell, Director of Public Health
Date:	19th March 2019
Subject:	Terms of Reference and Board Membership Update
Author of Report:	Dan Spicer – 27 34554

Summary:

This paper confirms that the Board's updated Terms of Reference have been approved by the City Council in line with requirements, and updates the Board on progress recruiting to new and recently vacated positions.

Questions for the Health and Wellbeing Board:

None.

Recommendations for the Health and Wellbeing Board:

The Board are asked to:

1. note the revised Terms of Reference for the Board which were approved by the City Council at its meeting held on 6th February 2019;
2. appoint, in accordance with the Board's new membership composition Dr David Hughes (Medical Director, Sheffield Teaching Hospitals NHD Foundation Trust) to serve as the NHS Provider – Clinical Representative, in place of Dr David Throssell; and
3. note that work continues to confirm appointments to the new places for VCF Organisation and University representatives

Background Papers:

- Sheffield Health & Wellbeing Board Terms of Reference

What outcome(s) of the Joint Health and Wellbeing Strategy does this align with?

N/A

Who have you collaborated with in the writing of this paper?

N/A

TERMS OF REFERENCE AND BOARD MEMBERSHIP UPDATE

1.0 SUMMARY

1.1 This paper confirms that the Board's updated Terms of Reference (attached) have been approved by the City Council in line with requirements, and updates the Board on progress recruiting to new and recently vacated positions.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 This work ensures that the Health & Wellbeing Board is properly constituted to carry out its statutory duties.

3.0 TERMS OF REFERENCE AND RECRUITMENT

3.1 Following agreement at the Board's December meeting, the revised Terms of Reference were approved by the City Council at its meeting held on 6th February 2019 and will be incorporated into the Council's Constitution.

3.2 Work has been undertaken to recruit to the new positions created, for a VCF Organisation representative and a University representative.

3.3 In addition, Dr David Throssell's retirement from the post of Medical Director of Sheffield Teaching Hospitals (STH) in January 2019 also created a vacancy for the NHS Provider – Clinical Representative.

3.4 It is proposed that this latter place be filled by Dr David Hughes, the new Medical Director of STH.

3.5 Work continues to identify appropriate individuals to fill the two new places, through discussions with VCF sector organisations and University leadership respectively. The outcome of these discussions will be confirmed at a future public meeting of the Board.

4.0 RECOMMENDATIONS

4.1 The Board are asked to:

1. note the revised Terms of Reference for the Board which were approved by the City Council at its meeting held on 6th February 2019;
2. appoint, in accordance with the Board's new membership composition Dr David Hughes (Medical Director, Sheffield Teaching Hospitals NHD Foundation Trust) to serve as the NHS Provider – Clinical Representative, in place of Dr David Throssell; and
3. note that work continues to confirm appointments to the new places for VCF Organisation and University representatives

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Sheffield Health and Wellbeing Board

Terms of Reference

(Approved by Sheffield City Council on 6 February 2019)

1. Role and Function of the Health and Wellbeing Board

1.1 The Sheffield Health and Wellbeing Board (the Board) is established under the Health and Social Care Act 2012 as a statutory committee of Sheffield City Council (the Council) from 1 April 2013. However, it will operate as a multi-agency board of equal partners.

1.2 The Board will develop and maintain a vision for a city free from inequalities in health and wellbeing, taking a view of the whole population from pre-birth to end of life.

1.3 The Board will be the system leader for health & wellbeing, acting as a strong and effective partnership to improve the commissioning and delivery of services across the NHS and the Council, leading in turn to improved health and wellbeing outcomes and reduced health inequalities for the people of Sheffield.

1.4 In doing this, the Board will take an interest in all the determinants of health and wellbeing in Sheffield and will work across organisational boundaries in pursuit of this.

1.5 The Board will be ambitious for Sheffield and hold organisations in Sheffield to account for the delivery of the Board's vision for the city. It should enable organisations to work in an integrated way, for the purpose of advancing the health and wellbeing of people in Sheffield.

