SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 27 March 2014

PRESENT:

Dr Tim Moorhead (in the Chair), Chair, Clinical Commissioning Group

Dr Amir Afzal, GP Governing Body Member, Clinical Commissioning Group

Ian Atkinson, Accountable Officer, Clinical Commissioning Group

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

Professor Pam Enderby, Chair, Healthwatch Sheffield

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

Jayne Ludlam, Executive Director, Children, Young People and Families

Dr Zak McMurray, Clinical Director, Clinical Commissioning Group

John Mothersole, Chief Executive, Sheffield City Council

Laura Sherburn, NHS England

Dr Ted Turner, GP Governing Body Member, Clinical Commissioning Group

Dr Jeremy Wight, Director of Public Health

Moira Wilson, Interim Director of Care and Support, Sheffield City Council

In Attendance

Tim Furness, Director of Business Planning & Partnerships, Sheffield Clinical Commissioning Group

Joe Fowler, Director of Commissioning, Sheffield City Council

Sue Greig, Consultant in Public Health, Sheffield City Council

Chris Shaw, Head of Health Improvement, Sheffield City Council

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Julie Dore, Councillor Harry Harpham, Laraine Manley and Margaret Kitching.

2. DECLARATIONS OF INTEREST

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

3. PUBLIC QUESTIONS

3.1 Public Question Concerning Personal Health Budgets

Professor Pam Enderby asked a question concerning changes to personal health budgets, including who was leading and managing the changes and in relation to the budgetary split.

Tim Furness, Director of Business, Planning and Partnerships, Clinical Commissioning Group, responded that people who receive funding through NHS Continuing Health Care (CHC) have the right to ask for a Personal Health Budget (PHB) from April 2014, and to have a PHB from October 2014.

Kevin Clifford, Chief Nurse, was leading the implementation of the arrangements relating to the introduction of PHBs. The NHS Clinical Commissioning Group was responsible for the implementation.

In relation to split budgets, there were a number of patients who receive care jointly funded from both health and social care budgets. Tim Furness commented that the Clinical Commissioning Group and the City Council would need to join up processes so that PHBs are integrated for those patients.

The implementation of PHBs was also related to integration of health and social care. There was not, as yet, a protocol for PHBs but one would be developed. He suggested that Professor Enderby speaks further with Kevin Clifford.

3.2 Public Question Concerning Public Health Grant

Mr Peter Hartley asked that a written response also be provided to his questions, which were as follows:-

1. What was the Public Health Grant for 2010-11, 2011-12, 2012-13, 2013-14 and 2014-15;

2. What were the four activities organised by the Board for 2013-14 and how much did each of these activities cost;

3. What are the four activities, with dates, planned for 2014-15; and

4. How is Healthwatch Sheffield funded and does it come out of the Public Health Grant?

Dr Tim Moorhead (Chair) responded to Mr Hartley, stating that the information which he had requested would be provided to him in writing and the written information would also be published with the minutes and documents for this meeting of the Board.

4. HEALTH AND WELLBEING PLANS FOR SHEFFIELD IN 2014-15

4.1 The Board considered a joint report of the Leader of Sheffield City Council, Chair of the NHS Sheffield Clinical Commissioning Group and Director of Quality and Nursing, NHS England. The report outlined the Health and Wellbeing Board's

priorities for Sheffield in 2014-15; presented the plans of the organisations represented on the Board; and outlined the plans for integrating health and social care, including in relation to use of the Better Care Fund. Approval was sought to the plans for the use of the Better Care Fund as set out at Appendix D to the report.

The Board was asked to consider the following four questions, together with the recommendations set out in the report now submitted:

- Do the plans contribute enough to delivering the Joint Health and Wellbeing Strategy?
- Are there areas for greater joint working between the four organisations on the Health and Wellbeing Board (and others) in 2014-15 and looking to the 2015-16 budget setting process?
- Does the Board have any specific comments to make regarding any of the organisations' plans?
- What role is there for Healthwatch Sheffield over the coming year in assisting with the implementation of these plans?

