Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 13 December 2018 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 and Crime Commissioner
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
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
Laraine Manley	Executive Director, Place

Sheffield City Council

John Mothersole	Chief Executive, Sheffield City Council
Prof Chris Newman	University of Sheffield
Judy Robinson	Chair, Healthwatch Sheffield
Maddy Ruff	Accountable Officer, Clinical Commissioning Group
Councillor Jim Steinke	Cabinet Member for Neighbourhoods and Community Safety
Dr David Throssell	Sheffield Teaching Hospitals NHS Foundation Trust

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

13 DECEMBER 2018

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. Multiple Morbidity
Report marked 'to follow'

5. Draft Joint Health and Wellbeing Strategy (Pages 5 - 34)
Report of the Director of Public Health.

6. Health and Wellbeing Board Terms of Reference Review (Pages 35 - 50)
Report of the Director of Public Health.

7. Minutes of the Previous Meeting (Pages 51 - 60)

8. Date and Time of Next Meeting
The next meeting is on Thursday 28 March 2019 at 3pm, at the Town Hall Sheffield.

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 28 March 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
Date:	13th December 2018
Subject:	Draft Joint Health & Wellbeing Strategy 2019-23
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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DRAFT

Sheffield Joint Health & Wellbeing Strategy

2019-2023

v0.2

Version control

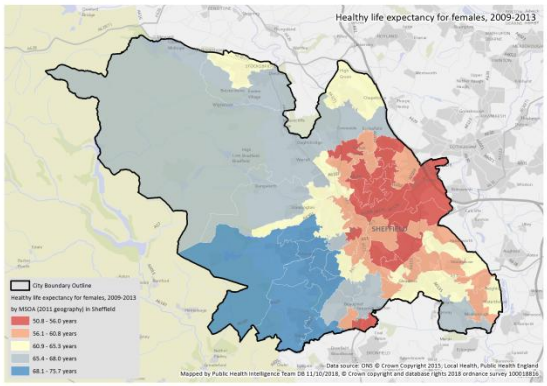
Title	Sheffield Joint Health & Wellbeing Strategy 2019-23
Status	Draft
Version	0.2
Date Created	03/12/18
Approved By	Greg Fell
Audience	HWBB Members Public
Distribution	Email HWBB Public Board Papers
FOI Category	Open
Author	JHWBS Editorial Group
Owner (if different)	Health and Wellbeing Board
Amendment History	
Review date	
Comments	

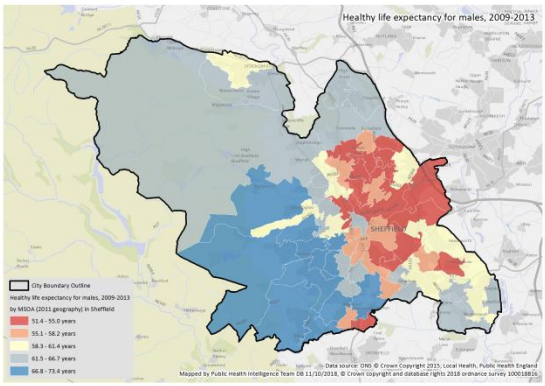
Contents

Introduction – Why should we focus on health inequalities?

Much has changed since 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, and broadly the health and wellbeing of Sheffield's population has held up well in the face of the significant challenges posed by national policy.

But we know that there is still more to do, and too many people in Sheffield still struggle with poor health and wellbeing.





We know that, in general, people in the more deprived parts of Sheffield live shorter lives than those in the richer parts; we also know that the gap in the length of life they can expect to live in good health is even greater. We also know that this challenge applies equally to vulnerable groups in the city as well, such as BME communities or those with learning disabilities; it is not just a matter of socio-economic and geographical distributions. This is the clearest expression of the health inequalities that exist in our city, and that we see as unacceptable.

Health inequalities are a social justice issue, but they are also an economic and a public service sustainability issue. It is not right that some people can expect to live a less healthy life because of who they are or where they live, but it is also not good for our economy, because people who are living with ill health cannot contribute to life in our city in the way they would want to. It is bad news for our public services, because people who live long periods of life with avoidable health needs represent demand that our public services must and should meet, but are struggling to do so.

And beyond this, it is bad for everyone in Sheffield: it has been definitively established that places that suffer from greater inequalities have worse outcomes at all levels of deprivation, not just for those who are worst off. In the report of the Sheffield Fairness Commission, published in early 2013, a vision was set out of "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. This Strategy reflects a continuing commitment to that vision and aspiration, which remain widely accepted by stakeholders in our city.

Health inequalities will only be reduced in a meaningful way over a long period: we do not shy away from recognising that this is a generational challenge. There are three components to achieving this: a long term vision; a medium term strategy; and short term actions. This strategy does two of these. It commits the Board to a generational vision of a city free from health inequalities, and it sets out the things we can focus on over the next five years to set the foundational steps toward achieving that vision, with nine ambitions for the city that will help to reduce health inequalities.

The third will follow the strategy. This will be about the Board convening the system around those ambitions to set out in detail what we are all going to do together to achieve those ambitions, developing action plans against which the Board will hold the system to account. We think this is the right approach to achieve ambitions, and the right one for our city. Together, we can make this happen.

Health Inequalities and a Life Course Approach

What is our target?

Health inequalities manifest in many ways, and could be measured in a similar number of different ways. Our judgement is that the best way to look at this is through the lens of healthy life expectancy, as a measure that best captures the widest range of factors. With this in mind, the Board commits to

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

How do we do this?

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 20 years from now.

But we cannot just think about these long term actions. We also need to think about what we can do now to make a difference to people's lives and about how actions in these different time frames relate to and impact on each other.

This means 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.

What do we mean by a Life Course Approach?

This approach 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.

We will do this by approaching a healthy life in three stages:

- Starting & Developing Well – where we lay the foundations for a healthy life
- Living & Working Well – where we ensure people have the opportunity to live a healthy life
- Ageing & Dying Well – where we capitalise on the work done above to live a healthy old age

In each of these stages we identify three critical ambitions to focus on over the coming five years. These ambitions are based on local evidence of where there are likely to be significant opportunities to improve life chances. They don't cover every aspect of health and wellbeing; there are already a range of strategies and programmes to address these. Rather we want to focus on where we believe the upstream opportunities are greatest. If we get these right we will make significant progress towards achieving healthier lives for all the people of Sheffield, and begin our journey towards eliminating health inequalities in our city.