1.6 The Board is statutorily required to carry out the following functions:

- To undertake a Joint Strategic Needs Assessment (JSNA)[1];
- To undertake a Pharmaceutical Needs Assessment (PNA)[2];
- To develop and publish a Joint Health and Wellbeing Strategy (JHWS) for Sheffield[3]
- To provide an opinion on whether the Council is discharging its duty to have regard to the JSNA, and the JHWS, in the exercise of its functions[4];
- To review the extent to which the Clinical Commissioning Group (CCG) has contributed to the delivery of the JHWS[5]; to provide an opinion to the CCG on

[1] Section 116 Local Government and Public Involvement in Health Act 2007 (the LGPIHA 2007)
[2] Section 128A National Health Service Act 2006 (the NHSA 2006).
[3] Under Section 116A LGPIHA 2007
[4] Under Section 116B LGPIHA 2007
[5] Under Section 14Z15(3) and Section 14Z16 NHSA 2006

whether their draft commissioning plan takes proper account of the JHWS[6]; and, to provide an opinion to NHS England on whether a commissioning plan published by the CCG takes proper account of the JHWS[7];

- To support joint commissioning and encourage integrated working and pooled budget arrangements[8] in relation to arrangements for providing health, health-related or social care services;
- To discharge all functions relating to the Better Care Fund that are required or permitted by law to be exercised by the Board; and
- To receive and approve any other plans or strategies that are required either as a matter of law or policy to be approved by the Board.

1.7 In addition to these the Board will also take an interest in how all organisations in Sheffield function together to deliver on the Joint Health & Wellbeing Strategy.

1.8 The Board will own and oversee the strategic vision for health and wellbeing in Sheffield, hold all partners and organisations to account for delivering against this by taking an interest in all associated strategies and plans and when appropriate requesting details on how specific policies or strategies help to achieve the aims of the Joint Health & Wellbeing Strategy.

1.9 The Board will continue to oversee the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of its statutory duty to encourage integrated working between commissioners. This will include signing off quarterly and annual Better Care Fund submissions

2. Membership

2.1 The membership of the Board is as follows:

- Sheffield City Council:
  - Cabinet Member for Health & Social Care
  - Cabinet Member for Children & Families
  - Cabinet Member for Neighbourhoods & Community Safety
  - Chief Executive
  - Director of Adult Social Services
  - Director of Children's Services
  - Executive Director for Place
- Sheffield NHS Clinical Commissioning Group
  - Governing Body Chair
  - One other Governing Body GP

[6] Section 14Z13(5) NHSA 2006
[7] Section 14Z14 NHSA 2006
[8] In accordance with Section 195 Health and Social Care Act 2012. This includes encouraging arrangements under Section 75 NHSA 2006.

    - Accountable Officer
    - Medical Director
    - Director of Strategy
- Other Commissioners
    - Senior Representative from NHS England
- Providers
    - Accountable Care Partnership Programme Director
    - NHS Provider – Clinical Representative
    - NHS Provider – Non-Executive Representative
    - VCF Provider
    - VCF Organisation
    - Blue Light Service
- Independent Voice
    - Chair of Healthwatch Sheffield
    - Director of Public Health
    - University

2.2 Other representatives from the wider health and wellbeing community in Sheffield may be invited to attend the Board from time to time to contribute to discussion of specific issues.

2.3 Any changes to personnel will be approved through Full Council on an annual basis.

3. Governance

3.1 **Chair:** The Board will be co-chaired by the Council Cabinet Member for Health & Social Care and the Chair of the CCG, with chairing of meetings generally alternating between them.

3.2 Attendance at meetings and deputies: In order to maintain consistency it is assumed that Board members will attend all meetings. Each member must name 1 deputy, who should be well briefed on the Board's purpose and activities, fulfil the same or similar function in their primary role (as opposed to being from the same organisation), and attend meetings and vote on behalf of the member when they are absent.