4.2 Members of the Board commented upon the content of the plans, as summarised below:-

It was welcome that all the plans of constituent organisations were in one document, which was a reflection of co-ordinated joint planning. Nonetheless, there were also opportunities to do more.

Particular attention was drawn to the themes relating to "a good start in life" and health inequalities, which were intrinsic to other plans. Integrated health and social care commissioning plans included children and young people and community and intensive support. Sheffield's 'Best Start' bid to the Big Lottery fund represented a more integrated approach.

The plans as presented had been informed by patient and public involvement throughout. However, in the proposed transformational changes, there appeared to be no measures by which to evaluate how the changes will affect people.

It was confirmed that discussions had taken place with regards suitable metrics to facilitate evaluation.

In relation to the NHS England plans, as outlined at appendix 4 (iv), these were presented as a high level document and reassurance should be given to people that the plans of NHS England were joined with those of the City Council, a fact that may not be apparent from the plans as presented.

The high level plans would be supplemented by more detailed 2 year operational plans, which would be submitted to NHS England on 4 April and would then be made publically available when the final version was completed. It was intended that the plans would align with those of the Council.

The NHS England Plan as it stood could be perceived as relating to South

Yorkshire and more detailed plans, specific to Sheffield and also reflecting NHS England's public health and commissioning role were desirable.

Whilst the plan as presented was at a high level, as the detailed plans developed, there would be more local discussion, which had in fact already begun. The local detail would be contained in five year plans.

It was important for the Board to hear what the community and patients' views were regarding the plans and in that context Healthwatch was most important. Work was being done to ensure that the voice of children and young people was heard.

Healthwatch Sheffield had a role in relation to monitoring the Health and Wellbeing plans and looked forward to working with the City Council, CCG and NHS England.

It was not clear where financial cuts would be made owing to financial pressures and the public should know where, as a result, there would be substantial change.

There was a desire to involve people and the CCG was launching an involvement network and was working with Healthwatch Sheffield.

Financial resources were decreasing and, therefore, the City had to prioritise use of resources and plan accordingly. The reduced level of resources was a problem which people and organisations in Sheffield should understand and own and there should be open discussion about the issue. The plans did contribute to addressing delivery issues within the Health and Wellbeing Strategy. There were also areas in relation to which more joint working could take place.

In Sheffield, it was considered that the social model of health and wellbeing was important. Some public health resources were deployed to do things specific to health and other initiatives concerned the wider issues, such as smoking and obesity, which might be contributed to by lifestyle, where people live and the environment. Activity Sheffield was contributing to health improvement and it was recognised that better health was the result of a wide set of factors.

The public health grant in 2014 was £31 million and it would be used to address matters including health inequalities, people's lifestyles and the root causes which led to ill health and early death. Other Council initiatives also contributed to better health, such as reducing the number of road safety accidents.

The Better Care Fund related to funding which the CCG had already been allocated and was not new money. The emphasis was on using these resources differently.

The Board should be given credit for putting forward ambitions in relation to integration, which were quite well developed in comparison to other places in the country.

4.3 RESOLVED that:

(1) The Board formally approves the plan for the Better Care Fund as outlined in Appendix D to the report now submitted; and

(2) Members of the Board and the Board's constituent organisations commit to working together in an integrated way over the coming year.

5. JOINT STRATEGIC NEEDS ASSESSMENT ANNUAL REPORT 2013-14

5.1 The Board considered a report of the Director of Public Health concerning the Joint Strategic Needs Assessment (JSNA) Annual Report 2013-14. The report provided an update on the progress in gathering additional JSNA evidence and identified topics for further analysis in 2014-15. Proposals were also made for the development of indicators for outcome 5 of the Health and Wellbeing Strategy, namely that the health and wellbeing system is innovative, affordable and provides good value for money.

Dr Jeremy Wight, the Director of Public Health, informed the Board that the report set out some initial thoughts on developing outcome measures for outcome 5 of the Strategy. The proposals for topics to be considered in more detail in 2014-15 included climate change and adaptation. Topics would be considered in relation to all age groups.