The rest of this Strategy will talk about each stage in more detail, and set out our specific ambitions for change that we will ask the city to implement with us.

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:

1. Every child in Sheffield achieves the level of development needed in their early years to provide the foundation for a healthy life
2. Every child is included in their education and can access their local school
3. Every young person in Sheffield is equipped to be successful in the next stage of their life
4. Everyone in Sheffield has access to a home that supports their health
5. Everyone in Sheffield has a fulfilling occupation and the resources to support their needs
6. Everyone in Sheffield can safely walk or cycle in their local area regardless of age or ability
7. A decisive shift of resources from acute hospital settings to preventative primary and community settings
8. Everyone in Sheffield has the level of meaningful social contact that they want
9. Everyone in Sheffield lives the end of their life with dignity in the place of their choice

To be inserted

A diagram setting out the life course approach and showing how the ambitions relate to it and link to each other

Starting and Developing 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. It is estimated that there is a 6–10% annual rate of return on investment through funding early years developments. The evidence clearly demonstrates that promoting bonding and attachment and protecting babies' brain development provides the foundations for future health and wellbeing.

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

Over a quarter of children and young people (age 0–19) in Sheffield are in or at risk of poverty or social exclusion, compared with the overall population of 22.6%. Adverse Childhood Experiences (ACEs) are also common and can cause chronic health outcomes. ACEs are stressful experiences such as neglect, abuse during childhood that directly harm a child or the environment in which they live. Almost half of adults are estimated to have been exposed to at least one adverse experience during their childhood. The downstream consequences are significant for crime, social, educational and health & wellbeing outcomes.

Childhood obesity rates are also increasing particularly in the most disadvantaged areas of Sheffield. The inequalities gap for Reception Year (4-5 year olds) overweight & obesity prevalence has increased from 9.4% in 2009/10 to 2011/12 to 13.1% in the most recent period (2014-15 to 2016-17). Economic deprivation seems to be an increasing predictor of obesity and overweight prevalence in Reception Year.

A Health Needs Assessment for Children & Young People's Emotional Wellbeing and Mental Health completed in 2014 estimated that 7000 5-15 year olds in Sheffield have a clinically recognisable mental health disorder and approximately 10% of 0-3 year olds in Sheffield 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. 40% of Sheffield children experience insecure attachment which is a risk factor for poor mental health. Emotional wellbeing and mental health in the early years and families is a key priority.

Bad experiences in childhood can have an impact on health inequalities for the rest of an individual's life. By understanding ACEs and ensuring that children have a great start in life we can:

- improve health and wellbeing outcomes and prevent disease in adulthood
- improve emotional wellbeing and mental health
- reduce costs to the health and welfare system and increase economic productivity.

Starting and Developing Well is an existing priority for the Children & Young People's Health and Wellbeing Transformation Board. The 'Great Start in Life' early years' strategy provides vision and direction for our work focusing on maternity, early years and families 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. The delivery of integrated support by Multi-Agency Support Teams (MAST) is key a priority in the Prevention and Early Intervention Strategy.

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

The evidence for improving early years and starting well is indisputable. Our local plans specifically draw on the evidence base focusing particularly on:

- Early Intervention and prevention
- Adverse Childhood Experiences (ACEs)
- Parenting
- Proportionate universalism (0-19 Healthy Child Programme)
- Building resilience - helping young people and communities develop successful response to life's challenges
- Oral Health Promotion and Dental Health
- The role of schools in developing sense of connectedness/wellbeing
- Transforming emotional wellbeing and mental health following our Future in Mind Plan
- Improved data collection, sharing across agencies and analysis
- Developing community based approaches such as 'Ryegate In The Community' which focus on prevention and ensure access to health services closer to home

What are the Board's ambitions?

- 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

Every child in Sheffield achieves the level of development needed in their early years to provide the foundation for a healthy 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 and 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 capability 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.

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 and schools is essential to create a service which is joined-up, responsive, understanding, fair, and consistent.

Every young person in Sheffield is equipped to be successful in the next stage of their life

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.

Living & Working 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.

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 health service or the Council. To make a difference, we need to work together across the public and voluntary sector to advocate for health 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 place where they live.

What are the Board's ambitions?

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

Everyone in Sheffield 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; single people under 35 years 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.

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. 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 in Sheffield has a fulfilling occupation and the resources to support their needs

A good job can significantly improve a person's life by offering security, rights, personal development, career progression, a supportive environment and a fair income. Being unemployed or unable to work, because of caring responsibilities for example, can have a damaging effect on 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, the economy and the city.

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 city.

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[1]. Three-quarters of adults in working families in poverty are themselves working, with female employees as the single largest category in this group.

Families with children are the most likely to be locked in poverty despite being in work, particularly 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 even possible for some workers. In Sheffield, 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. By paying the National Living Wage of £7.83 per hour for people over 25 years of age, an employer is helping workers to earn enough to cover their basic costs of living. Longer term, we need to ensure that people have the right training to get on once in work and have the opportunity to earn more to improve their living standards and reduce the need for welfare.

[1] Joseph Rowntree Foundation

Everyone in Sheffield 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 67% 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 2.2% 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 experience these impacts disproportionately.

Walking and cycling is the most likely way that children and adults can achieve the recommended levels of physical activity: that is, walking for at least 10 minutes on at least five days a week. 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 and Dying Well

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. Yet many individuals enjoy the opportunity of older age, seeing it as a time of positive change. This gulf between public and media perceptions and lived experience is a function of deeply ingrained ageism which sees old age in negative terms.

For some people later life can be marked by disability and dependency rather than offering opportunities to lead an active life. Thus 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 number of healthy life years a person is able to enjoy into retirement and old age.

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 long term conditions are preventable or at least delay-able: the evidence on this is overwhelming. Relevant actions range from simple activities such as physical exercise through to societal changes which ensure access to good quality housing, clean air, green spaces, safe and meaningful employment and access to fresh food, whilst also limiting access to alcohol, tobacco and highly calorific food. These interventions will be most effective if they are made at earlier stages if the life course, from birth in fact or even earlier.