3.3 **Quorum:** 1 Elected Member of the Council & 1 other Council Representative (Elected Member or Officer), 1 CCG Governing Body GP and 1 other CCG Representative, 1 Provider Representative, and 1 Independent Voice Representative, with an in-meeting majority for Commissioners.

3.4 **Decision-making and voting:** The Board will operate on a consensus basis. Where consensus cannot be achieved the matter will be put to a vote. Decisions will be made by simple majority: the Chair for the meeting at which the vote is taken will have the casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chair.

3.5 **Authority of representatives:** It is accepted that some decisions and / or representations will need to be made in accordance with the governance procedures of the organisations represented on the Board: however, representatives should have sufficient authority to speak for their organisations and make decisions within their own delegations.

3.6 **Accountability and scrutiny:** As a Council committee, the Board will be formally accountable to the Council. Its work may be subject to scrutiny by any of the Council's relevant scrutiny committees

3.7 Relationship to other groups: The Board has formally agreed a protocol with the city's Safeguarding Boards. The Board will seek to develop close relationships with the city's Accountable Care Partnership and Sheffield City Council's Scrutiny Committees, as part of its work to hold the health and wellbeing system to account. It will also develop relationships with other bodies in the city such as the Sheffield City Partnership Board and Safer & Sustainable Communities Partnership, especially where the agendas of such bodies overlap with the Board's.

4. Meetings, agendas and papers

4.1 The Board will normally meet quarterly in public, interspersed with private strategy development meetings. There will be no fewer than 2 meetings per financial year, with a maximum of 32 weeks between meetings.

4.2 Dates, venues, agendas and papers for public meetings will be published in advance on the Council's website.

4.3 The co-Chairs will agree the agenda for each meeting, supported by an officer subgroup

4.4 Agendas and papers will be circulated to all members and be available on the Council's website 7 days in advance of the meeting

4.5 Minutes will be circulated to all members, and published on the Council's website as soon as possible after the meeting

4.6 It is expected that those who write papers will work collaboratively with others to provide a city-wide perspective on any given issue.

5. Role of a Health and Wellbeing Board member

5.1 All members of the Board, as a statutory committee of the Council, must observe the Council's code of conduct for members and co-opted members. Other responsibilities include:

- Attending Board meetings whenever possible and fully and positively contributing to discussions, reading and digesting any documents and information provided prior to meetings
- The membership of the Health & Wellbeing Board is constructed to provide a broad range of perspectives on the development of strategy. With this in mind, members are asked to bring the insight, knowledge, perspective and strategic capacity they have as a consequence of their everyday role, and not act simply as a representative of their organisation, but with the interests of the whole city and its residents at heart.
- Fully and effectively communicating outcomes and key decisions of the Board to their own organisations, acting as ambassadors for the work of the Board, and participating where appropriate in communications/marketing and stakeholder engagement activity to support the objectives of the Board, including working with the media
- Contributing to the development of the JSNA and JHWS
- Ensuring that commissioning is in line with the requirements of the JHWS and working to deliver improvements in performance against measures within the public health, NHS and adult social care outcomes frameworks
- Declaring any conflict of interest, particularly in the event of a vote being required and in relation to the providing of services
- Acting in a respectful, inclusive and open manner with all colleagues to encourage debate and challenge.

6. Engagement with the public and providers

6.1 Healthwatch Sheffield is the Board's statutory partner for involving Sheffield people in discussions and decision-making around health and wellbeing in the city. It is expected that the Healthwatch Sheffield representative(s) will clearly ensure Sheffield people's views are included in all Board discussions, with Elected Members, and other Independent Voice members also having a role in this regard.

6.2 Formal public meetings will be held quarterly, with members of the public invited to ask questions. An answer may take the form of:

- An oral answer
- A written answer to the member of the public, circulated to the Board and placed on the Council's website

- Where the desired information is contained in a publication, a reference to that publication.