The Board was requested to consider four questions, as follows:

- Is the level of detail in the report sufficient and if not, should it be more or less detailed?
- Are there other aspects of JSNA work that it would be helpful to report on (e.g. JSNA online resource)?
- Is the proposed approach to the development of outcome 5 indicators acceptable?
- Are there other JSNA topics that should be explored further?

5.2 Members of the Board commented upon the report as follows:-

It was important that health care professionals, when in contact with the public, took such opportunities to educate and inform. This was a matter that should also be included for health care professionals at undergraduate level.

There were resources to enable such activity and it was important to make every contact with patients and the public count. It was intended to recruit to a post, the responsibilities of which would include promotion of activity with Council staff that were in contact with the public and patients.

The findings relating to the JSNA should be more widely distributed to enable people to provide comments.

It was not intended that the Needs Assessment was a document which simply sat on the shelf. It had been produced in partnership and was a document open to the public. The issue of wider distribution of the JSNA was a matter which needed further consideration.

It might it be possible to use some of the information from the results of the Every Child Matters survey to inform the JSNA. The survey was thought quite powerful as the views from it came directly from children and young people and it could be used as evidence to inform the JSNA.

The CCG used the JSNA to inform and kick-start the planning process and identify priorities. Consideration should be given as to where action should be taken sooner. This had been done to some extent, through the Health and Wellbeing Strategy, which had been agreed and now needed to be implemented. There was also opportunity to take stock and to identify any new matters that need attention.

People with poor mental health might have a 20 year shorter life expectancy than average and people who had learning disabilities also had a shorter life expectancy and had physical health needs. There were actions in the Health and Wellbeing Strategy concerning such inequality and this would also be included in the Inequalities Action Plan, which was to be submitted to the Board later in the Spring.

There was a distinction between the detail in the JSNA and the amount of detail which was considered by this Board. It was a question for the Board as to whether it wished to see more or less detail. Members of the Board indicated that they were content with the amount of detail they received.

In relation to developing indicators for outcome 5 of the Joint Health and Wellbeing Strategy and the extent to which the system was innovative, if the Board concentrated on the commissioning of new services to improve health and wellbeing, it may overlook other existing innovative investment that was already underway. The Board had to be careful to tell the story on innovation.

It was proposed that a small group should be established to progress the development of indicators.

It was confirmed that children and young people would be included within the other topics identified for further investigation in the JSNA in 2014-15, including epilepsy, end of life care and offender health.

5.3 RESOLVED that the Board:

(1) Notes the significant progress achieved to date;

(2) Agrees that a paper outlining the proposed Health Equity programme be presented to a future meeting of the Board;

(3) Agrees (i) the proposed way forward for developing indicators for outcome 5 of the Joint Health and Wellbeing Strategy and (ii) to the establishment

of a time-limited working group, including Members of the Board, to further progress the development of indicators;

(4) Requests a full update on all the outcome indicators when the most up to date data are available (which is likely to be September 2014); and

(5) Agrees the additional Joint Strategic Needs Assessment (JSNA) topics to be investigated in 2014-15.

5.4 **Reasons for the recommendations**

It was important that the Board shaped and agreed the JSNA process and related areas of work as this is the key means by which it obtains evidence to support development and evaluation of the Joint Health and Wellbeing Strategy.

6. JOINT HEALTH AND WELLBEING STRATEGY WORK PROGRAMMES

6.1 The Board received presentations concerning the five work programmes which support the Health and Wellbeing Strategy, as follows:

6.2 A Good Start in life

Sue Greig, Consultant in Public Health, Sheffield City Council presented the ambitions, what it is intended will happen next and governance arrangements relating to the Good Start in Life Workstream, which was overseen by the Sheffield Children's Health and Wellbeing Partnership Board.

The Partnership Board's Future Shape Children's Health Programme comprised 4 areas:

- Children with Complex Health Needs
- Emotional Wellbeing and Mental Health
- Supporting the delivery of the Healthy Child Programme including Best Start Sheffield – Early Years
- Communications, Participation and Engagement

Ambitions included reducing health inequalities, establishing care pathways that are effective in a multi-agency environment, improving transition for young people and families, from children's to adult services and improving Children & Young People's emotional wellbeing.

