Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 30 March 2017 at 3.00 pm

Town Hall, Sheffield S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Cate McDonald	Cabinet Member for Health and Social Care
Dr Tim Moorhead	Chair of the Clinical Commissioning Group
Dr Nikki Bates	Governing Body Member, Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children, Young People and Families
Greg Fell	Director of Public Health, Sheffield City Council
Phil Holmes	Director of Adult Services, Sheffield City Council
Alison Knowles	Locality Director, NHS England
Jayne Ludlam	Executive Director, Children, Young People & Families
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
Peter Moore	Director of Strategy and Integration, Clinical Commissioning Group
John Mothersole	Chief Executive, Sheffield City Council
Judy Robinson	Chair, Healthwatch Sheffield
Maddy Ruff	Accountable Officer, Clinical Commissioning Group

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. www.sheffield.gov.uk/healthwellbeingboard

PUBLIC ACCESS TO THE MEETING

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

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

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

FACILITIES

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

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

30 MARCH 2017

Order of Business

1. **Apologies for Absence**
2. **Declarations of Interest** (Pages 1 - 4)
   Members to declare any interests they have in the business to be considered at the meeting.
3. **Public Questions**
   To receive any questions from members of the public.
4. **Updating the Joint Strategic Needs Assessment** (Pages 5 - 16)
   Report of the Director of Public Health.
5. **Better Care Fund**
   To receive a presentation.
6. **Health and Wellbeing Board Forward Plan** (Pages 17 - 20)
   Report of the Director of Public Health.
7. **Minutes of the Previous Meeting** (Pages 21 - 26)
   Minutes of the meeting of the Board held on 29 September 2016.

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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

PUBLIC MEETING

Report of:	Greg Fell, Director of Public Health
Date:	30th March 2017
Subject:	Updating the Joint Strategic Needs Assessment
Author of Report:	Louise Brewins – (0114) 205 7455

Summary:

This paper reports on the progress made with implementing changes to updating, maintaining and using the Sheffield Joint Strategic Needs Assessment (JSNA), as agreed at the Board's meeting 31st March 2016.

It notes that the two key actions of incorporating an up to date JSNA position into the 2016 DPH Report and development of an online JSNA resource have been completed. The link to the JSNA online is here: http://data.sheffield.gov.uk/stories/s/fs4w-cygv

The paper also notes that work to complete all sections of the online resource will be undertaken in time to inform the DPH Report for 2017 (a full list of topics is included as Appendix A to this paper).

Questions for the Health and Wellbeing Board:

Does the Board have any comments or questions about the design, usage or content of the online resource?

Does the Board have any specific topics that it wants to see included in the online resource that are not currently listed in Appendix A to this paper?

Are there any specific changes or improvements that the Board would like to see made to the online resource?

Recommendations for the Health and Wellbeing Board:

Endorse that work continues to complete all sections of the online resource, subject to any amendments

Incorporate a summary of 'what the (updated) JSNA is telling us' into the DPH Report 2017

Request proposals for further development of the online resource to be presented to a Board meeting later in the year

Background Papers:

JSNA online resource: http://data.sheffield.gov.uk/stories/s/fs4w-cygv

DPH Report 2016: https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html

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

All

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

Based on previous discussion with Board members and stakeholders as part of the review of the JSNA conducted January to March 2016.

Updating the Joint Strategic Needs Assessment

1. Background

This paper reports on the progress made with implementing changes to updating, maintaining and using the Sheffield Joint Strategic Needs Assessment (JSNA), as agreed at the Board's meeting 31st March 2016.

It notes that the two key actions of incorporating an up to date JSNA position into the 2016 DPH Report and development of an online resource have been completed. The link to the JSNA online is here: http://data.sheffield.gov.uk/stories/s/fs4w-cygv

The paper also sets out the remaining work required to complete all sections of the online resource, in time to inform the DPH Report for 2017 (a list of all topics is included as Appendix A to this paper).

2. Progress to date

The two key actions to be taken forward in 2016-17 were to: (a) incorporate a 'what the JSNA is telling us' section into the 2016 DPH Report; and (b) to create (and start to populate) an online JSNA resource.