The Board's chairs retain the right to restrict the length of time given to answering public questions at any meetings held.

6.3 The Board will work with Healthwatch Sheffield to engage with the public on the issues affecting health and wellbeing in Sheffield through a range of means, ensuring the output from this engagement is linked to the Board's Forward Plan, and is fed into and reflected in Board discussions. This work will:

- Provide an avenue for members of the public to impact on the Board's discussions and work;
- Engage the public and/or providers in the development of the Joint Health & Wellbeing Strategy;
- Develop the Board's understanding of local people's and providers' experiences and priorities for health and wellbeing;
- Communicate the work of the Board in shaping health and wellbeing in Sheffield;
- Develop a shared perspective of the ways in which providers can contribute to the Board's delivery.

6.4 The Board will maintain a website with up-to-date information about its work and send out regular newsletters.

7. Review

7.1 These Terms of Reference will be reviewed annually.

SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 13 December 2018

PRESENT: Councillor Chris Peace (Chair), Cabinet Member for Health and Social Care

Nicki Doherty, Director of Delivery, Care out of Hospital, Clinical Commissioning Group

Councillor Jackie Drayton, Cabinet Member for Children and Families

Greg Fell, Director of Public Health, Sheffield City Council

Phil Holmes, Director of Adult Services, Sheffield City Council

Rebecca Joyce, Accountable Care Partnership Programme Director

Professor Chris Newman, University of Sheffield

Judy Robinson, Chair of Sheffield Healthwatch

Councillor Jim Steinke, Cabinet Member for Neighbourhoods and Community Safety

Dr David Throssell, Sheffield Teaching Hospitals NHS Foundation Trust

Also In Attendance:

Jennie Milner – Better Care Fund Programme Manager

Eleanor Rutter - Consultant in Public Health, SCC

John Soady - Public Health Principal, SCC

Iolanthe Fowler - Clinical Director, Integrated Community Care and Primary Care Interface Services, Sheffield Teaching Hospitals NHS Foundation Trust

Ollie Hart – GP

Dan Spicer - Policy & Improvement Officer, Public Health Intelligence Team, SCC

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from the Co-Chair, Dr. Tim Moorhead (Chair of the CCG); Chief Superintendent Stuart Barton (South Yorkshire Police, representing the South Yorkshire Police and Crime Commissioner); Dr. Nikki Bates (Governing Body Member, CCG); Jayne Brown (Sheffield Health and Social Care Trust); Alison Knowles (Locality Director, NHS England); Jayne Ludlam (Executive Director, People Services, SCC); Laraine Manley (Executive Director, Place, SCC); Clare Mappin (The Burton Street Foundation); Dr. Zak McMurray (Clinical Director, CCG); John Mothersole (Chief Executive, SCC); and Maddy Ruff (Accountable Officer, CCG).

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest from members of the Health and Wellbeing Board.

3. PUBLIC QUESTIONS

3.1 There were no questions received from members of the public.

4. MULTIPLE MORBIDITY

4.1 The Board considered a report of the Director of Public Health, Sheffield City Council, providing a background summary of the challenge of multiple morbidity (where an individual is living with two or more long term conditions) and introducing a Board conversation on how Sheffield should meet that challenge.

4.2 Set out in the report were five sets of questions for the Board in relation to the challenge of multi-morbidity.

4.3 The report was supported by a presentation given jointly by Eleanor Rutter (Consultant in Public Health, SCC), John Soady (Public Health Principal, SCC), Iolanthe Fowler (Clinical Director, Integrated Community Care and Primary Care Interface Services, Sheffield Teaching Hospitals NHS Foundation Trust) and Ollie Hart (GP), which (a) provided details of and commented upon research and statistical data pertaining to life-course functional decline, prevalence of cumulative multi-morbidity by age, multi-morbidity prevalence by age and areas of deprivation, and the impact that delaying the onset and complexity of multi-morbidity in adults would have in terms of reducing secondary care costs, and (b) commented on the need for the approach to dealing with multi-morbidity to shift its emphasis from medical solutions, and acknowledged that GP training was now giving greater emphasis to more holistic ways of dealing with multi-morbidity.

