Public Document Pack

# Sheffield Health and Wellbeing Board

**Sheffield City Council • Sheffield Clinical Commissioning Group**

## Thursday 25 June 2020 at 3.00 pm

## To be held as a video conference

**The Press and Public are Welcome to Attend**

**Membership**

| | |
|---|---|
| Chief Superintendent Stuart Barton | South Yorkshire Police |
| Dr Nikki Bates | Governing Body Member, Clinical Commissioning Group |
| 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 |
| Jane Ginniver | |
| Phil Holmes | Director of Adult Services, Sheffield City Council |
| Dr Terry Hudsen | NHS Sheffield CCG |
| David Hughes | Sheffield Teaching Hospitals NHS Foundation Trust |
| Alison Knowles | Locality Director, NHS England |
| Councillor George Lindars-Hammond | Cabinet Member for Health and Social Care |
| Laraine Manley | Executive Director, Place |

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|---|---|
| Clare Mappin | The Burton Street Foundation |
| Dr Zak McMurray | Clinical Director, Clinical Commissioning Group |
| Alison Metcalfe | |
| Prof Chris Newman | University of Sheffield |
| Judy Robinson | Chair, Healthwatch Sheffield |
| David Warwicker | |
| Councillor Paul Wood | |

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 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 require any further information please contact Abby Brownsword on 0114 273 35033 or email abby.brownsword@sheffield.gov.uk

## FACILITIES

N/A

# SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

**25 JUNE 2020**

**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. Chair's Message of Thanks**

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

**5. Covid-19: Rapid Health Impact Assessments** (Pages 5 - 14)
Report of the Director of Public Health.

**6. Healthwatch Update** (Pages 15 - 24)
Report of the Chair of Healthwatch Sheffield

**7. Health Inequalities and Covid-19** (Pages 25 - 42)
Report of the Director of Public Health.

**8. Minutes of the Previous Meeting** (Pages 43 - 50)
Minutes of the meeting of the Health and Wellbeing Board held on Thursday 30th January 2020.

**9. Date and Time of Next Meeting**
The next meeting will be held on Thursday 24th September 2020 at 3pm, venue to be confirmed.

## 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:** | 16th June 2020 |
| **Subject:** | Covid-19 Rapid Health Impact Assessment |
| **Author of Report:** | Eleanor Rutter |

**Summary:**

*This paper briefs the Board on work to produce Rapid Health Impact Assessments to guide work in response to Covid-19, in order that stakeholders can focus their work in the most impactful places to minimise the long-term, negative, health impact and maximise the many positive changes that have come from the crisis.*

**Questions for the Health and Wellbeing Board:**

Do the Board have any comments on the proposed approach to guide development of the work?

**Recommendations for the Health and Wellbeing Board:**

The Board are asked to:

- Note the intended approach to producing a Rapid Health Impact Assessment in relation to the Covid-19 pandemic;
- Provide feedback on the intended approach;
- Receive the output from the work at a future Board meeting.

**Background Papers:**

- *The Health Impact of the Covid-19 Pandemic in Sheffield Rapid Health Impact Assessment - Framework and Guidance for Contributors*

**Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?**

This addresses the issue of health inequalities in general.

**Who has contributed to this paper?**

Dan Spicer – Policy & Improvement Officer, Sheffield City Council

# COVID-19 RAPID HEALTH IMPACT ASSESSMENT

## 1.0 SUMMARY

1.1 This paper briefs the Board on work to produce Rapid Health Impact Assessments to guide work in response to Covid-19, in order that stakeholders can focus their work in the most impactful places to minimise the long-term, negative, health impact and maximise the many positive changes that have come from the crisis.

## 2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 Covid-19 and the actions taken in response to it will have long-term effects on people's health in addition to their current experiences. Those impacts are disproportionately spread across Sheffield's population. Recording and formally recognising them (quantifying if possible), is vital if we are to be successful in mitigating the detrimental effects and building on the positive.

## 3.0 OUR APPROACH TO RAPID HEALTH IMPACT ASSESSMENT

3.1 The appended framework and guidance document provides more detail on the approach being taken to develop this work; the key points of this are as follows:

- Underpinned by the view that communities in Sheffield have shown incredible levels of resilience during this pandemic and that the central purpose for conducting this assessment is not to quantify an assumed surge in demand for 'business as usual', but to identify and target mitigating and preventive actions and interventions that will strengthen communities;
- The end product of the rapid HIA project will be comprised of a number of chapters, each of these a 'mini-HIA' on a specific theme, raised as an area of concern by partners across the city;
- Each HIA chapter will be produced by an individual task and finish group, following the outline framework;
- Task and finish groups will comprise a small number of individuals with knowledge and expertise on the given theme, supported Public Health staff and a Steering Group.

## 4.0 QUESTIONS FOR THE BOARD

4.1 Do the Board have any comments on the proposed approach to guide development of the work?

## 5.0 RECOMMENDATIONS

5.1 The Board are asked to:

- Note the intended approach to producing a Rapid Health Impact Assessment in relation to the Covid-19 pandemic;
- Provide feedback on the intended approach;
- Receive the output from the work at a future Board meeting.

**The Health Impact of the Covid-19 Pandemic in Sheffield**
**Rapid Health Impact Assessment - Framework and Guidance for Contributors**

## Context

We know that Covid-19 and the actions taken in response to it will have long-term effects on people's health in addition to their current experiences. Those impacts are disproportionately spread across Sheffield's population. Recording and formally recognising them (quantifying if possible), is vital if we are to be successful in mitigating the detrimental effects and building on the positive.

It has been agreed by the H&WB board that a rapid health impact assessment (HIA) should be produced in order that stakeholders can focus their work in the most impactful places to minimise the long-term, negative, health impact and maximise the many positive changes that have come from the crisis.

This rapid HIA is underpinned by the view that communities in Sheffield have shown incredible levels of resilience during this pandemic and that the central purpose for conducting this assessment is not to quantify an assumed surge in demand for 'business as usual', but to identify and target mitigating and preventive actions and interventions that will strengthen communities, and to learn from innovative developments in order that they can be expanded and shared more widely as the city moves into its recovery and recalibration phases.

It is proposed that the end product of the rapid HIA project will be comprised of a number of chapters, each of these a 'mini-HIA' on a specific theme, raised as an area of concern by partners across the city. The themes are listed at appendix 1. These HIAs are intended to be of benefit beyond commissioning and service planning. They have the potential to add to similar work which is already underway by providing intelligence that can be widely used to aid recovery planning and decision-making. It will be important to use the rapid HIA data and narrative to influence the city's economic strategy so that the impact on health and wellbeing is considered alongside business and financial recovery plans, and reduce the risk of further adverse effects on deprivation and inequality.

Under the Equality Act, our statutory requirements are to appropriately evidence impact and our mitigating actions by protected characteristic and other communities of interest. This therefore should be inherent in how this work is approached and presented.

Each HIA chapter will be produced by an individual task and finish group. It is proposed that each of these will follow the outline framework below to provide a degree of uniformity. The framework will act as a guide and structure thoughts/trigger discussion but is not set in stone, individual task and finish groups may apply their own expertise and decide to deviate from the framework.

Task and finish groups will comprise a small number of individuals with knowledge and expertise on the given theme, supported by the Public Health Intelligence team and the Rapid HIA Steering Group. This impact assessment process will rapidly review data and intelligence to help identify the key risk factors for deteriorating health and wellbeing and any widening of health inequalities during the Covid-19 pandemic.

## Framework

1. **Theme**
2. **Lead**
3. **Brief rationale for inclusion of this theme**
4. **Summary**
5. **Aim**

To understand local people's experiences of the pandemic including their hopes and concerns about the future in order to help statutory, voluntary and informal providers focus their efforts in areas of greatest need and on interventions which are most impactful and sustainable. In order to:

i. minimise the long-term negative health impact
ii. maximise the many positive outcomes that have come from the crisis
iii. further strengthen and develop individual, household and community resilience
iv. aid recovery planning and decision-making
v. influence the city's economic strategy
vi. reduce the risk of further adverse effects on deprivation and inequality.