Many of the chronic conditions affecting older people have their causes at earlier stages of life; therefore the support and care we give in later years is often remedial or palliative. The main challenge is to prevent those conditions or to delay their onset or progression, and to ensure that good health in old age is evenly spread through the population.

This 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. Research in the city covering more than two decades has shown the stark inequalities in both life expectancy and healthy life expectancy between the most and least deprived areas. These inequalities, documented by successive reports from the Director of Public Health and the Sheffield Fairness Commission, demonstrate that later life is where health inequalities become most extreme.

For men in Sheffield life expectancy ranges from 85.3 years in parts of Fulwood, Dore & Totley to 73.2 years in parts of Beauchief & Greenhill, a gap of 12 years. Female life expectancy varies from 90 years in parts of Stocksbridge & Upper Don to 76.2 years in parts of Park & Arbourthorne, Gleadless Valley and the City Centre, a gap of 13.8 years. Healthy life expectancy in Sheffield is falling meaning that people are living more years of life in poor health. On average older men spend 18 years in poor health and women 22 years. The healthy life expectancy gap between the most and least deprived areas is even wider than for overall life expectancy. For men this gap is 18.8 years and for women it is 19.7 years.

In 2012, the Sheffield Fairness Commission, documented inequalities in life expectancy as an expression of unfairness and set out an aspiration that Sheffield should be the fairest city in the country. 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.

It is not inevitable that later life should be a time of senescence. A whole life course approach to prevention, which includes teaching children how to age well, is the most effective way of maximising healthy life expectancy. Remedial actions undertaken later in life, such as eating a healthy diet, aerobic and weight bearing exercise, maintaining mental stimulation and participating in social activities can improve outcomes in later life.

What are the Board's ambitions?

- 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

A decisive shift of resources from acute hospital settings to preventative primary and community settings

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, including very elderly people, live fully independent lives and the increase in demand far outweighs the increase in older people.

The demand on services is, in fact, due to increasing numbers of people living with one or more long term condition. GP records show that 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 hypertension (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 multiple chronic illnesses are more common in the 60-69 years age group than in those aged 80-89 years.

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. Local data show a 15 year gap in the onset of multiple illnesses between the most and least deprived people in Sheffield. Two-fifths of 50 year olds in the most deprived groups have multiple long term conditions compared to just under one-fifth in the least deprived.

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. It thus represents a vicious cycle of worsening outcomes.

Our long term ambition is to delay and prevent multiple chronic illness, as well as ameliorating its effects. We are planning to take this forward through the Sheffield Healthy Life Span concept: the number of healthy life years all Sheffield residents should expect to live, irrespective of who they are or where they live. This means a city-wide life course focus on healthy ageing aimed at increasing the number of healthy life years lived.

A hospital system designed to treat people with single episodes of ill-health is not the best response to this challenge. We need to focus on prevention, early identification and a person-centred approach. This must be done at the community level and we must shift resources accordingly. The Joint Strategic Needs Assessment shows that a one year delay in onset and development of complexity could save £4 million per year in hospital costs alone. This could be achieved in part by shifting the focus of monitoring the known diseases of people on GP registers, to using that as an opportunity to prevent second and subsequent long term conditions.

A highly specialised, disease specific approach is not appropriate for people with multiple long-term conditions as 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 that can end up being worse than the symptoms of the diseases. Consequently 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.

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. Implementing the aim of becoming a person centred city is the responsibility of the Long Term Conditions Board of Sheffield's Accountable Care Partnership, as is the development of a business case for prevention.

Everyone in Sheffield has the level of meaningful social contact that they want

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.

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 single, objective measure of loneliness in use in the UK. The Joint Strategic Needs Assessment suggests there could be as many as 12,000 older people in Sheffield who are often or always lonely. This does not mean it is just an issue for older people; loneliness and isolation affects people of all ages, and has long term impacts for those who suffer from it.

There is no silver bullet 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.

In addition, there are strong connections to the other areas set out in this Strategy: Supportive development in the early years sets us on the course of developing the social skills and empathy needed to sustain relationships; An inclusive education offers the opportunity to develop social bonds that can be sustained across the life course; 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 with each other and maintain relationships; Loneliness and isolation are linked to a range of long term conditions; and People with strong and supportive social networks are more likely to live the end of 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.

Evidence also shows that men and women respond differently to loneliness and social isolation with older women more likely to admit to feeling lonely than older men. 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 also seem to 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 greater 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.

Everyone in Sheffield 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 hearth 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

As can be seen from those ambitions, this is not just about NHS and social care services working together; this is the responsibility of everyone in all our communities.

Implementation

The Health & Wellbeing Board is not an executive board. It is a partnership group that brings together a collective view on a strategic approach to improving health and wellbeing in Sheffield. It has a role in shaping, influencing and focusing attention on issues that determine wellbeing and health outcomes.

Implementation of this strategy will be the responsibility of the board, but it will only be effective if all relevant stakeholders participate. We commit to focusing our discussions over the coming period around the ambitions of this strategy, seeking to understand the motivations of stakeholders, and the best intervention & inflection points.

The Board will convene a set of workshops, bringing together insights and perspectives of different stakeholders, for each of the ambitions. This process will shape and define the steps needed to achieve those stated ambitions.

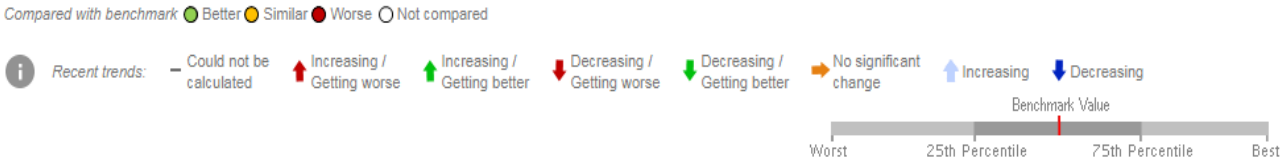
This Strategy is a document against which the Board will attempt to hold the whole system to account, not just the partners around the table. We have engaged with the whole system as far as possible while developing it to ensure the strongest possible buy-in from all parts of the city. To continue this approach through to delivery, the Board will develop an ongoing engagement process feeding into those workshops and generating a city wide conversation about what different approaches are needed, and develop broader support for change.