Achievements comprised improved and enhanced partnership working, alignment with the Children's Joint Commissioning, focus on parenting and attachment/attunement in Early Years, improvements in health indicators such as a reduction in childhood obesity and teenage pregnancy rates, a successful stage 2 Lottery Bid Submission – Best Start Sheffield and 'Inde' Travel Transport for young people – promoting independence.

Sue Greig also outlined key future priorities and governance arrangements. The outcome of the Lottery Bid relating to early years would be known in May 2014.

6.3 Building Mental Wellbeing and Emotional Resilience

Dr Jeremy Wight, Director of Public Health, presented the ambitions, what it is intended will happen next and governance arrangements of the Building Mental Wellbeing and Emotional Resilience workstream.

He acknowledged that not as much progress has been made with this workstream as with the others, or as we all would have wished. This had been due primarily to lack of officer capacity working on this agenda, as well as lack of clarity about the governance of this workstream.

A wide range of ambitions were identified, including: work programme development (leadership/workforce capacity); to promote understanding of five ways to wellbeing, build upon community based assets, making every contact count; and that understanding mental wellbeing can lead us to do things differently.

Three social cafés had been commissioned, provided from community bases, the mental health information and advice service had been reviewed and there had been a wellbeing assessment of care homes. Events had been held, such as the Wellbeing Festival and Older People's Day. A Mental Health First Aid training programme had been developed and a City Council Members' task and finish group was established.

Plans included: promoting 5 ways to wellbeing, beginning with the Council workforce (April 2014); that the integration agenda is explicitly physical *and* mental health; working to bring £6 million of lottery funding for loneliness and isolation amongst older people; to implement Mental Wellbeing NICE (National Institute for Health and Care Excellence) guidance for older people in residential care and creating better links across programmes to build social capital and connect people.

A refresh was required of governance relating to mental health and wellbeing and the aim was to engage with academic and clinical expertise, the public and service users, and providers to guide future strategy and commissioning.

6.4 Food and Physical Activity

Dr Jeremy Wight outlined the ambitions, plans and governance arrangements for the Food and Physical Activity workstream. Food and physical activity, independently and together, were major determinants of health and Sheffield's Food Strategy vision was that the local community are food literate, and have a good understanding of how important food is for their health; *Everyone* can access food that is safe, nutritious and that benefits their health and wellbeing; food plays a key role in strengthening our local economy; and our local food system is sustainable. The City's *Move More* vision was to create a culture of physical activity resulting in Sheffield becoming the most active city in the UK by

2020.

Achievements included: stopping the rise in children overweight and obesity; the establishment of the Food and Physical Activity Board; the development of two new strategies for the City; and dedicated investment from the Public Health Grant.

The Board was requested to ratify the Sheffield Food Strategy and the Move More Strategy. The priorities of the Food Strategy were:

- Tackle food poverty in Sheffield.
- Improve the takeaway food offer in Sheffield.
- Support local communities in their efforts to eat well.
- Encourage more people to learn about and get involved in growing their own food.
- Boost the role food plays in the local economy.
- Establish an Independent Sheffield Food Trust.

A detailed implementation plan and evaluation framework was in development.

The outcomes of the Move More Strategy were: empowered communities; active environments; active people and families; physical activity as medicine; active schools and active pupils; active workplaces and an active workforce. Dr Wight also set out the principles of the Move More plan.

The Food and Physical Activity Board had oversight of the plans and the workstream, three executive groups had been established and more work was to be done on monitoring outcomes and progress for both food and physical activity.

6.5 Health, Disability and Employment

Chris Shaw, Head of Health Improvement, Sheffield City Council presented the ambitions, achievements, plans and governance arrangements relating to the Health, Disability and Employment workstream.

There were a number of ambitions which recognised that there were things that could be done to bring about interventions or reduce gaps in relation to health and employment, including employment as a realisable ambition for more young people with a disability.

Among the achievements relating to health, disability and employment were the development of a referral pathway from primary care to employment and a pilot with Macmillan Cancer Support to enable employment for those with or recovering from cancer.