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6. **Objectives**

i. To rapidly collate and review the available and emerging data and provider intelligence to help identify key risk factors for deterioration in health and wellbeing during the pandemic and the sub populations (appendix 2) that are most likely to be affected.
ii. Gather the views of local people to better understand their experience of, and reaction to, both the pandemic and the measures to manage it and its impact on their futures.
iii. To predict and quantify where possible the likely health impact of Covid-19 on the Sheffield population, in the short, medium and long term and identify groups at particularly high risk.
iv. To collate current supportive and preventative mechanisms in place across the city to alleviate this impact and to identify any gaps which require input to further strengthen communities.
v. To identify capabilities, opportunities and motivations which may help to embed positive behaviours, initiated as a reaction to the pandemic and its management, as permanent.
vi. To make recommendations to relevant commissioners and providers on interventions the city could put in place to mitigate the risks to health and wellbeing and minimise the impact on services across the city.

7. **Methods and Sources of Intelligence**

The rapidity of these HIAs and need for urgent, local action means they are unlikely to be made up of large, published data-sets (although such may be included if relevant), but a mixture of local quantitative and qualitative data, anecdote, case studies, stories and literature reviews. Service-level intelligence and data from all sector providers will help to identify emerging issues, demands and the capacity of providers to respond to needs.

Where possible, data should be broken down demographically to identify any differential impacts on certain population groups, particularly those with protected characteristics and known high-risk groups.

**8. Key Lines of Enquiry**

i. What are the overarching impacts relating this theme brought about by Covid-19 and the response to it?
ii. Which groups are likely to be differentially affected by this issue?
iii. How is each of the identified groups being differentially affected?
iv. What is the scale of the impact now? Can we predict what it will be in the medium and long term?
v. What services/support is already in place (including community response) to mitigate any negative impacts? Can any judgements be made about the sufficiency (i.e. effectiveness and comprehensiveness) of this?
vi. What interventions can be identified to promote wellbeing and prevent ill-health, which can be sustained or developed as we move on from the crisis response phase?
vii. What local, community-level intelligence do we have to substantiate our findings?
viii. How can we use this information to ensure negative impacts are mitigated in our future decision-making?

**9. Scope**

The purpose of this intelligence necessitates rapidity and responsiveness and thus large, data-driven, surge-capacity modelling is out of scope. That said the output from this work is likely to sit well alongside intelligence developed by other partners which should be identified in the 'links' at section 12.

**10.Timeline**

- First draft of themes to steering group ASAP – by 23rd June 2020 at the latest
- Early report to H&WB board – End of July 2020
- Final report for H&WB board – Aug 2020 latest

**11.Contributors**

It is expected that as wide a group of stakeholders as necessary/practicable contribute to this rapid HIA including new/ad hoc/informal providers. They may also need to speak to a number of individuals not directly involved in the task and finish group as part of the information gathering process.

**12.Links**

Please document other relevant work that may be happening, for example: work commissioned by the CCG, outreach community-based intelligence being undertaken by VAS, Healthwatch etc.

**13.Recommendations**

Points to consider:

- How can we/the city prevent or mitigate any negative impacts?
- How might our services/approach flex to meet the needs identified here to aid recovery?
- What are the good things happening that we want to keep?  How could we do this?
- If there's no such thing as business as usual any more, what are the opportunities for more radical change?
- Other work that is in the planning or early implementation stage, that might add substantial information to his HIA that may change the recommendations or mitigations we currently believe to be appropriate?
- What more do we need to know?

**Appendix 1**

| Theme | Lead |
|---|---|
| ACEs | Debbie Hanson |
| Education (including transition) | Helen Nicholls |
| Housing | Suzanne Allen |
| Employment & working environments | Ed Highfield |
| Income and poverty (including food poverty) | Laura White |
| Active Travel | Matt Reynolds |
| Access to care and support | Linda Cutter |
| Social contact/isolation | Emma Dickinson |
| Individual lifestyles | Sarah Hepworth/Jess Wilson |
| Mental Wellbeing | Jim Milns |
| Discrimination/marginalisation | |
| End of Life | Sam Kyerematen g |
| Domestic Abuse | Alison Higgins |
| | |
| **Cross cutting themes** | |
| BAME | Sarah Hepworth |
| Behaviour change | Isobel Howie |
| Compassionate City | ER |
| Link to recovery | Laurie Brennan |

**Appendix 2**

| Sub populations |
|---|
| Disability |
| Gender reassignment |
| Marriage and civil partnership |
| Pregnancy and maternity |
| Race |
| Religion and belief |
| Sex |
| Sexual orientation |
| Age<br>- Pre-term<br>- 0-5 years<br>- School years<br>- Working age adults<br>- Old age |

Eleanor Rutter on behalf of the Rapid Health Impact Assessment Steering Group

5th June 2020

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# HEALTH AND WELLBEING BOARD PAPER

# FORMAL PUBLIC MEETING

| | |
|---|---|
| **Report of:** | Judy Robinson, Chair Healthwatch Sheffield |
| **Date:** | 16th June 2020 |
| **Subject:** | Healthwatch Update Report |
| **Author of Report:** | Lucy Davies, Chief Officer Healthwatch Sheffield |

**Summary:** Since the outbreak of COVID 18 Healthwatch has produced reports drawn from its inquiry service, feedback from individuals and from partner organisations. It is a snapshot not a population study. A summary of these reports is attached here.

**Questions for the Health and Wellbeing Board:**

The Board are asked:

- Can we work out an engagement plan together?
- How can representation reflect the city better?
- How can services work with Healthwatch to provide information more quickly?
- How can good practice be shared to improve some of the difficult situations experienced, as described?

**Recommendations for the Health and Wellbeing Board:**

The Board are asked to:

- Note the report from Healthwatch Sheffield on the impacts of Covid-19
- Consider how to address the issues raised

**Background Papers:**

- *How is covid-19 impacting on people's access to and experience of health and social care services in Sheffield? Health and Wellbeing Board Summary*

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**Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?**

All, in different ways.

**Who has contributed to this paper?**

This paper reflects the work of a range of Healthwatch Sheffield staff and the members of the public who have given their time.

## HOW IS COVID-19 IMPACTING ON PEOPLE IN SHEFFIELD

### 1.0 SUMMARY

1.1 Since the outbreak of COVID 18 Healthwatch has produced reports drawn from its inquiry service, feedback from individuals and from partner organisations. It is a snapshot not a population study. A summary of these reports is attached here.

### 2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 The issues mentioned in this paper and the appendix are specifically concerned with some of the most marginalised people and communities in the city. Healthwatch aims to help them have a voice about the impact of health inequality on their lives.

### 3.0 KEY POINTS FROM OUR WORK

3.1 Board members are recommended to read the appendix to this paper in full, but below we highlight some key messages:

3.1.1 Lack of clear information is a consistent concern for example what might be provided in mental health crisis care or what shielding means in different situations. Services sometimes do not explain how provision has changed, what other choices there may be or how their care may change. Some services, however, have communicated well.

3.1.2 Carers for people with dementia have been affected badly by the closing of day centres, sitting services etc.

3.1.3 Care packages: these have sometimes changed but in inconsistent ways so some providers have been flexible and creative but some people have lost support that was very important to them.

3.1.4 Care homes: PPE supplies were a concern a month or so ago. It was often staff members who contacted Healthwatch about their concerns: people discharged to homes without testing, PPE etc. (Healthwatch isn't primarily aimed at staff so this maybe indicative of blockages in staff feedback).

3.1.5 Dentistry has been of great concern and Healthwatch has found it impossible to get clear information to share.

3.1.6 Digital services work for some people but not all *and* for different reasons.

3.1.7 Healthwatch is currently running a general survey about the impact of COVID and people's experiences of it and of services which will report at the end of June.

3.1.8 In addition, surveys, interviews and engagement are being carried out with excluded communities for example refugee and asylum seekers, disabled people, carers and with BAME people about their particular experiences.

## 4.0 WHAT NEEDS TO HAPPEN TO MAKE A DIFFERENCE IN THIS AREA?

4.1 Our work has highlighted a number of areas where we believe more needs to be done, as follows:

4.1.1 **Engagement**: More *systematic* work to broaden and deepen *work* with voice and VCS organisations at different levels is vital because they have critical characteristics which will be needed in the aftermath:

- Reach
- Trust
- Volunteers

4.1.2 Healthwatch Sheffield is working on new ways to engage with citizens, not face to face.

4.1.3 Empowering patients and citizens means they are involved, knowledgeable and can discuss policy dilemmas and trade-offs. This will be vital to keeping people on board and to buy-in to new ways of living because they understand the choices etc.