2a Incorporating JSNA into the DPH Report

A JSNA chapter was included in the DPH Report published in October 2016 https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html this covered the following intelligence:

Population – projections updated to show how Sheffield's population is changing and how it compares with elsewhere. Demonstrated that the population growth we have experienced for the last few years is slowing down and will continue to do so for the next few years although Sheffield will continue to become more ethnically diverse. Overall, the City remains similar to most other major cities in the UK
Headlines – life expectancy and healthy life expectancy, mortality and morbidity indicators all updated to identify key health improvement challenges facing the City, the extent of health inequalities and how Sheffield compares with the rest of the Country. This emphasised that the historical gains in life expectancy are beginning to slow down and we need to focus on improving healthy life expectancy, especially for women
Life course indicators covering starting well, living well and ageing well analysed to help prioritise the specific aspects of health and wellbeing to focus on, the level of improvement required and which groups to target. Mental health, smoking, physical activity, diet and alcohol consumption featured as the priorities for action
Ward and neighbourhood health and wellbeing quilts produced providing a small area summary of variation in health and wellbeing across Sheffield. These reinforced the message that children and adults in the poorest parts of the City continue to experience the greatest burden of ill health, disability and early death.

2b JSNA Online

A JSNA online resource, using the Council's Open Data platform has been created http://data.sheffield.gov.uk/stories/s/fs4w-cygv and covers the following 'chapters':

Population

Communities of interest

Economic, social and environmental determinants of health

Child , maternal and reproductive health

Disease and disability

Mental health and wellbeing

Commercial determinants of health

To date, the chapters dealing with population and communities of interest have been completed in full. A number of individual topics for other chapters have also been completed. A full outline of topics to be updated is attached as Appendix A to this paper.

The advantage of using an Open Data platform is that the data featured in the tables, maps, graphs and infographics can all be opened, downloaded and manipulated by the user, facilitating wider engagement with the JSNA and creating opportunities for generating new insights. Going forward this also means it will be more straightforward to update the JSNA.

3. Next steps

There are a number of areas where we need to develop the JSNA.

There is further work to do to ensure that the JSNA continues to focus on strategic assessments of need, and is supplemented by more detailed and bespoke pieces of analysis of specific areas where more granular information is needed. A future work programme is to be defined, but will include many of the issues appended.

There is also further work to do around addressing data linkage and data sharing across organisations; this is being considered through the Public Service Reform work. The difficulty of change on the issue of data sharing is not underestimated.

There is more to do on developing a narrative, and the underpinning analysis, on how multiple illnesses differentially affect our communities. There is a pervasive narrative of "the ageing population" and current challenges around health & social care; this will be reframed around multiple morbidities and particularly inequalities in morbidity which is one of the principal drivers of the well documented issues.

Finally there is work to do on ensuring that there is better alignment of need (and especially inequality in need) with performance measures by which our organisations measure themselves and outcomes. By way of an example, relatively few of the indicators by which a CCG is performance managed (the CCG Assurance Framework) reflect the illness profile of the population, the framework largely misses the high impact areas of need.

CCG Information and Assessment Framework clinical priorities map poorly to population health priorities

	Leading causes of lost life	Leading causes of disability	Leading risk factors for poor health
1	Ischaemic heart disease	Low back and neck pain	Diet
2	Lung cancer	Ischaemic heart disease	Tobacco smoke
3	Cerebrovascular disease	Cerebrovascular disease	High BMI
4	COPD	COPD	Hypertension
5	Alzheimer's disease	Lung Cancer	Alcohol and drug use
6	Lower respiratory infections	Alzheimer's disease	High fasting glucose
7	Colorectal cancer	Sense organ diseases	High cholesterol
8	Breast cancer	Depression	Low glomerular filtration rate
9	Self harm	Falls	Low physical activity

Measured to some extent in CCG IaAF	Not measured in CCG IaAF

Source: Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet 2015

The aim will be to complete all chapters of the JSNA by June 2017 and to feed the key messages from this into the DPH Report due to be published in October 2017. To this end we propose to produce a 'what the JSNA is telling us' chapter, as we did for the 2016 report.

As for ongoing development of the online resource, we will add *new* topics as and when required after updating all *existing* topics and create associated links and resources on the Health and Wellbeing Board pages of the Council's website (i.e. from June 2017 onwards). This will include creating links to more in-depth health needs assessment work and enhancing the type and range of data used for each topic to include qualitative, asset-based information and case studies.

We are also keen to understand how we can expand the online resource to facilitate further development and use of the JSNA by stakeholders and this could include developing survey and feedback tools, blogs and discussion forum.