4.4 Greg Fell, in supporting the principle that the development of health and care services should be shaped more around the needs of the individual and less around the interests of the services, asked what key changes would secure the step change required in that regard. In response, Ollie Hart suggested that there was a need to ensure that adequate resources were made available to fund the provision of non-medical services, and Iolanthe Fowler highlighted the importance of the multi-disciplinary team approach to service delivery.

4.5 In reply to Councillor Jim Steinke's query about health trends, John Soady stated that health levels, in general, were improving from generation to generation, adding that baseline functional capacity in the early years and early adulthood was hugely important to the trajectory from that time on. He emphasised that multi-morbidity and functional decline are interrelated and that it was a whole life-course issue, not just an issue of older age. He commented, however, that levels of physical inactivity were increasing and this was a concern which needed to be addressed.

4.6 Nicki Doherty emphasised the need to connect to work already taking place in this area, and agreed that the direction of travel should be to move more towards prevention. However, she queried whether our approach would be to promote different ways of working or to advocate budget transfer. In response, Ollie Hart suggested that addressing the challenge of multi-morbidity was primarily about different ways of working and was therefore more a cultural issue, but one which may then result in budget shift taking place over the medium term.

4.7 Judy Robinson, in referring to the proposed increased focus on community based interventions, highlighted the significant role played by voluntary and community sector partners in that regard, and stressed the need for a commensurate shift in the relationship between the public and VCF sector. She also stated that it was important to develop a range of health and care services in order to be able to provide people with options to consider when involving them in decision-making about their care.

4.8 Phil Holmes commented on the need to link to the action plan produced in response to the Care Quality Commission's (CQC) Local System Review of Sheffield, and he enquired as to whether efforts to address the challenge of multi-morbidity should be targeted towards specific cohorts/groups. In response, it was suggested that there was a need to promote a shift in mindset in the professions, acknowledging that the medical approach, on its own, is not the solution, and it was expected that the benefits would be maximised by focussing efforts towards the most deprived communities in the city.

4.9 Councillor Jackie Drayton suggested that the ambition was for Sheffield's citizens to enjoy life whilst they grow older, and in order to achieve this, efforts would need to be directed at a younger age and address a range of issues, such as working conditions, healthy eating, poverty, and provision of enriching experiences.

4.10 Dr. David Throssell suggested that the challenge of multi-morbidity was much wider than the focus of the CQC review, and he added that efforts would need to be carefully implemented and managed, particularly where this involved stopping or reducing treatments and providing alternative support via a greater role for primary care.

4.11 Prof. Chris Newman also emphasised the importance of ensuring that non-medical treatment/support was readily available.

4.12 **RESOLVED**: That, in considering the five sets of questions set out in the report in relation to the challenge of multi-morbidity, the Board's answers be as follows:-

1. *Does the Board agree that what matters most to a person, should be the basis of all decisions and support the development of person-centred approaches to care across the entirety of the spectrum of need? What will the Board commit to do to ensure that staff have the required skills to focus on quality (not just quantity) of life?* Answer – Yes, on the understanding that consultation takes place with individuals in relation to their care provision.

2. *Is the Board committed to delivering a 'Sheffield Healthy Lifespan': the number of healthy life years Sheffield residents should expect to live, and ensuring that it is fairly distributed across the city?* Answer - Yes

3. *Is the Board committed to a whole life-course, whole city approach, to ensure that Sheffield is a great place to grow older? What are the Board's asks and expectations of its members, partners and stakeholders (including the long term conditions work stream of the ACP)?* Answer – Yes. This should be reflected in the Sheffield Joint Health and Wellbeing Strategy and the Board should provide leadership and challenge progress on delivery, and all partners should take responsibility for ensuring improvements in this area.