4.1.4 **Communication & messaging**: especially to excluded communities needs a range of players working together & particularly those close to communities. Using volunteers from those communities is critical too.

4.1.5 **Improving information for the public**: Information has been hard for many people to find and, whilst it is important to be accurate it has proved difficult sometimes for system partners to accept that getting some information out is as important as it being absolutely watertight.

4.1.6 **Widening representation and perspectives**: Improving the range and depth of people and communities involved in the H&WB Board and its Strategy will bring new perspectives and help services to plan appropriately but it needs a commitment, new ways of working and, in some cases, resources for example front line community groups providing a service cannot attend strategy meetings without back fill funding. And, in general, widening the representation on decision making bodies so these bodies reflect better the makeup of the city.

## 5.0 QUESTIONS FOR THE BOARD

5.1 The Board are asked:

5.1.1 Can we work out an engagement plan together?

5.1.2 How can representation reflect the city better?

5.1.3 How can services work with Healthwatch to provide information more quickly?

5.1.4 How can good practice be shared to improve some of the difficult situations experienced, as described?

## 6.0 RECOMMENDATIONS

6.1 The Board are asked to:

6.1.1 Note the report from Healthwatch Sheffield on the impacts of Covid-19

6.1.2 Consider how to address the issues raised

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# How is covid-19 impacting on people's access to and experience of health and social care services in Sheffield?

## Health and Wellbeing Board Summary

*The content of this report comes from feedback we have received from individuals, as well as issues that have been brought to us via voluntary and community sector partners. It is a snapshot of what we have been hearing about since the start of May.*

## Mental health

**Crisis care:**

- People have said they need more support than usual right now. People have also reported a lack of clear information about what they can expect when accessing crisis care at the moment.
- One person with severe depression told us their appointment with the Specialist Psychotherapy Service was cancelled. They were offered no other support and told to ring the out of hours team if they reached crisis point, but they do not feel able to do this.

**Mental health – other concerns:**

- We have heard other examples of therapy being cancelled or put on hold.
- Worries about lack of social support (family/friends, support groups) becoming more detrimental the longer that lockdown continues. Digital options aren't suitable for all, either because people do not feel comfortable using them, or lack the money/skills to access IT.
- People are struggling with uncertainty about what will happen to their care. This is compounded by a lack of clear information from staff and services about what they can expect.
- Redeployment and/or sickness means more people are being treated by unfamiliar staff. We have heard particular concerns about the redeployment of IAPT staff.
- Issues with telephone appointments – sometimes these are late or missed entirely. Waiting for calls can make some people feel anxious. Calls come through on private numbers which causes issues for some, and people cannot check answerphone messages if they have no credit, meaning they do not know which service has phoned.

**Recovery services/substance misuse services**:
Many people are understanding of the disruption to services and are accessing telephone support or alternative community support. However, for some this disruption has set their recovery back.

## Shielding and lockdown messaging / information

- Every week we hear from people who are confused around shielding. Earlier in lockdown much of this related to people's uncertainty about whether they fell into this category, which was compounded by the different ways in which this information was reaching people, and at different times.
- People have reported that application of the 'shielding letters' seems inconsistent, with many people expecting a letter but not receiving one, and some being surprised to find

their doctor considers them vulnerable. We have also heard that spinal units have sent letters to patients inconsistently.

- We have heard concerns for the safety of some people with Learning Disabilities who do not fully understand the issues around coronavirus, and are choosing to go out into the community more often than government guidance states.
- At the same time, we have heard about care providers who have applied stricter conditions than government guidance sets out, for example one person with a learning disability told us they were not allowed visits from family members in the garden even once lockdown restrictions were eased.
- We have continued to hear from people who found the wording of the advice distressing – particularly being told they are 'extremely vulnerable'.
- For people who are vulnerable and need further support (e.g. groceries, medication collection, emotional support), there appears to have been inconsistency in where they are signposted to. We have spoken to council staff and social workers who were unsure of the city's support offer – i.e. the Council helpline, voluntary sector community hubs, and the NHS volunteer scheme.
- More recently, we have heard concerns from people who are confused about what the easing of lockdown restrictions means for them. Some people do not feel that the plans have been fully explained and would appreciate some local guidance that they can more easily apply to their own situations. Additionally, we spoke to someone who was shielding who felt that they were being left out of government plans – social isolation is having an increasingly negative effect on their mental health.

## People with Dementia and their carers

- We've continued to hear from voluntary sector organisations about the challenges facing people living with dementia and those who care for them. Building on previous concerns that PPE can be distressing for those who don't fully understand the situation, we've heard that opaque PPE makes it more difficult to communicate with people who rely heavily on nonverbal communication and facial expressions in order to understand what's being said.
- We have continued to hear from carers that it is challenging for staff in care homes to implement social distancing guidelines with people who have dementia.
- Lack of respite care (day centres and sitting services are closed, and many families feel their relative is at risk of covid-19 in care home respite) is leading to increased stress amongst family carers.

## Care Packages

- Although Care Act easements haven't taken place in Sheffield, some people are getting fewer hours of care and support than previously because lots of social/day activities aren't possible.
- In some instances, this part of a support package has been used in a different way - we've been told that some social workers have been creative and supportive in finding different ways to meet people's needs.
- We have also heard about providers who have been pro-active and flexible in finding new ways of working to support people.
- But we've also been told that some people have lost part of their care package, and haven't had the chance to talk about alternatives.

- Continuing Healthcare – we have had two examples of people having difficulty with CHC processes, and it has not been easy to find information about how this is currently operating in Sheffield.

## Care homes

We have heard from members of staff in 7 care homes, as well as hearing from advocates who are supporting clients in 31 care homes across Sheffield. We are in ongoing discussions with Sheffield City Council about issues raised.

**What we've heard from staff:**

- Care homes report struggling with staff shortages at the beginning of lockdown, but for some this has now improved. Linked to staff shortages, some staff members told us they are feeling under pressure to go into work when they are unwell or shielding.
- Several people working in care homes have told us that lack of information, or information not being passed to them in a timely way, has negatively impacted their work and planning.
- We've heard mixed feedback about GPs – some GPs are extremely supportive, while others have reportedly been unwilling to visit care homes even when residents are very unwell.
- Staff at one care home told us they had ample PPE, but most of those who got in touch with us raised real worries about PPE supplies. Some homes managed to stock up in March but these supplies are now dwindling and they're struggling to source more, while others have had very little for several weeks now.
- Staff members at several care homes told us of the difficulty they're having in getting staff tested, particularly those who are asymptomatic but in some cases those who are displaying symptoms as well. Some told us they're also still having trouble getting residents tested.
- Staff members told us about the impact covid-19 is having on relatives who cannot see their loved ones. Some homes have been able to arrange end of life visits but this is challenging.
- Admissions from hospital – one care home spoke about good practice in this regard, reporting that they are requesting tests if a hospital patient has been on a ward with covid-19 patients, and all new residents are isolated for 14 days. They shared concerns that one resident went into hospital for other health concerns, and was discharged back into the care home without being tested, despite having been on a ward with covid-19 patients.
- In care homes who haven't had any covid-19 cases, or who have managed to limit spread within the home, there is a sense that this is because of good leadership decisions, willingness of staff to be extremely flexible, and taking action before government guidelines came into force, rather than being the result of following national or local guidance.
- One care home reported involving residents in decisions about social isolation and other guidance, which has made them more confident in following the advice.

**What we've heard from advocates:**

- We've heard positive stories about many care homes who are supporting residents to be able to speak to their relatives and advocates. Many care homes have begun using video calls, while others are supporting people to talk on the phone over loud speaker or conference calls. One care home is allowing relatives to come to the garden and see their loved one through the window, while another is making good use of social media and their website to keep relatives up to date. Some care homes report not having the capacity for these initiatives – there is a need for support so that all homes can provide these opportunities.
- Many care homes are making proactive contact with advocates, and note taking and information sharing about clients is generally good.

- In some instances however, advocates reported that care home staff are not sharing adequate information about their clients, and some care homes are difficult to contact. One advocate raised concerns about their client not being able to speak to them privately, as poor telephone signal in the home meant they had to speak in the office rather than a private area.
- We heard from one advocate that communication with relatives had been an issue, where a relative had not been given information about their loved one's death.
- Advocates told us that some Deprivation of Liberty Safeguards (DoLS) conditions cannot be met due to current restrictions, and not all care homes are considering alternative ways they could try to meet these conditions.