The Health & Wellbeing Board is a committee of the Council and as such it will seek to advocate for positive change from Government in support of its ambitions. Similarly, it will advocate for positive change both within agencies in the city and with government and other national and regional stakeholders.

The partners in the board will commit their resources to implementing the objectives set out in the strategy. The role of the board is to exert influence in a complex system rather than implementing a defined set of programmes. Individual members of the board and the agencies they represent are already involved in other partnerships or individual agency boards responsible for improving outcomes. Members of the Health & Wellbeing Board commit to influencing other bodies to ensure we build a culture of improving health and wellbeing into the core business of our respective organisations.

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 based on those identified by the Marmot Review as 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%

Just as the actions to deliver on our ambitions must be developed with the system, so must the success measures be developed. We commit to developing a robust approach to judging whether our ambitions have been achieved, and whether they have had the impact we expect.

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	13th December 2018
Subject:	Health & Wellbeing Board Terms of Reference Review
Author of Report:	Dan Spicer, 0114 273 4554

Summary:

This paper provides a summary of discussions with a range of members around the Board's development, and makes recommendations for some minor amendments to the Board's Terms of Reference.

Questions for the Health and Wellbeing Board:

- 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 agree with the other proposals set out in this paper?

Recommendations for the Health and Wellbeing Board:

- The Board are asked to discuss, amend and if appropriate approve the proposed changes to the Terms of Reference
- Following this the Board are asked to agree to submit the resulting revised Terms of Reference for consideration by Full Council at the next opportunity.

Background Papers:

1.0 *Health & Wellbeing Board Terms of Reference – July 2017*

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

This paper relates to the operation of the Health & Wellbeing Board and therefore aligns with all outcomes in the Strategy?

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

- Members of the Board's Steering Group
- Members recruited to the Board following the 2017 Review.

HEALTH & WELLBEING BOARD TERMS OF REFERENCE REVIEW

1.0 SUMMARY

1.1 The Health & Wellbeing Board's Terms of Reference commit the Board to reviewing them annually. To meet this requirement, and to align with the current review of the Accountable Care Partnership, a series of informal interviews with Board members was carried out during November 2018 to assess the state of the Board. In light of the still fresh comprehensive review of the Board carried out last year, it was decided to keep this light touch, and to focus on the Board's steering group (in their role guiding the development of the Board) and new members recruited through that review (to gain fresh perspective on the Board's operations).

1.2 This paper provides a summary of those discussions and makes recommendations for some minor amendments to the Board's Terms of Reference.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 This seeks to ensure that the Board continues to be fit for purpose in delivering improved health and wellbeing for Sheffield people.

3.0 SUMMARY OF KEY POINTS RAISED IN INTERVIEWS

3.1 Broadly, the view from those interviewed was that the measures proposed in the 2017 review are making a difference and that the Board continues to develop in the right direction. Beyond this, there were a number of points raised that worth further consideration:

Board culture

3.2 Interviewees broadly agreed that meetings are increasingly more constructive and drawing more clear conclusions. Strong but inclusive chairing plays a part in this and all are keen to see this continue to develop in this way.

3.3 A number of new members made a specific point about being exposed to new issues and taking these away into their organisations, emphasising the value of the space for sharing challenges and organisations can be influenced by the perspective gained in HWBB.

3.4 Concerns were raised around levels of absence from meetings, with one interviewee describing this as "Health & Wellbeing Board seems like the meeting it's ok to give your apologies to". This may reflect an inevitable tension between partnership working and organisational responsibilities; it is suggested that named deputies could help with this to ensure better balance.

3.5 Interviewees reflected recent discussions in Board around the need to be clear that some Board members represent areas of expertise rather than their

organisation, and that it would be helpful to be clearer where this is the case in the Board's arrangements.

Accountability

3.6 The importance of the Board's role in holding the system to account was raised repeatedly, in the particular the need to ensure this is balanced with the board's role around developing strategy.

3.7 Links were drawn to the discussion of Board culture, with some suggesting that the Board is collectively reluctant to challenge as much as it should, while recognising the need to keep this constructive. This was described by more than one interviewee as the need to "look people in the eye and ask: what have you done, and what difference has it made?".

3.8 It was noted by more than one person that the Board's statutory powers are limited, but that the Board itself has moral authority beyond this due to its position in the system and its statutory role, added to the organisational authority of those round the table.

3.9 It was also noted that the Board could do more to utilise its statutory powers as provided under the Health & Social Care Act 2012, for example by challenging the CCG and Council more directly on how their commissioning plans relate to the Joint Health & Wellbeing Strategy, through this strengthening the connections between the Joint Health & Wellbeing Strategy, and the strategies and policies developed within other organisations..

3.10 Beyond this, the suggestion was made that there may be a role for a formal or informal relationship with the Council's Scrutiny Committees as part of an approach to accountability (both in terms of holding the system to account, and in terms of the Board itself being democratically accountable).

Membership

3.11 All those interviewed were clear that the Board is quite large already, and that there is limited to no appetite for a significant expansion of the membership.

3.12 There was broad agreement that a perspective from a housing specialist would be beneficial, and that this could be achieved by filling the currently vacant space for a housing association. However, some interviewees questioned whether this necessarily had to be a housing association, with other voices in the housing field (such as housing focused charities) potentially having useful insight, and others asking whether the addition of the Executive Director for Place and Cabinet Member for Neighbourhoods & Community Safety from SCC would cover this.

3.13 The role of VCS voice on the Board was raised, asking whether current arrangements provide the broadest possible input from and to the sector. This potential concern is worth putting in the context that the VCS place on the Board is intended to be an expert voice, not an organisational or sector one.

3.14 The role of the University places on the Board were raised. It was noted that the two places are not fully utilised, and also asked whether these spaces should be about providing academic expertise, or about tying the Universities into the Board in their role as major employers. This could be addressed by reducing the number of places to one, and by taking the opportunity of the current vacancy in the SHU place to rethink the purpose, should the Board wish to.

3.15 A number of interviewees asked whether, given the developing themes in the Strategy, there should be a voice on the Board from the education sector, such as a Headteacher, though it was also noted that this may be covered by the membership of the Director of Children's Services and the Cabinet Member for Children & Young People.