4. *Is the Board committed to a meaningful shift in the budget from hospital to community-based interventions, ensuring the money is allocated according to need, to deliver the long term ambition of a radical programme to delay and prevent multi-morbidity, as well as ameliorating its effects? What does the Board believe its role is in making this happen?* Answer – The Board is committed to a different way of working on a care and wellbeing model driving change which is likely to result in resource shift. The Board will campaign for appropriate funding from the Government.

5. *Does the Board support the principle that care services should be integrated and wrapped around individuals and families and that people should be encouraged to be experts in their own health? What is the Board's role in ensuring that systems will be designed on that basis?* Answer – Yes. This should be articulated as a bold strategic intent of the Board.

5. DRAFT JOINT HEALTH AND WELLBEING STRATEGY

5.1 The Board considered a report of the Director of Public Health, Sheffield City Council, which commented on and appended the draft refreshed Joint Health and Wellbeing Strategy to cover the period 2019-23. The report also asked the Board to advise on the future development of the Strategy ahead of its planned agreement at the Board's March 2019 public meeting, and posed the following questions:-

- Are the Board content with the specific wording of each ambition statement?
- Are the Board content with the development of the substance underpinning the ambitions?
- Do the Board feel the Strategy properly addresses mental health and wellbeing, and healthy communities, and other issues that cut across the life course?
- Are the Board content with the proposed approach to implementation and measurement?

5.2 Greg Fell (Director of Public Health) introduced the report, referring in particular to the proposed structure of the new Strategy which was to set out, as nine ambitions for the city, the critical foundations that must be laid for achieving the

previously agreed vision to close the gap in healthy life expectancy in Sheffield by improving the health and wellbeing of the poorest and most vulnerable the fastest. These ambitions were articulated in the Strategy and structured into the three Life Course stages of Starting and Developing Well, Living and Working Well, and Ageing and Dying Well.

5.3 He commented that it was not intended that the Strategy would detail all of the work being undertaken to improve public health in the city, tobacco control being one such example. He added that the issue of loneliness was proving difficult to articulate and incorporate into the Strategy, and suggested that the content in relation to mental health and wellbeing, and healthy communities, required further strengthening. He also highlighted the proposed approach to delivery of the Strategy including developing the Board's future work programme around the Strategy.

5.4 Comments from members of the Board included:-

- Acknowledge that everyone in the city having a fulfilling occupation would not necessarily apply to people within the older age groups.
- Review how the ambitions are presented in page 7 of the Strategy to remove the impression of an order of priority.
- Targets/timescales be built into the subsequent metrics and action plans to be developed in relation to the ambitions.
- Acknowledge relationships to other plans and strategies for the city, for example, Shaping Sheffield.

5.5 **RESOLVED**: That:-

(a) the wording of the proposed ambitions, and the proposed approach to implementation of the Strategy and measurement of success, be approved;

(b) the Board commits to further engagement and development of the Strategy, for agreement at the Board's March 2019 public meeting; and

(c) the Director of Public Health be requested to undertake further work in relation to the content on loneliness, mental health and healthy communities, and members of the Board be requested to forward to the Director any comments or suggestions they may have in relation to the content of the Strategy.

6. HEALTH AND WELLBEING BOARD TERMS OF REFERENCE REVIEW

6.1 Further to the consideration given at the meeting of the Board on 27th September 2018 to future meeting arrangements, including proposals to conduct reviews of Accountable Care Partnership governance and Health and Wellbeing Board membership and terms of reference, the Director of Public Health, Sheffield City Council, submitted a report (a) providing a summary of the discussions held during November with a range of members around the Board's development, (b) recommending some minor amendments to the Board's terms of reference in the light of those discussions and (c) posing the following questions:-

- Do the Board wish to make any recommendations for changes to membership, beyond the formal addition of the Executive Director of Place and the Cabinet Member for Neighbourhoods & Community Safety?
- Do the Board wish to discuss the requirements of Board members in more depth, and make further recommendations for change as a consequence?
- Do the Board wish to make formal commitments in the Terms of Reference (or elsewhere) with regard to communication?
- Do the Board agree with the other proposals set out in the report?