## Other areas of care and support

**Dentists**
Since the beginning of lockdown we have had a lot of feedback about dentistry. People have found it difficult to find out about what treatment they can access and how; we have also found it very challenging to get good clear information to share with people. HWS compiled an accessible helpsheet on the dentistry which we were not able to publish due to barriers in verifying the details; we were provided with 'generic' messaging which was not responding to the specific questions and concerns being raised.

**Sheffield City Council**
We have heard reports of people being unable to get through to First Contact. They are able to leave voicemails but say they do not get a response to these.

**Advance Care Planning and DNARs**
We have heard that conversations about Advance Care Planning have been raised with patients in inappropriate or distressing ways, but we have also had feedback on some good practice around DNARs are being applied in a blanket way.

**Community Nursing Services**
We've had feedback that community nursing teams have delivered an excellent service during Covid.

# HEALTH AND WELLBEING BOARD PAPER

# FORMAL PUBLIC MEETING

| | |
|---|---|
| **Report of:** | Greg Fell, Director of Public Health |
| **Date:** | 19th June 2020 |
| **Subject:** | Health Inequalities and Covid-19 |
| **Author of Report:** | Dan Spicer, Policy & Improvement Officer, Sheffield City Council<br>Sarah Hepworth, Health Improvement Principal, Sheffield City Council |

**Summary:**

This paper summarises the key findings of three recent reports considering health inequalities in England:

1) Health Equity in England: the Marmot Review 10 Years On, produced by the Institute of Health Equity and published on 25th February 2020;
2) Disparities in the risk and outcomes of COVID-19, produced by Public Health England (PHE) and published on 2nd June 2020; and
3) Beyond the data: Understanding the impact of COVID-19 on BAME groups (PHE) and published on June 16th 2020

It reflects on the Sheffield position in relation to these, and how this interacts with the current crisis. It also reflects on work underway that is aiming to consider how Covid-19 is impacting on Sheffielders, and how this will contribute to addressing some of the issues raised in these reports, in the short term.

Finally it invites the Board to reflect on how the two reports interact with and inform the Board's strategic commitment to eliminating health inequalities, and what steps should be considered to address health inequalities between specific groups in Sheffield, over the longer term.

**Questions for the Health and Wellbeing Board:**

The Board are asked:

- Are there any other areas of work that should be explored as part of the work to address health inequalities in Sheffield, both pre-existing and those created and exacerbated by Covid-19?
- How work to address questions of representation and engagement in relation to the Board's work be approached?

**Recommendations for the Health and Wellbeing Board:**

The Board are recommended to:

1. Note the content, conclusions and recommendations of the Marmot report, and the PHE reports
2. Recognise that work is ongoing to understand the impact of Covid-19 in Sheffield and how this impacts on different groups, with short term actions being put in place as these deliver intelligence
3. Recommit to delivering the Health & Wellbeing Strategy, recognising that the ambitions within it remain the building blocks of healthy lives for Sheffielders, and that the challenge in and importance of delivering on them is greater in the context of the pandemic
4. Commit to delivering at the local level the recommendations laid out in the second PHE report, where we have the powers to do so
5. Agree that responding to the challenges outlined above is not the responsibility of one organisation but of the whole city
6. Use the opportunity of the delayed Terms of Reference review to reflect on questions of representation and ways of working to ensure that the strategies it develops and delivers on reflects the concerns and interests of all Sheffielders, reflecting on this at their July Strategy Development Session and bringing proposals in response to the next Public Committee Meeting
7. Commit to working with all city partners and other bodies in the city on addressing the disparities in the impacts of Covid-19, health inequalities in general, and the root causes of these, in the short and long term, especially recognising the vital role of the VCS, BAME and Faith sector organisations and leads in this approach.

**Background Papers:**

- *Health Equity in England: the Marmot Review 10 Years On*
- *Disparities in the risk and outcomes of COVID-19*
- *Beyond the data: Understanding the impact of COVID-19 on BAME groups*

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**Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?**

This paper addresses health inequalities in general and therefore cuts across all ambitions in the Strategy

**Who has contributed to this paper?**

Adele Robinson, Equalities & Engagement Manager, Sheffield City Council

Health & Wellbeing Board Steering Group

## HEALTH INEQUALITIES AND COVID-19

## 1.0 SUMMARY

1.1 This paper summarises the key findings of three recent reports considering health inequalities in England:

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1.2 It reflects on the Sheffield position in relation to these, and how this interacts with the current crisis. It also reflects on work underway that is aiming to consider how Covid-19 is impacting on Sheffielders, and how this will contribute to addressing some of the issues raised in these reports, in the short term.

1.3 Finally it invites the Board to reflect on how the two reports interact with and inform the Board's strategic commitment to eliminating health inequalities, and what steps should be considered to address health inequalities between specific groups in Sheffield, over the longer term.

## 2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 The issues mentioned in this paper are specifically concerned with health inequalities and how they connect with the current crisis.

## 3.0 SUMMARY OF HEALTH EQUITY IN ENGLAND: THE MARMOT REVIEW 10 YEARS ON

3.1 In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy will include policies and interventions that address the social determinants of health inequalities.

3.2 The Review had four tasks:

- Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action
- Show how this evidence could be translated into practice
- Advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy
- Publish a report of the Review's work that will contribute to the development of a post2010 health inequalities strategy

3.3 The review concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

3.4 Following the review being published in February 2010, there was a change in government in May 2010, with Labour succeeded by the Coalition of Conservatives and Liberal Democrats. Initially the new government welcomed the report and accepted all but one of its recommendations, but since that point health inequalities have had a lower priority level for successive governments. Beyond this, the impact of budget cuts to local government have principally been felt in areas focused on the social determinants of health, as Councils have made difficult decisions to protect critical services such as social care.

3.5 Ten years on from the publication of the original report, the Health Foundation commissioned a follow up report to review progress and propose recommendations for future action.

3.6 The report only focuses on five of the six areas identified in the original review. The policy area focused on ill health prevention was omitted as "it has been explored in detail by others since 2010 and there have been many programmes and interventions – led by Public Health England and NHS England and public health teams in local government." However the report emphasised that recommendations from 2010 were still relevant and vitally important, and called for "an increase in public health funding and increased focus on prevention from the NHS."[1]

3.7 The review featured some key new areas for analysis:

- a stronger focus on regional inequalities;
- a greater emphasis on poverty as well as the socioeconomic gradient;
- a stronger focus on ethnicity, recognising that ethnicity intersects with socioeconomic position to produce particularly poor outcomes for some minority ethnic groups

3.8 In relation to the last of these, lack of data remains a limitation in understanding ethnic inequalities in health, and the report made recommendations that this should be addressed.

3.9 The key findings of the report are as follows:

[1] https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

- Since 2010 life expectancy in England has stalled; this has not happened since at least 1900.
- The slowdown in life expectancy increase cannot for the most part be attributed to severe winters. More than 80% of the slowdown, between 2011 and 2019, results from influences other than winter-associated mortality. There are marked regional differences in life expectancy, particularly among people living in more deprived areas.
- Inequalities in life expectancy have increased. Among women in the most deprived 10% of areas, life expectancy fell between 2010-12 and 2016-18.
- There has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45-49. It is likely that social and economic conditions have undermined health at these ages.
- In every region men and women in the least deprived 10 percent of neighbourhoods have seen increases in life expectancy and differences between regions for these neighbourhoods are much smaller than for more deprived neighbourhoods.
- Routinely collected data on ethnicity in relation to health outcomes is in short supply which makes analysis of inequalities in health along these lines challenging; however the data available indicate that there are a range of inequalities associated with differences in ethnicity, such as:
    - Two research studies using area data pointed to those with Pakistani and Bangladeshi ethnicity having the lowest life expectancy and non-British Whites having the highest.
    - Public Health England's survey of quality life by different ethnic groups shows Pakistani, Bangladeshi and White Gypsy Travellers have much lower quality of life than other ethnic groups
    - Some minority ethnic groups have particularly high rates of child poverty. In 2017/18, 45 percent of minority ethnic children lived in families in poverty after housing costs, compared with 20 percent of children in White British families in the UK
    - Data show significant inequalities in attainment 8 scores related to eligibility for free school meals and ethnicity. For each ethnic group described, those eligible for free school meals do worse but there are different levels of attainment related to ethnicity. Chinese, Asian and mixed ethnic background children scored higher than average for Attainment 8
    - White people, married men, people with no disabilities and those with higher qualifications have higher employment rates than minority ethnic groups, women, lone parents and people with disabilities

    - Some ethnic groups also face much higher rates of poverty than others, particularly those who are Black and Bangladeshi and Pakistani origin where rates of poverty after housing costs are as high as 50 percent

- The amount of time people spend in poor health has increased across England since 2010.
- Large funding cuts have affected the social determinants across the whole of England, but deprived areas and areas outside London and the South East experienced larger cuts; their capacity to improve social determinants of health has been undermined.
- Cuts to local authorities have been hugely significant; local government allocations from MHCLG declined by 77% between 2009–10 and 2018–19. There have also been large cuts to most other Departments' expenditure. Spending on social protection and education, both vital for health, have declined the most – by 1.5 percent of GDP.
- UK government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010.