Relationships with other bodies

3.16 From recent discussions in the Board and the interviews conducted for this paper, there is a clear view emerging of the relationship between the Board and the Accountable Care Partnership: that the Health & Wellbeing Board develops and sets the long term vision and medium term strategy for health and wellbeing in Sheffield, and that the ACP's role is to operationalise this in the NHS and Social Care system. There was agreement among interviewees that the Board needs to assert its authority on this, and that the Strategy will be crucial to this.

3.17 It was also noted that the Board's agenda overlaps with those of a range of other bodies in the city, such as the Sheffield City Partnership Board, and the Safer & Sustainable Communities Partnership. It has been suggested that the Board should consider developing more formal relationships with other bodies operating in the same space to coordinate and reinforce, and to enhance each other's work.

Engagement

3.18 There was broad agreement amongst interviewees that the Board could do more to effectively engage with Sheffield's citizens around its work, but that the previous model of two set-piece engagement events a year didn't do enough to drive engagement with, and offer an opportunity to impact, the Board's work programme.

3.19 There was agreement that bringing a greater range of voices into Board discussions beyond officers has been a positive development.

3.20 There was a view expressed that the Board could do more than it does with Healthwatch in its statutory role on the Board, and as an engagement partner more generally.

3.21 There is a need to do more around engagement, and the view broadly expressed was that this will require some additional resource.

3.22 It was suggested that the Board's use of social media could improve, while recognising this has limitations as an engagement tool.

3.23 It was asked whether the Board does enough to communicate and promote the JSNA and JHWBS out into the world as critical documents for the city.

4.0 POTENTIAL CHANGES TO THE BOARD'S TERMS OF REFERENCE

4.1 In light of the above summary, it does not appear that there is significant appetite for major changes to the Board's Terms of Reference, with a greater focus on ensuring that the positive developments over the past 18 months are continued. However there are a number of areas where it may be beneficial to tweak the existing terms to better reflect developments in that time, such as the relationship with the ACP, and to lay the foundations for continued development.

4.2 It is noted that the matter of the Board's Terms of Reference, as a statutory committee of the Council, can only be determined by Full Council. This paper, its recommendations and the discussion within the Board should therefore be seen as making proposals for Full Council to consider.

4.3 This paper will now take each section in the existing Terms of Reference in turn, highlighting potential changes for consideration in each.

5.0 ROLE AND FUNCTION

5.1 As noted above, there is broad agreement around the role and purpose of the Board, and this is well reflected in this section. However in light of developing understanding of the relationship between the Board and the ACP, it might be appropriate to consider a small change to make this clearer, so that paragraph 1.8 reads as follows:

> 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.

6.0 MEMBERSHIP

6.1 As a minimum, there is a need to alter this section to reflect the addition of the Executive Director of Place and Cabinet Member for Neighbourhoods and Community Safety to the Board.

6.2 Beyond this, although there is broad agreement that the membership is not in need of fundamental rethinking, in light of the points raised above there is a need for the Board to ascertain that there is no need for minor changes, particularly covering:

- The vacant space for a Housing Association voice: should this be altered to cover housing in general, or should it be deleted?

- Are the Board content with current arrangements around VCS voice, and if not what would they like to see instead?
- Do the Board wish to make changes to the purpose and allocation of academic places?
- Do the Board wish to consider the addition of an educational expert voice?

6.3 The Board are asked to discuss this, and suggest amendments as they see fit.

7.0 GOVERNANCE

7.1 To reflect concerns about attendance and representation described above, it is suggested that paragraph 3.2 could be amended to make the naming of deputies a requirement rather than an option, and to make clear deputies must be well briefed, as follows:

> 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.

7.2 In addition, in light of the discussion of relationships with other bodies, paragraph 3.7 could be amended to stipulate the need for formal relationships with the Accountable Care Partnership and the Council's Scrutiny Committees, and to develop stronger but informal relationships with other partnerships, as follows:

> 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.

8.0 MEETINGS, AGENDAS AND PAPERS

8.1 Paragraph 4.1 needs to be altered to reflect the recent change to quarterly public meetings, as follows:

> 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.

9.0 ROLE OF A HEALTH & WELLBEING BOARD MEMBER

9.1 This section would also benefit from making clear that Board members must name an appropriate deputy and ensure they are briefed appropriately to give them the best opportunity to make positive contributions to Board discussions.

9.2 However, beyond this it was suggested by interviewees that in light of concerns about levels of commitment to the Board amongst its membership, that it might be beneficial for the Board to have a broader discussion of what they expect from each other. This would have the effect of redrafting this section, and could take place as part of the discussion of this paper, or be planned for a future meeting. The intention behind this suggestion is to promote ownership of Board culture and behaviours amongst the membership.

10.0 ENGAGEMENT WITH THE PUBLIC AND PROVIDERS

10.1 It is suggested that this section could be adjusted to ensure that the statutory role of Healthwatch is more clearly reflected. This could be achieved by adjusting the first sentence of paragraph 6.1 to read:

> Healthwatch Sheffield is the Board's statutory partner for involving Sheffield people in discussions and decision-making around health and wellbeing in the city.

10.2 Beyond this, the Board's engagement approach has shifted away from a focus on formal events to a broad-based approach. With this in mind, it is suggested that paragraph 6.2 could be adjusted to read:

> Formal public meetings will be held quarterly, with members of the public invited to ask questions.

10.3 Paragraph 6.3 could also be adjusted to commit the Board to working with Healthwatch to put this broad-based approach into action:

> 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 JHWS;
> - 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.

10.4 The point raised in interviews regarding greater promotion of the JSNA and Strategy is not covered by the existing Terms of Reference, as these are matters of communication as much as engagement. The Board currently have no resource or plans in place around communication, and may wish to consider whether formal commitments need to be made with regard to this.

11.0 REVIEW

11.1 The Board may wish to consider whether an annual review of the Terms of Reference is required.

12.0 QUESTIONS FOR THE BOARD

- 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 their Terms of Reference (or elsewhere) with regard to communication?
- Do the Board agree with the other proposals set out in this paper?

13.0 RECOMMENDATIONS

- The Board are asked to discuss, amend and if appropriate approve the proposed changes to the Terms of Reference
- Following this the Board are asked to agree to submit the resulting revised Terms of Reference for consideration by Full Council at the next opportunity.