6.2 The Board gave consideration to each of the recommendations and questions, set out in the report, pertaining to each section of its terms of reference, and the following matters were agreed/supported:-

Role and Function

- Paragraph 1.6 be revised to articulate the requirements relating to the Better Care Fund (Jennie Milner to supply details to Greg Fell).
- Paragraph 1.8 be revised as proposed.

Membership

- To include the Executive Director, Place, Sheffield City Council, and the Cabinet Member for Neighbourhoods and Community Safety.
- Remove the place for a Housing Association voice.
- To include a 2nd VCF place.
- The academic place be retained but it be recommended that the appointee be a student representative from one of the city's universities.
- To discuss with the Executive Director, People Services, Sheffield City Council, whether to include a place for an educational expert, possibly from the Schools Forum.
- To include formalisation of the Accountable Care Partnership's representation.

Governance

- Paragraph 3.2 be revised as proposed.
- Paragraph 3.7 be revised as proposed.

Meetings, Agendas & Papers

- Paragraph 4.1 be revised as proposed.

Role of a Health & Wellbeing Board Member

- No changes be made to this section, recognising that the requirement to name one deputy and ensure deputies are well briefed is incorporated in the proposed revision to paragraph 3.2 of the terms of reference.

Engagement with the Public & Providers

- Paragraphs 6.1 and 6.3 be revised as proposed, whilst acknowledging that there is need to be mindful of the resource implications for Healthwatch Sheffield.
- Paragraph 6.2 be revised as proposed.

Review

- Retain the requirement to review the terms of reference on an annual basis.

6.3 **RESOLVED**: That the Director of Public Health be requested to (A) produce revised terms of reference for the Board, as now agreed, (B) obtain the approval of the Co-Chairs to the proposed revised terms of reference and then circulate them to all members of the Board for information, (C) submit the proposed revised terms of reference for formal approval at the meeting of the Council to be held on 6th February 2019 and (D) circulate the approved terms of reference to all the partner organisations.

7. MINUTES OF THE PREVIOUS MEETING

7.1 It was **RESOLVED**: That the minutes of the meeting of the Board held on 27th September 2018, be approved as a correct record.

7.2 Arising from consideration of the minutes, Greg Fell (Director of Public Health, Sheffield City Council) reported that, in relation to paragraph 3.3.1 of the minutes (Written Question Concerning Blue Badge Policy), a written response had been provided to Mr. Clegg. However, Mr. Clegg had deemed the response to be unacceptable, believing that our statement that almost all applications are dealt with within the 28 day target, was an unsupported assertion "as the Council has openly stated it maintains no records in this area". Mr. Fell commented that he had received further information on this matter from the Council's Customer Services service (who administer the Blue Badge Scheme), which indicated that the time taken to process Blue Badge applications is recorded and can be made available, and that, in terms of the 28 day target, if an applicant has not provided all the information required and officers have to request it, the clock is stopped and recommences at the point that the information is received. Mr. Fell stated that, accordingly, he would provide a further response to Mr. Clegg.

8. DATE AND TIME OF NEXT MEETING

8.1 It was noted that the next meeting of the Health and Wellbeing Board would be held on Thursday 28th March 2019, starting at 3.00pm.

9. DR. DAVID THROSSELL

9.1 It was reported that Dr. David Throssell was attending his last meeting of the Board prior to his retirement, and the Board placed on record its thanks and appreciation to him for his expertise, commitment and contribution to the work of the Board, and extended to him its best wishes for the future.

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