## 4.0 MARMOT RECOMMENDATIONS

4.1 The report made a number of recommendations, split into:

- Proposals to support action on health inequalities; and
- Recommendations against five of the six marmot principles

4.2 **Proposals to support action on health inequalities**

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health
    a. Development of a national strategy on health inequalities led by the Prime Minister.
    b. Ensuring a strong focus on social determinants of health in the new strategy and by Public Health England and NHS England.
    c. Establishing a Cabinet Level cross-departmental committee to lead implementation of the work on the health inequalities strategy.
    d. The cross departmental committee to lead prioritisation of equity considerations at the heart of policy formulation and implementation in all sectors
2. Ensure proportionate universal allocation of resources and implementation of policies.
    a. Health inequalities targets to reduce socioeconomic and area inequalities in health. Regional health inequalities should be reduced by achieving proportionately greater improvements in health inequalities in the North.
    b. Strengthen the deprivation components in the Revenue Support Grant to local authorities. The NHS Resource allocation formula should also be increased to better reflect social need.

c. Fund and adopt a proportionate universalist approach to building community resources and involve communities in the design and implementation of programmes to reduce inequalities.

3. Early intervention to prevent health inequalities

    a. Take action on the five areas outlined in the report in the ways set out and summarised here and continue to take action in the sixth area of the 2010 Marmot Review
    b. We also propose increasing spending on public health to seven percent of the NHS budget as set out in the 2010 Marmot Review

4. Develop the social determinants of health workforce

    a. Development of education programmes focusing on the social determinants for a range of workforces
    b. Development of anchor institution approaches
    c. Develop a health system approach to population health, with partnerships to improve population health among a range of sectors, locally and nationally.

5. Engage the public

    a. Government and Public Health England initiate a highly visible and accessible public debate highlighting widening health inequalities and addressing how the social determinants affect health.
    b. Development of appropriate public facing reporting mechanisms for inequalities in health.

6. Develop whole systems monitoring and strengthen accountability for health inequalities

    a. We therefore propose development of targets to bring the level of health of deprived areas in the North up to the level of good health enjoyed by people living in affluent areas in London and the South.
    b. In support of meeting those targets we propose to:
        i. Strengthen accountability mechanisms for health inequalities including through legislation
        ii. Build more effective whole system data sets and improve data for ethnicity

4.3 **Recommendations against the Marmot Principles**

**1. Giving every child the best start in life**

    a. Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.
    b. Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
    c. Improve availability and quality of early years services, including Children's Centres, in all regions of England.
    d. Increase pay and qualification requirements for the childcare workforce.

2. **Enabling all children, young people and adults to maximise their capabilities and have control over their lives**

    a. Put equity at the heart of national decisions about education policy and funding.
    b. Increase attainment to match the best in Europe by reducing inequalities in attainment.
    c. Invest in preventative services to reduce exclusions and support schools to stop offrolling pupils.
    d. Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).

3. **Creating fair employment and good work for all**

    a. Invest in good quality active labour market policies and reduce conditionalities and sanctions in benefit entitlement, particularly for those with children.
    b. Reduce in-work poverty by increasing the National Living Wage, achieving a minimum income for healthy living for those in work.
    c. Increase the number of post-school apprenticeships and support in-work training throughout the life course.
    d. Reduce the high levels of poor quality work and precarious employment.

4. **Ensuring a healthy standard of living for all**

    a. Ensure everyone has a minimum income for healthy living through increases to the National Living Wage and redesign of Universal Credit.
    b. Remove sanctions and reduce conditionalities in welfare payments.
    c. Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.
    d. Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.
    e. Review the taxation and benefit system to ensure it achieves greater equity and ensure effective tax rates are not regressive.

5. **Creating and sustaining healthy and sustainable places and communities.**

    a. Invest in the development of economic, social and cultural resources in the most deprived communities.
    b. 100% of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector.
    c. Aim for net zero carbon emissions by 2030 ensuring inequalities do not widen as a result.

4.4 The report was published shortly before the onset of the Covid-19 pandemic in the United Kingdom, and as such a formal Government response is still awaited. In the main, the audience for the report is national government, but there is much within it that

is relevant to Sheffield, and that should provide a guide for the actions the Board should be interested in as part of the delivery of the Joint Health & Wellbeing Strategy.

4.5 A critical point worth noting is that since the publication of the first Marmot report in 2010, much research has been done around the impact of the Labour Government's approach to reducing health inequalities during its time in office from 1997 to 2010. It is increasingly clear that the approach made an impact, demonstrating that a focused approach to the issue can lead to a closing of the gap.2 The clear lesson is: it can be done.

## 5.0 SUMMARY OF THE PHE REPORT "COVID-19: REVIEW OF DISPARITIES IN RISKS AND OUTCOMES"

5.1 The PHE report "COVID-19: review of disparities in risks and outcomes", published 2nd June 2020, was initially commissioned by the Chief Medical Officer (CMO) and Government on 16th April to review the disproportionate impact of coronavirus on BAME communities. This was following reports of patients admitted to intensive care that showed around 1/3 were from people of BAME background[3] as well as NHS and media reports of deaths of keyworkers in health and social care which showed that many were from BAME groups, often born outside the UK. A HSJ analysis of 106 reported deaths found that 63% were from various BAME backgrounds[4].

5.2 However the government asked for the scope of the review to become broader during April and May as a wider number factors were emerging as important for Covid19 risk, severe disease and death. Therefore this report now takes into account disparities in COVID19 risk and outcomes by age, sex, deprivation, region and ethnicity.

5.3 **Key findings of the report include:**

- The largest disparity found was by age. Among people already diagnosed with COVID-19: people who were 80 or older were seventy times more likely to die than those under 40
- Males were twice as likely as females to die;
- Those living in the more deprived areas were twice as likely to die as those living in the least deprived areas; with the same risk amongst men and women.
- The risk of dying was higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups
- Risk varies significantly by BAME population. People of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10% and 50% higher risk of death when compared to White British populations.

[3] https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports

[4] https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

- Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.
- Diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. This proportion was higher in all BAME groups when compared to White ethnic groups
- Local authorities with the highest diagnoses and death rates are mostly urban. This is likely explained by close proximity in which people live and work.

## 6.0 LIMITATIONS OF THE REPORT

6.1 The report did not analyse or take into account the effect of occupation, comorbidities or obesity on infection rates, severe disease or death rates. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both.

6.2 Also the report does not explore and therefore doesn't explain how the combination of risk factors (specifically occupation, obesity and co-morbidities) impact on the level of risk of infection from Covid19, risk of severe disease and death and how this differs between groups. The report also focuses on diagnosed hospital cases so does not account for what is happening at a community level and does not cover all those who get infected.

6.3 The report states it is important to note also that other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced between white and BAME populations. However some BAME populations still remained 1.8 to 3 times at higher risk of dying from Covid-19 than white populations. This remaining risk has yet to be fully accounted for scientifically. However from the emerging evidence, likely explanations include differences in socioeconomic factors, housing (multigenerational), occupation and cultural factors. The risk and exposure to Covid-19 infection appears to be multifactorial for BAME communities and therefore our response must be multifaceted to address these risk factors effectively and reduce inequalities.