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Sheffield Health and Wellbeing Board

Terms of Reference

Revised February 2017

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 whether their draft commissioning plan takes proper account of the JHWS[6]; and, to

[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
[6] Section 14Z13(5) NHSA 2006

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 strategic planning for the health and care system in Sheffield, hold all organisations to account for delivering against it and take an interest in all associated strategies and plans.

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, Young People & Families
  - Chief Executive
  - Director of Adult Social Services
  - Director of Children's Services
- Sheffield NHS Clinical Commissioning Group
  - Governing Body Chair
  - One other Governing Body GP
  - Accountable Officer
  - Medical Director
  - Director of Strategy
- Other Commissioners
  - Senior Representative from NHS England
- Providers
  - NHS Provider – Clinical Representative
  - NHS Provider – Non-Executive Representative
  - VCF Provider
  - Blue Light Service
  - Housing Association

[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.

- Independent Voice
    - Chair of Healthwatch Sheffield
    - Director of Public Health
    - Academic

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 may name 1 deputy, one of whom may attend a meeting and vote in place of the member.

3.3 **Quorum:** 1 Elected Member of the Council & 1 other Council Representative, 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 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 and will develop relationships with other bodies in the city such as the Council's scrutiny committees, and other partnership and commissioning boards.

4. Meetings, agendas and papers

4.1 The Board will normally meet every six months in public, interspersed with engagement events and 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 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, but must 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 lead for involving Sheffield people in decision-making around health and social care. 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 twice a year and will be preceded/followed by a discussion forum on a particular issue. In addition, members of the public are invited to ask questions at the formal public meetings. 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 hold a range of engagement events every year, open to the public and/or providers. These events will be in addition to the formal, public meetings of the Board and will be a means of:

- Providing an avenue for members of the public to impact on the Board's discussions and work;
- Engaging the public and/or providers in the development of the JHWS;
- Developing the Board's understanding of local people's and providers' experiences and priorities for health and wellbeing;
- Communicating the work of the Board in shaping health and wellbeing in Sheffield;
- Developing 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.

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 27 September 2018

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

Councillor Chris Peace, Cabinet Member for Health and Social Care

Dr Nikki Bates, Governing Body Member, CCG

Jayne Brown, Sheffield Health and 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

Alison Knowles, Locality Director, NHS England

Jayne Ludlam, Executive Director, People Services, Sheffield City Council

Judy Robinson, Chair of Sheffield Healthwatch

Maddy Ruff, Accountable Officer, Clinical Commissioning Group

Also In Attendance:

Maddy Desforges – Voluntary Sector

Chief Inspector Helen Lewis – South Yorkshire Police

Jennie Milner – Better Care Fund Programme Manager

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Chief Superintendent Stuart Barton (South Yorkshire Police, representing the South Yorkshire Police and Crime Commissioner); Professor Chris Newman (University of Sheffield); Dr David Throssell (Sheffield Teaching Hospitals NHS Foundation Trust); John Mothersole (Sheffield City Council); Clare Mappin (The Burton Street Foundation); and Rebecca Joyce (Accountable Care Partnership Programme Director).

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 Public Question Concerning Stop Smoking Services

3.1.1 Mr. Mike Lawrence stated that he provides a stop smoking programme as part of his holistic therapy practice and the majority of the public who want to stop smoking have previously been given Champix or NRT either from their GP or local pharmacy, which hasn't worked for them, but they still are informed to continue to try them. He added that in the Health & Wellbeing Board meeting on 29th March 2018, mention was made that advice given by pharmacies was to signpost patients to 'other services as appropriate', and he queried what are the other services?

3.1.2 In response, Greg Fell (Director of Public Health, Sheffield City Council) stated that he would provide a written response to Mr. Lawrence, but commented that smoking cessation services in Sheffield were commissioned in line with NICE guidance. There were a range of services made available to support individuals to stop smoking, or to switch to vaping, but that holistic therapies were not commissioned due to insufficient evidence of their effectiveness.

3.2 Public Question Concerning Stress

3.2.1 Mr. Mike Lawrence commented that, in an Axa PPP survey published on 13th November 2017, Sheffield was highlighted as one of the most stressed cities in the UK, behind Cardiff and Belfast. He asked is this an issue that the Board have discussed in previous meetings and is this of concern?

3.2.2 In response, Greg Fell (Director of Public Health, Sheffield City Council) stated that he had read the report on this relatively small survey, and added that, in his opinion, Sheffield was not significantly more stressed than the majority of other cities in the UK. He confirmed that Sheffield does regard stress as a serious issue and referred to various initiatives which were supported in Sheffield, and stated that although the Board had not specifically discussed mental health recently, it would be doing so within the next few months.

3.3 Written Question Concerning Blue Badge Policy

3.3.1 Greg Fell reported the receipt of a question addressed to the Health and Wellbeing Board from Mr. Ian Clegg regarding the administration of the Blue Badge Scheme, and particularly the timescales for processing applications and the appeals process. Mr. Fell stated that he had obtained a response from the Council's Customer Services service (who administer the Scheme), which indicated that the Service does process almost all applications within the 28 day target, and added that he would arrange for a written response to be provided to Mr. Clegg.

4. BETTER CARE FUND UPDATE

4.1 The Board considered a joint report of the Executive Director, People Services, Sheffield City Council, and the Director of Delivery, NHS Sheffield CCG, providing an update on the delivery of Sheffield's Better Care Fund (BCF).

4.2 The report, in asking the Board to consider progress against its ambitions, and to support the key next steps in relation to integrated commissioning, posed the following questions:-

- Is the Board satisfied that these plans will progress the Board's ambition to transform the health and care landscape, reduce health inequalities and deliver better outcomes for Sheffield people?
- How can the Board contribute to the development of priority areas and enablers to support transformation at pace and scale?