Next steps were to create a GP referral pathway; to deliver Fit Note development between Primary Care and Employers; deliver the ESA (Employment and Support Allowance) employment pilot with Job Centre Plus; deliver the Employment Award; review existing ‘Employment Support’; deliver Core Cities

agreement; and hold the first Employment Disability and Health Summit.

Chris Shaw also outlined areas in which this Board might assist or accelerate change as regards the development of a referral pathway, supporting the Job Centre Plus pilot and the Good Employer' award – such as through a joint endorsement with the Chamber of Commerce or Local Enterprise Partnership; to steer LEP investment regarding support funding (through the European Social Fund) for employment of those with health conditions or disabilities to recognise and therefore support funding of health/disability oriented interventions and to engage in how this should be delivered.

6.6 Supporting People Closer to Home

Joe Fowler, Director of Commissioning, Sheffield City Council, outlined the ambitions, achievements, plans and governance arrangements relating to the Supporting People Closer to Home work programme.

Ambitions were to ensure more care is provided at or closer to home; enable service users to take control of their care and treatment; reduce dependency on hospital and long term care; and to help people to live independently for longer.

The work programme was part of the Health and Wellbeing Board's work on integrating health and social care, which had a clearly defined vision, supported by the Board's engagement events. At this meeting of the Board, approval was attained for plans relating to the Better Care Fund, which had a focus on supporting people closer to home.

The work programme would be delivered through the Health and Wellbeing Board's work on integrated commissioning and it would initially focus on services to help people stay well and at home, on intermediate care, community equipment and on long-term care.

6.7 Members of the Board made general comments on the work programmes/streams as follows:

The work streams would progress, all at a different pace and would have specific governance arrangements. In terms of this Board's relationship to those governance arrangements, there needed to be understanding of the strategy in the various workstreams, which may need to be seen in greater detail, to inform the Board and to avoid not only duplication but also the occurrence of gaps. There were some cross-cutting themes and greater emphasis could also be given to health inequalities issues.

Where there were links between workstreams, these should be identified. Consideration should be given as to how actions to reduce inequalities could be measured, so we know what was making a difference. Thanks were given to people involved in the various workstreams, including volunteers, such as those on the Food and Physical Activity Board.

There was a lot of work in other workstreams which would contribute to the

Building Mental Wellbeing and Emotional Resilience workstream. In relation to community resilience, there were significant assets in communities which could be drawn upon.

The most valuable contribution of Dr Margaret Ainger to the development of the Children's Health and Wellbeing Partnership Board was noted.

Thought would need to be given as to how this work was communicated. There was a significant amount of work involving co-production, redesign and integration. There should also be a method of sharing information between the various workstreams.

The degree of change within the workstreams required the right amount of support and resources to enable its delivery and evaluation of the extent to which change had been successful. Some form of communication of how people have been involved in that change was necessary and consideration would be given to the resources required.

In relation to health inequalities, it was right that there was challenge as to whether it was explicit as to how far inequalities featured within work programmes. A distinction was necessary between programmes that would impact upon health inequalities (for example those concerning employment) and other programmes, where a programme might prove successful but have little impact on health inequalities. Such an example might be in relation to the Move More Strategy, where there may be different outcomes in the East and the South West of the City and these might be seen to perpetuate or exacerbate existing inequalities in relation to physical activity.

Therefore, work which would improve health overall but not necessarily reduce health inequalities needed to be specifically targeted, and the impact on health inequalities monitored. There was a role for both commissioning organisations and providers in making the necessary interventions to address health inequalities.

6.8 RESOLVED that the Board:

(1) Notes the presentations and the information received relating to ambitions, achievements, plans and governance arrangements for the following five work streams:

(a) A Good Start in Life
(b) Building Mental Wellbeing and Emotional Resilience
(c) Food and Physical Activity
(d) Health, Disability and Employment
(e) Supporting People at or Closer to Home; and

(2) Ratifies the Sheffield Food Strategy and the Move More Strategy, which are integral to the Food and Physical Activity work stream.

7. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the Board held on 12 December 2013 were approved as a correct record.

8. DATE AND TIME OF NEXT MEETING

The next meeting of the Board would be held on 26 June 2014 at 2.00pm.