6.4 The report found particularly high increase in all cause deaths (not just Covid-19) among those born outside the UK and Ireland; those in a range of caring occupations including social care and nursing auxiliaries and assistants; those who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs; those working as security guards and related occupations; and those in care homes. These are essentially lower paid, non secure, key worker jobs which people in disadvantaged communities and BAME communities are more likely to occupy and therefore were less likely to be able to work from home during the lockdown period and have more exposure to others.

6.5 The inequalities described in the report largely replicate existing inequalities in death rates in previous years, except for BAME groups, as mortality was previously higher in White ethnic groups.

## 7.0 CONCLUSIONS OF THE REPORT

7.1 The report concluded that relevant guidance, certain aspects of recording and reporting of data, and key policies should be adapted to recognise and wherever possible mitigate or reduce the impact of COVID-19 on the population groups that are shown in this review to be more affected by the infection and its adverse outcomes (e.g. workplace risk assessments, implementing government and PHE guidance on Covid19 across all sectors, PH Covid19 related communication campaigns).

7.2 As the numbers of new COVID-19 cases decrease, monitoring the infection among those most at risk will become increasingly important. It seems likely that it will be difficult to control the spread of COVID-19 unless these inequalities can be addressed.

7.3 The report did not make specific recommendations and was widely criticized for this.

7.4 At the time of the publication of this report the Government failed to publish work by Professor Kevin Fenton on behalf of PHE, which was due to outline findings from engagement with over 4000 individuals and organisations within the BAME community to understand their views, concerns and ideas in relation to the impact of Covid19 on communities. This would provide insight and recommendations into what action was needed to further protect BAME communities.

7.5 The Government announced on the 4th of June that Kemi Badeoch, Minister of Equalities will take forward this work via the Government's Equality Hub and the terms of reference were published. This mainly involved more investigative and inquiry into the issue[5].

## 8.0 SUMMARY OF PHE REPORT "BEYOND THE DATA: UNDERSTANDING THE IMPACT OF COVID-19 ON BAME POPULATIONS"

8.1 The PHE report "Beyond the data: understanding the impact of Covid-19 on BAME populations" was finally published on the 16th of June following public outcry and an open letter from the BMA. This was also in the context of a number of Black Lives Matter protests taking place across the UK and around the world, which arose out of the feelings that little was being done to protect BAME communities from Covid19 when they were clearly being disproportionately affected. This was further compounded by the unlawful killing of a Black man, George Floyd by a US police officer.

8.2 This report outlines many deep rooted and fundamental issues of health and society that need to be addressed both in Sheffield and across the UK.

[5] https://www.gov.uk/government/news/next-steps-for-work-on-covid-19-disparities-announced

8.3 It highlights that the unequal impact of Covid-19 on BAME communities may be explained by a number of factors ranging from social and economic inequalities, racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, CVD and asthma. Unpacking the relative contributions made by different factors is challenging as they do not all act independently.

8.4 The report states that stakeholders consistently expressed deep concern and anxiety that without explicit consideration of ethnicity, racism and structural disadvantage in our responses to Covid-19 and tackling health inequalities there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention in relation to Covid19. Future waves of the disease could again have severe and disproportionate impacts. The report calls for urgent, collaborative and decisive action to avoid a repeat of this in the future and makes seven very helpful and tangible recommendations for immediate action.

8.5 **Recommendations for action include:**

1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.
2. Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of Covid-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.
3. Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.
4. Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of Covid-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.
5. Fund, develop and implement culturally competent Covid-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
7. Ensure that Covid-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

## 9.0 GENETICS AND COVID-19

9.1 Neither PHE report reviewed the inherent genetic or biological risk of BAME communities and Covid-19; we have considered this locally. Whilst this can't be ruled out completely, it is still probably one of the least likely explanations. There are not many genetic factors that all BAME groups have in common with each other and not with people of White British heritage. Further, if genetics were a risk factor for infection and/or deaths from Covid-19, we would expect to see increased infection and death rates in countries such as India, Pakistan and Bangladesh; this is not something that is borne out by the evidence at the moment. However the evidence on this is not definitive and we will keep this under review.

## 10.0 LINKS BETWEEN THE THREE REPORTS

10.1 The three reports cover much of the same territory and as a result there are a number of consistent messages that come through strongly, as well as links between them:

- Inequalities remain a major cause of disparities in health outcomes within and between groups;
- Many of the drivers of disparities identified in the PHE reports have their roots in inequalities identified by the Marmot Review;
- Disparities and inequalities occur across many groups and can be viewed through a range of different frames: addressing them properly requires recognising all of these; and
- Disparities in outcomes are in large part a consequence of structural inequalities in our country, not of something inherent in individuals or groups.

10.2 From this, it is clear that making a difference in these areas is the responsibility of everyone and all organisations in Sheffield and England, and the city will need to work together to do so.

## 11.0 WHAT SHOULD THE SHEFFIELD RESPONSE BE?

11.1 There is no reason to suspect that the national picture described by the two reports summarised above is not reflected in Sheffield; indeed previous experience suggests

that we can expect this to be the case. However, we need to do more work locally to understand the detail of the picture in Sheffield and what action we need to take, and this paper now summarises some of that activity.

## 12.0 WHAT'S GOING ON IN SHEFFIELD?

12.1 In relation to the broader challenge of health inequalities, this is already the primary aim of our Joint Health & Wellbeing Strategy, with a specific commitment to address these within and between groups as well as on a geographical basis. It is heartening to see that the territory the Strategy covers is similar to that which the Marmot Review reiterates as crucial: this indicates the Board are trying to operate in the right space. **The Joint Health & Wellbeing Strategy should remain the mechanism by which these challenges are addressed, and the Board must continue to drive change in this space.**

12.2 Successful delivery is the key, and it is acknowledged that the pandemic and the consequences of the necessary response will make achieving the nine ambitions set out in the Strategy harder. The Board is actively working to consider how the crisis has changed the challenge facing Sheffield and how delivery of the Strategy might need to change as a result.

12.3 In relation to the impact of Covid-19 on Sheffield's population, there is a range of work underway to build up local intelligence and start to develop the city's response:

- **Vulnerability "quilts"**: the Council's public health intelligence officers produced an analysis of vulnerability to Covid-19, which demonstrated that pre-existing inequality was the biggest risk factor, backing up some of the discussion above.
- **Rapid Health Impact Assessments**: as set out above, it is well understood that Covid-19 and the actions taken in response to it will have long-term effects on people's health in addition to their current experiences, and that these are disproportionately spread across Sheffield's population. To address this the Health & Wellbeing Board has agreed that rapid health impact assessment (HIA) should be produced in order that stakeholders can focus their work in the most impactful places to minimise the long-term, negative, health impact and maximise the many positive changes that have come from the crisis.
- **Population wide questionnaire**: to understand people's specific experiences (positive and negative) of Covid-19 and lockdown and what support is needed locally in response to this as lockdown restrictions are eased.
- **Sheffield BAME Inequalities Communities Group (Public Health)**, developed to:
    - Seek views, experiences from the BAME communities/organisations on what the impacts of Covid19 have been locally during the last 4 months (positive & negative)

- Identify what are the current concerns in relation to the impact of Covid19 on BAME communities and the immediate need and response in Sheffield?
- Identify what local public sector services (inc. Council, Health and Care) and voluntary services could do better to ensure they engage and communicate effectively with BAME communities as part of this process.
- Help reduce the barriers to accessing services and support now and in the future.

- **Sheffield Race Equality Commission**: Sheffield City Council are in the process of establishing an independent Race Equality Commission to look at structural inequalities in Sheffield, hearing evidence and proposing recommendations in response;
- **Healthwatch Sheffield survey**: Healthwatch Sheffield is currently running a general survey about the impact of Covid-19 and people's experiences of it and of other services, which will report at the end of June/early July.
- **SpeakUp Grants**: a small grants programme run by Healthwatch to support smaller community groups to find out about the health and social care concerns of their communities, which has been re-purposed to find out about Covid-19 experience.
- **Ongoing engagement work**: In addition, surveys, interviews and engagement is being carried out by Healthwatch Sheffield with excluded communities for example refugee and asylum seekers, disabled people, carers and with BAME people & others about their particular experiences of COVID and of service changes, improvements etc.
- **Emergency response**: there has been a wide range of activity by partners across the city working to address the most immediate impacts of Covid-19 on the most vulnerable in Sheffield.