4.3 The report was jointly presented by Jennie Milner (Better Care Fund Programme Manager), Phil Holmes (Director of Adult Services, Sheffield City Council), and Nicki Doherty (Director of Delivery, NHS Sheffield CCG), with (a) Jennie Milner outlining the history of the Better Care Fund and highlighting successes to date, (b) Phil Holmes referring to and commenting upon the proposals for utilising the Improved Better Care Fund (iBCF) in 2018/19 and (c) Nicki Doherty outlining the ongoing priorities for the Better Care Fund in 2018/19 and the work to develop Sheffield's approach to integrated health and social care commissioning and improving outcomes for Sheffield people, referring in particular to the continued focus on reducing demand on hospital services, including delayed transfers of care, and the scaling up of good practice.

4.4 In response to questions from Councillor Jackie Drayton regarding the funding for mental health services and community support workers, and regarding the governance of the BCF, Nicki Doherty commented that funding for these services was allocated from the wider BCF and that, although this didn't include children's mental health services, those services were to form part of the overall integrated commissioning plans. The BCF's governance arrangements were outlined and it was confirmed that the Board was responsible for overseeing the strategic direction of the Fund.

4.5 In response to a query from Dr Nikki Bates, Nicki Doherty undertook to provide her with performance data for the core cities, and Phil Holmes confirmed that, generally, the core cities' performance was below the national average.

4.6 Councillor Chris Peace commented on the importance of the prevention and early intervention agenda, addressing delayed transfers of care, and providing support for joint workforce development. In response, Nicki Doherty acknowledged that different working cultures existed within health and social care and it was important to build up trust. Joint workforce development and closer working arrangements and integration, for example in the Active Recovery Service, would assist this process.

4.7 In response to a suggestion made by Judy Robinson, Nicki Doherty undertook to incorporate reference to the recommendations from the recent Care Quality Commission's Local Area Review of Sheffield, within the Better Care Fund Plans.

4.8 The Chair (Dr Tim Moorhead), in referring to the need to have clear objectives for the BCF, asked how success would be measured, and in response, Nicki Doherty commented that the BCF Plan set out clear objectives, the outcomes ambitions, CQC metrics, etc, which would enable performance to be measured and assessed, and indicated that performance monitoring information could be included in future update reports to the Board on the BCF.

4.9 Alison Knowles referred to the need for data on trends to be made available to assist the process of assessing performance, and, in referring to the recommendation in the report that final approval of the BCF submission be delegated to the Executive Director, People Services (SCC) and Director of Delivery (CCG), she queried whether the Board was in a position to do this, given that the report does not provide details of the resources available within the overall BCF. In response, it was reported that discussion on the overall BCF had been held at the previous meeting of the Board on 29th March.

4.10 **RESOLVED**: That, following consideration of the information contained in the report now submitted, and as now reported:-

(a) continued delivery of the Better Care Fund plans be formally approved;

(b) approval be given to the proposed allocation of the Improved Better Care Fund funding for 2018/19, as outlined in the report;

(c) final approval of the BCF submission be delegated to Jayne Ludlam (Executive Director, People Services, SCC) and Nicki Doherty (Director of Delivery, CCG), and details be circulated to Board Members following its submission;

(d) arrangements be made for the Board, at a future meeting, to discuss in more detail how integration can support strategic priorities; and

(e) performance monitoring information be included in future update reports to the Board on the BCF.

5. CQC SYSTEM REVIEW

5.1 The Board considered a report circulated by the Director of Adult Services, Sheffield City Council, providing a summary of performance across the NHS and social care in supporting older people with their health and wellbeing needs.

5.2 The report commented on and attached as appendices (a) the report of the Care Quality Commission's (CQC) Local System Review of Sheffield, carried out in Spring 2018, which focussed on three key areas in order to assess how

well older people move through the health and care system, namely (i) maintaining the wellbeing of a person in usual place of residence, (ii) crisis management and (iii) "step down" (return to usual place of residence or admission to new place of residence, and (b) Sheffield's Action Plan ("Making It Better") which had been produced in response to the CQC's Review, and agreed by partner organisations, to ensure continual improvement.

5.3 The Board was asked to consider the information set out in the report on the plans for improvement and the arrangements for ensuring improvements are maintained, including determining the role of the Board in that regard.

5.4 Phil Holmes (Director of Adult Services), in presenting the report, commented on the nature of the CQC Review and the reasons why Sheffield was one of 20 areas selected for Review. He outlined Sheffield's strengths, as identified in the Review report, and commented on Sheffield's response to the conclusions of the Review, as articulated in the Action Plan, which sets out the key areas of improvement for Sheffield. The Plan contained nine key actions which had been agreed for five priority areas, with these areas being (A) to work in a way that acknowledges and improves older people's views and experiences and which drives a city-wide vision; (B) to have a shared city-wide workforce strategy to support front-line staff to deliver the vision and which further develops multi-agency working; (C) clearer governance arrangements to ensure stronger joint working between organisations and greater involvement for the Voluntary, Community and Faith sector; (D) a shift to prevention at scale, supported by clear commissioning arrangements, including descaling what isn't working; and (E) a strong system focus on enabling the right support from the right people in the right place and at the right time to provide the best possible experience for older people and to ensure best use of resources. He concluded his presentation by outlining some thoughts on roles and responsibilities for ensuring progress against the Action Plan, including roles for this Board and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee in that regard.

5.5 Greg Fell, in supporting the Action Plan, asked how progress would be monitored, and in response, Phil Holmes outlined the measures which Sheffield's Accountable Care Partnership (being the body responsible for enabling and delivering the Plan) would utilise to monitor progress.

5.6 In response to a query from Councillor Jackie Drayton regarding health partners' views on the Action Plan, Phil Holmes confirmed that the Action Plan benefitted from whole system involvement, with the local health partner organisations taking shared ownership of the Plan. Nicki Doherty added that each health partner organisation had agreed the actions it would take and to ensure that their delivery would be overseen at senior leadership level.

5.7 Jayne Ludlam suggested that this Board should have the role of driving the agenda to shift resource deployment towards prevention.

5.8 Jayne Brown enquired as to the extent of progress already made on delivering the Action Plan, and in response, Phil Holmes outlined initiatives which had

recently been launched to provide momentum and to increase understanding of older people's service experiences. He added that the Accountable Care Partnership (ACP) would be monitoring progress on the delivery of the Action Plan, and that its performance monitoring information would be provided to this Board to enable progress to be appraised. He undertook to circulate the current monitoring data to Board members by email and to report more fully to the next meeting of the Board. In response to a further comment from Councillor Jackie Drayton, Phil Holmes confirmed that future Action Plan monitoring reports would include relevant statistical and trend information.