12.4 This demonstrates that work is underway to generate detailed qualitative and quantitative understanding of the Sheffield picture, which will be used to guide action in the short and long term.

12.5 However, the reports detailed above, and witnessing the disproportionate impact of Covid-19, suggest that we need to ask ourselves whether we have made anything like the sort of progress that we would want to on these issues. Like most other places and cities, we probably haven't.

12.6 So, while we should recognise that 'fixing' some of the issues in these reports will require a national government response, there are things that we can do within Sheffield. We need to decide how we are going to address these issues with renewed purpose, and to move from focussed discussion and intent, to tangible action and impact.

12.7 In doing this, it is important to reflect on the work referenced above, that found that the national Health Inequalities Strategy had made a measurable impact: again, it is

possible to make a difference with the right focused, coordinated approach and appropriate investment. But this also makes the clear depth of the challenge: there is not one, two or even three projects the city needs to undertake to make the change. Instead, the solution is to be found in coordinating the activity of all partners in the city around the aim of reducing health inequalities for all, building organisational machinery in support of this.

12.8 There is also a need to consider some risks and opportunities in relation to this work:

- **The dangers of medicalisation**: there is a risk that a focus on health inequalities leads to solutions based around a medical model. This approach will not address root causes.
- **The importance of community**: communities are where health is built, and Marmot underplays the importance of investing in communities, and embedding this approach across all services and organisations;
- **Devolution**: this will bring further opportunities to shape investment at the local level, and tie this to the inequalities challenge described in this paper;
- **Rate limiting steps**: these include things such as national policy, especially as it relates to the resources in local places; the dichotomy between redistribution and "levelling up"; and challenge involved in shifting resources around the system.

12.9 The other important thing to consider in looking at inequalities is the underlying legislation, The Equality Act 2010, is designed to protect people from discrimination in the workplace and in wider society.

12.10 The Public Sector Equality Duty, which is part of the Act, means that public bodies should consider all individuals, especially those who share protected characteristics, when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to our employees. It requires that we have to pay due regard to the need to: eliminate discrimination; advance equality of opportunity and foster good relations between different people. It also notes that compliance with the duty may involve treating some people more favourably than others.

12.11 The Act covers the protected characteristics of: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation and marriage or civil partnership status (only in relation to unlawful discrimination).

12.12 The PSED also has some Specific Duties to publish information annually to demonstrate its compliance with the duty in relation to citizens and staff; Publish Equality Objectives every 4 years; Report on the Gender Pay Gap annually and to publish in a way that is accessible to the public.

12.13 The broad purpose of the Duty is to integrate consideration of equality into the day-to-day business of public authorities. If you do not consider how a function can affect different groups in different ways, e.g. via an equality impact assessment, it is unlikely to have the intended effect. This will contribute to greater inequality and poor outcomes. These impact assessments need to be done early, robustly and consistently if they are to work.

## 13.0 HOW SHOULD THE BOARD RESPOND?

13.1 Although the work described is underway, this does not mean the Board should wait until it is complete before taking action. As discussed above, the Board is already reflecting on how its approach to delivering the Joint Health & Wellbeing Strategy might need to change to address the changing challenge presented due to the crisis, and to build on some of the positive work that has taken place in Sheffield as part of the pandemic response.

13.2 As part of this work, and reflecting on the discussion above of the Marmot and PHE reports, the Board should consider what it can do to better understand those challenges from the point of view of the people affected. This covers questions of engagement, but also of representation in Board conversations.

13.3 This in turn indicates a potential need to reflect on the Board's membership and approach to its work, and how this is set up to ensure that the Board's discussions, and the strategy that emerges from them, fully reflects the needs and aspirations of the city as a whole. This will need to balance:

- The need for the Board to ensure it engages effectively with the health and wellbeing system in Sheffield, covering key stakeholders across a range of agencies and organisations;
- The need to ensure that those contributing to Board conversations are representative of the city and in particular of those affected by the issue under discussion at a given time; and
- The need to maintain manageable working arrangements so that the Board is effective.

13.4 The Board was scheduled to conduct a review of its Terms of Reference in the first half of 2020, which was postponed as a result of the pandemic. The Board may wish to use this opportunity to consider some of the issues raised above, and how these could be addressed by a combination of working practices as well as membership, aiming to report with recommendations for the way forward as soon as possible.

## 14.0 QUESTIONS FOR THE BOARD

14.1 The Board are asked:

1. Are there any other areas of work that should be explored as part of the work to address health inequalities in Sheffield, both pre-existing and those created and exacerbated by Covid-19?
2. How work to address questions of representation and engagement in relation to the Board's work be approached?

## 15.0 RECOMMENDATIONS

15.1 The Board are recommended to:

1. Note the content, conclusions and recommendations of the Marmot report, and the PHE reports
2. Recognise that work is ongoing to understand the impact of Covid-19 in Sheffield and how this impacts on different groups, with short term actions being put in place as these deliver intelligence
3. Recommit to delivering the Health & Wellbeing Strategy, recognising that the ambitions within it remain the building blocks of healthy lives for Sheffielders, and that the challenge in and importance of delivering on them is greater in the context of the pandemic
4. Commit to delivering at the local level the recommendations laid out in the second PHE report, where we have the powers to do so
5. Agree that responding to the challenges outlined above is not the responsibility of one organisation but of the whole city
6. Use the opportunity of the delayed Terms of Reference review to reflect on questions of representation and ways of working to ensure that the strategies it develops and delivers on reflects the concerns and interests of all Sheffielders, reflecting on this at their July Strategy Development Session and bringing proposals in response to the next Public Committee Meeting
7. Commit to working with all city partners and other bodies in the city on addressing the disparities in the impacts of Covid-19, health inequalities in general, and the root causes of these, in the short and long term, especially recognising the vital role of the VCS, BAME and Faith sector organisations and leads in this approach.

**SHEFFIELD CITY COUNCIL**

# Sheffield Health and Wellbeing Board

## Meeting held 30 January 2020

**PRESENT:** Dr. Terry Hudsen (Chair) – GP Governing Body Chair, Sheffield CCG
Nikki Doherty – Director of Deliver Care Out of Hospital, Sheffield CCG
Councillor Jackie Drayton – Cabinet Member for Children and Families, SCC
Greg Fell – Director of Public Health, SCC
Alison Knowles – Locality Director, NHS England
Councillor George Lindars-Hammond – Cabinet Member for Health and Social Care, SCC
John Macilwraith – Executive Director of People Services, SCC
Prof. Chris Newman – University of Sheffield
Judy Robinson – Healthwatch Sheffield
Sara Storey – Interim Director of Adult Services, SCC
Mark Tuckett - Programme Director, ACP
David Warwicker - Governing Body GP, Sheffield CCG

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## 1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Charlie Adan, Stuart Barton, Bryan Hughes, David Hughes, James Henderson, Larraine Manley, Toni Schwarz, Lesley Smith and Councillor Paul Wood.

## 2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest made.

## 3. PUBLIC QUESTIONS

3.1 Councillor Douglas Johnson attended the meeting and asked the following questions on behalf of the Burngreave Clean Air Campaign.

1. Why are buses banned from the Northern General Hospital grounds?

2. What is being done about it?

3.2 Mike Hunter responded that he would supply an answer in writing.

3.3 Greg Fell stated that a number of queries had been received regarding this issue and would be answered in full.

## 4. HEALTHWATCH ANNUAL REPORT

4.1 Judy Robinson introduced the report and recommended that the Board read the Healthwatch England Annual Report that had been recently published. Healthwatch Sheffield had produced its own Annual Report for 2018/19.

4.2 Lucy Davis and Holly Robson presented the report and reminded the Board that Healthwatch had been established by legislation and received funding to operate. The aims of Healthwatch were to get the views of the users of health services and make recommendations.

4.3 Lucy Davis and Holly Robson gave a presentation which looked at the Annual Report and set out:

- The vision and purpose
- Highlights from the year
- How Healthwatch had made a difference

4.4 A Stories of Health exhibition had been held in the Winter Gardens and information and advice was given over the telephone. Healthwatch Sheffield was currently based in Voluntary Action Sheffield.

4.5 The challenges included how to effect change, how to value voices and experiences, how to obtain peoples' views to shape the commissioning process and how to effectively link voices across the city.

4.6 The 2020-2022 strategy was currently being written and would focus on specific priorities and include feedback from both individuals and organisations.

4.7 Councillor George Lindars-Hammond asked if Healthwatch felt that it was taking the place of health and social care complaints systems and was their work impacted by stress on the system. Holly Robson responded that some conversations were complaints and people valued the independence of Healthwatch, but it was not the best route for complaints.

4.8 Councillor Jackie Drayton said that Healthwatch were doing a good job. They had focussed on adults but had now broadened their scope as an organisation to hear everyone in the city. Young Healthwatch was fantastic. Healthwatch was valued and trusted in the city. It also provided an outlet for people who may have had a bad experience with the NHS but who didn't want to complain. How could Healthwatch influence without using peoples identity? She also thanked all of the volunteers for their hard work. Judy Robinson thanked Councillor Drayton for her comments and explained that there were a range of focus groups that people could attend to give their experiences.

4.9 Mike Hunter informed the Board that Healthwatch were invited to contribute and comment on the Health Trusts Annual Report and the Health Trust welcomed increasingly strong challenge.

4.10 **RESOLVED:** That, (1) in considering the questions set out in the report in relation to the Healthwatch Annual Report, the Board's answers be as follows:

1. *How are the board considering qualitative data coming from communities, alongside quantitative data when you plan an initiative or develop their work?* **The Board can steer and ask bodies to consider both qualitative and quantitative data when planning work.**

2. *How can you ensure that this happens in a timely way to enable it to have a true impact?* **The Board can look at quality data from a number of sources.**

3. *How does the Board make community engagement a consistent part of strategic planning?* **Community Engagement is part of the Health and Wellbeing Strategy.**

4. *How will you connect with Healthwatch in each of your own areas of work?* ***That is for each individual body to consider.***

(2) the board considers qualitative data alongside quantitative data in all its work: where there is dissonance between the two, the importance of citizen voice and experience should not be put aside,

(3) new systems embed engagement at an early (question formation) stage, and;

(4) that Board consider how it can support services to respond to feedback from engagement and in particular, how it can embed ownership of resulting action in strategies and workplans going forward.

## 5. HEALTHWATCH STRATEGY ENGAGEMENT REPORT

5.1 Maddy Desforges presented the report which presented the findings of the Health and Wellbeing Strategy engagement work undertaken by Voluntary Action Sheffield (VAS) andHealthwatch.

5.2 The engagement work had listened to the views of citizens on health and wellbeing. There had been a focus on seldom heard voices. The engagement had been carried out where people congregated, including the Beach and the Moor Market. Three key questions were asked at the feedback events. There were:

- What do you love most about Sheffield?
- What don't you like?
- What would you change?

5.3 The Board was informed that items such as dying well did not feature much in the feedback, but people were concerned about public transport, getting about and

using open spaces.

5.4 George Lindars-Hammond stated that he was glad that people were talking widely about things and asked whether there were any areas where Healthwatch would like to engage in a different way. Maddy Desforges said that it would be helpful to engage the community before the next strategy was written, which would help inform the direction of the strategy.

5.5 There were concerns regarding the effect of austerity on cohesion and resilience. Physical green spaces were good for health and wellbeing, but activities in those spaces had been cut.

5.6 Judy Robinson noted that people sometimes got lost in the system and Healthwatch tried to help them navigate through it. It had been agreed that Healthwatch would provide quarterly qualitative feedback.

5.7 Councillor Jackie Drayton said that although funding had been cut to outside activities, the Council was not very good at communicating what was actually being carried out. The community sector was making use of the spaces, but more information needed to be available to the public.

5.8 **RESOLVED:** That, (1) in considering the questions set out in the report in relation to the Healthwatch Strategy Engagement Report, the Board's answers be as follows:

1. *What are your reflections on feedback to date?* **As detailed above.**

2. *How can the engagement report and findings best be used to shape the next phase of work on the strategy? Specifically within that;*

   - *To inform planned workshops.* **To be determined by individual bodies.**
   - *To link back into the next phase of the engagement work to inform/refine the approach.* **To be determined by individual bodies.**

3. *Are there specific next steps the board would like to see in terms of engagement?* **Look at adult mental health and public transport.**

4. *How will the Board respond to the challenge where key messages don't align with the ambitions as described in the strategy?* **The Strategy should be fluid and responsive to changes in public ambition.**

(2) the information and intelligence gathered is actively used within the next phase of the Strategy development,

(3) the report is used to inform the discussion and action within the upcoming workshops, and;

(4) the Board notes and reflects on the findings, particularly where the key findings don't align directly to the ambitions as described in the strategy.

## 6. JOINT HEALTH AND WELLBEING STRATEGY UPDATE

6.1 Greg Fell presented the report which briefed the Board on progress made towards implementation of the Joint Health and Wellbeing Strategy. The report also set out a proposed programme of discussions for 2020, focused on each of the ambitions contained within the Strategy to be led by specific individuals and supported by a relevant Board Member.

6.2 Councillor George Lindars-Hammond welcomed the approach and felt that it could be challenging as in order to review the success of one ambition, may rely on the success of another.

6.3 Councillor Jackie Drayton said that there was a need to remind people what was already being done. The Strategy was not the beginning, but was building on successes already in place. Terry Hudsen (Chair) felt that this was an important point and the Board should celebrate what had been achieved.

6.4 Alison Knowles supported the approach and requested that a fourth column be added to the table to include the peoples voice.

6.5 Councillor George Lindars-Hammond stated that the role of the Health and Wellbeing Board was to recognise what had already been done, what was being done well and things that were important to Sheffielders.

6.6 **RESOLVED:** That in considering the questions set out in the report in relation to the Joint Health and Wellbeing Strategy Update, the Board's answers be as follows:

1. *Does the Board set out the approach set out in the report?* **Yes.**

2. *Does the board agree with the named leads and sponsors identified?* **Yes.**

3. *Does the Board support the broad approach to developing a Strategy performance framework?* **Yes.**

4. *How would the Board like to prioritise the ambitions in terms of Board agendas?* **To be set through the Steering Group.**

## 7. BETTER CARE FUND UPDATE

7.1 Jennie Milner attended the meeting and presented the report. The Better Care Fund (BCF) update built on the information provided at the previous meeting.

7.2 Jennie Milner informed the Board that the BCF programme was on track for Quarter 3. Delayed Transfer of Care (DTOC) statistics had maintained for 15 months. Next years' plan was currently being developed.

7.3 Sara Storey asked whether the targets were the correct ones as in the past, a lot of time had been spent chasing numbers and negative experiences should also

be reflected. Jennie Milner responded that it was only possible to measure things that could be counted, it was not possible to measure the impact that the voluntary sector had had on DTOC.

7.4 Nikki Doherty congratulated Jennie Milner who had changed the dynamic of the BCF Team. Consideration needed to be given to how the BCF had responded to the CQC inquiry and how it could listen to patient voices.

7.5 Councillor George Lindars-Hammond felt that the metrics were better than before, but there were weaknesses in terms of funding. There was a need to look at the Joint Commissioning approach and encourage the role of the Health and Wellbeing Board in the process.

7.6 **RESOLVED:** That, (1) in considering the questions set out in the report in relation to the Better Care Fund Update, the Board's answers be as follows:

1. *How does the Health and Wellbeing Board wish to influence and support the Joint Commissioning Plan for 2020/21?* ***A rhetorical question for the Board to consider.***

***2.*** *What additional assurance would Health and Wellbeing Board like to receive to be reassured that the financial position for each of the Better Care Fund themes is understood and being managed by the Commissioning organisations?* **Reassurance from the Joint Commissioning Committee.**

3. *Are there any particular Better Care Fund themes which the Board would like to be prioritised in future updates?* **Prevention and investment in communities.**

(2) the Quarter 3 submission be retrospectively approved for submission to the NHSE and LGA,

(3) the actual financial position to Month 8, of £0.959m overspent, be noted,

(4) the forecast outturn position, as calculated at Month 8, of £1.564m overspent, be noted,

(5) the KPI information available at the time of writing the report, be noted,

(6) the approval of the 2019/20 plan and actions to be taken to sign off section 75, be noted,

(7) actions required to seek assurance on financial balance at the end of the year be considered.

## 8. MINUTES OF THE PREVIOUS MEETING

8.1 **RESOLVED:** That the minutes of the meeting held on26th September 2019 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 26th March 2020 at 3pm, in the Town Hall, Sheffield.

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