5.9 In response to comments made by Chief Inspector Helen Lewis regarding inappropriate criminalisation of older people, Phil Holmes, in acknowledging the issue, indicated that this linked to safeguarding and that he would raise this matter with the Adult Safeguarding Board.

5.10 Greg Fell suggested that, as part of the Board's role in ensuring progress against the Action Plan, Board members could take personal responsibility for championing specific actions or sponsoring priority themes.

5.11 **RESOLVED**: That:-

(a) the information contained in the report now submitted be noted;

(b) the plans for continually improving the care and support for older people in Sheffield, as set out in the Action Plan, be supported;

(c) the recommendation that the focus of the Board should be to ensure that governance arrangements are robust to drive the right outcomes for older people, and that the Board evaluates progress every six months to ensure a meaningful shift to prevention at scale that results in a greater number of people being able to maintain health and wellbeing for longer, be supported; and

(d) the suggestion that Board members take personal responsibility for championing specific actions or sponsoring priority themes, be supported and the Director of Adult Services and Director of Public Health be requested to co-ordinate the allocation process.

6. HEALTH AND WELLBEING STRATEGY

6.1 The Board considered a report of the Director of Public Health, Sheffield City Council, setting out a proposed approach and timescale for producing a new Health and Wellbeing Strategy for Sheffield.

6.2 In order to help guide the development of the Strategy, the report also sought a steer from the Board in relation to the definition and focus of a couple of the proposed ambitions to be featured in the Strategy.

6.3 Greg Fell (Director of Public Health) introduced the report, referring in particular to the proposed structure of, and approach to, the new strategy, and seeking the views of Board members in relation to the "Living and Working" and "How We Live" ambition areas. He concluded his presentation by outlining the proposed schedule for the production of the new Strategy, culminating in the final Strategy being approved by the Board at its meeting to be held on 28th March 2019.

6.4 Councillor Jackie Drayton referred to the "Starting and Developing Well" section of the proposed Strategy, and in particular, the ambition area of "School Readiness", and suggested that the ambition should be that all children at age 5 in Sheffield were ready for school and for life, and this suggestion was accepted by Greg Fell.

6.5 In response to comments made by Councillor Chris Peace in relation to defining and articulating the "Living and Working" section of the Strategy, Greg Fell outlined potential ambitions and sources for measuring success.

6.6 Judy Robinson referred to the "Ageing and Dying Well" section of the proposed Strategy, and in particular, the ambition area of "Loneliness and Isolation", and suggested that this issue was a cross cutting one, and this was acknowledged by the Board.

6.7 Maddy Ruff suggested that the proposed Strategy should clearly articulate what we want to do to improve health and wellbeing and reduce health inequalities in the city and how success would be measured. She recommended that lead responsibilities for delivering each of the ambitions should also be included in the Strategy.

6.8 In response to a comment made by Phil Holmes that the proposed new Strategy needed to flow from the Joint Strategic Needs Assessment (JSNA) and link to the city's Place-based plans, Greg Fell confirmed that the JSNA would form a key feature of the Strategy.

6.9 Dr Nikki Bates suggested that regard should be had in the Strategy to the role that the health and social care partners can play, being major employers in the city.

6.10 **RESOLVED**: That the Board:-

(a) approves the proposed approach to developing the updated Health & Wellbeing Strategy, as outlined in the report;

(b) agrees to receive drafts of the Strategy at the Board's October private strategy development session and December public meeting;

(c) agrees to work towards signing off a final version of the Strategy at the Board's March 2019 public meeting, following formal consultation to be undertaken early in the new year;

(d) agrees to discuss in further detail how successful implementation of the Strategy will be delivered and evaluated; and

(e) requests the Director of Public Health to circulate to Board members, details of the proposed sponsors for delivery of each of the proposed ambitions in the Strategy.

7. HEALTH AND WELLBEING BOARD FUTURE MEETING ARRANGEMENTS

7.1 The Board considered a joint report of the Director of Public Health, Sheffield City Council, and the Accountable Care Partnership Programme Director, containing proposals for future meeting arrangements for the Board, designed to improve openness and transparency around the work of the Board.

7.2 The report also proposed a broader review of Board membership, and of the relationship between the Board and the Accountable Care Partnership Board, to be conducted, building on the Board's discussions around the Care Quality Commission Local System Review and the Health and Wellbeing Strategy, and for recommendations in that regard to be submitted to the meeting of the Board on 13 December 2018.

7.3 In relation to future meeting arrangements, comments from members of the Board included that consideration should also be given to the format and venues for some of the meetings, to make them less formal and more interactive, and possibly to include presentations from service recipients. Whilst broadly supporting the proposal to make more meetings open to the public, it was accepted that the option to occasionally meet in private, for reasons of confidentiality, should be retained. It was also suggested that there should be clear plans and focus for the co-production work to be undertaken in the strategy development sessions.

7.4 In relation to Board membership, comments from members of the Board included support for the skill sets of the Board's membership to be kept under regular review, and for consideration to be given to Board membership being extended to include representation from the Council's Place Portfolio and voluntary sector.

7.5 RESOLVED: That this Board:-

(a) agrees to the proposal to implement quarterly formal public meetings, open strategy development sessions to the public, and publish agendas and minutes of these sessions online, as outlined in the report;

(b) requests that all members of the Board participate in the governance review to ensure all views are considered;

(c) agrees to receive recommendations from the reviews of Accountable Care Partnership governance, and Health and Wellbeing Board membership and terms of reference, at the Board's meeting on

13 December 2018; and

(d) notwithstanding the forthcoming review of membership, approves the appointment of the Executive Director, Place, Sheffield City Council, and the Cabinet Member for Neighbourhoods and Community Safety, to serve as additional members of the Board.

8. MINUTES OF THE PREVIOUS MEETING

8.1 **RESOLVED**: That the minutes of the meeting of the Board held on 29 March 2018 be approved as a correct record.

9. DATE AND TIME OF NEXT MEETING

9.1 It was noted that the next meeting of the Health and Wellbeing Board would be held on Thursday 13 December 2018, starting at 3.00pm.

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