Proposals for enhancing the resource will be developed for discussion with the Board later in the year, when we have a better idea of how it is being used and by whom.

4. Questions

The Board is asked whether it has any:

Comments or questions about the design, usage or content of the online resource

Specific topics that it wants to see included that are not currently listed in Appendix A to this paper

Suggested changes or improvements to the resource.

5. Recommendations

The Board is asked to:

Endorse that work continues to complete all sections of the online resource by June 2017, subject to any amendments

Request a summary of 'what the (updated) JSNA is telling us' be incorporated into the DPH Report 2017

Request proposals for further development of the online resource to be presented to one of its meetings later in the year.

Appendix A: JSNA Chapters and Topics

All chapters and topics cover all ages unless otherwise stated.

1. Population

Age

Births

Deaths

Ethnicity

Gender

Life expectancy (and healthy life expectancy)

Migration

Population Projections

2. Communities of interest

Bangladeshi

Black African

Black Caribbean

Black and minority ethnic

Carers

Chinese

People with disabilities

Eastern European

Gypsy or Irish traveller

Indian

Lesbian, gay, bi-sexual or transgender

Lone parents

Pakistani

Roma

Somali

White Irish

Women

Yemeni

3. Economic, social and environmental determinants of health

Adult abuse

Adverse childhood experiences (including abuse, neglect and sexual exploitation)

Air quality

Antisocial behaviour

Deprivation (Index of Multiple Deprivation)

Early years development and school readiness (0-5s)

Education and skills

Employment

Equality, inclusion and cohesion

Excess winter deaths

Fear of crime

Flooding

Food (including food poverty)

Fuel poverty

Green spaces, parks and the outdoors

Health and work (Occupational Health)

Homelessness

Housing

Income (including living wage and poverty)

Noise

Road traffic accidents and fatalities

Transport and travel

Violence (including domestic and sexual violence)

Young people not in employment, education or training (NEETs)

4. Reproductive, maternal and child health

Accidents and undetermined injuries

Antenatal care

Breastfeeding

Childhood obesity

Complex needs

Dental and oral health

Emotional health and wellbeing

Low birth weight

Infant mortality

Maternal obesity

Parenting

Sexually transmitted infections

Smoking in pregnancy

Substance misuse (drugs, alcohol, tobacco)

Teenage conceptions and births

Terminations

Vaccination and immunisation

5. Disease and disability

Autism and ASD

Cancer

Cardiovascular disease (heart attacks and strokes)

Dementia and Alzheimer’s Disease

Diabetes

Falls

Hepatitis (A, B, C and E)

High blood pressure (Hypertension)

HIV/AIDS

Influenza and pneumonia

Kidney disease

Learning disabilities

Liver disease

Multiple morbidity

Musculoskeletal disorders

Neurological conditions

Respiratory disease (COPD and Asthma)

Sensory impairment (sight and hearing)

Severe mental illness

Tuberculosis

6. Mental health and wellbeing

Depression and anxiety

Social capital and resilience

Social isolation

Suicide and self-harm

Wellbeing

7. Commercial determinants of health

Alcohol

Diet

Drugs

Obesity

Physical activity

Tobacco (including vaping)

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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	17th March 2017
Subject:	Health & Wellbeing Board – Forward Plan
Author of Report:	Dan Spicer – 27 34554

Summary:

At their strategy development meeting on 16th February, the Health & Wellbeing Board conducted an initial discussion around the Board's Forward Plan for the year from April 2017 to March 2018. Chairs have discussed the feedback on early suggestions of topics for inclusion on the Forward Plan and have developed an initial proposal covering the period to the end of August 2017.

Questions for the Health and Wellbeing Board:

1) What do members see as priorities for the rest of the year?

Recommendations for the Health and Wellbeing Board:

1) Agree the forward plan to the end of August 2017.

Background Papers:

None

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

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

HEALTH & WELLBEING BOARD FORWARD PLAN – 2017-18

1.0 SUMMARY

1.1 At their strategy development meeting on 16th February, the Health & Wellbeing Board conducted an initial discussion around the Board's Forward Plan for the year from April 2017 to March 2018. Chairs have discussed the feedback on early suggestions of topics for inclusion on the Forward Plan and have developed an initial proposal covering the period to the end of August 2017, as set out below.

2.0 FORWARD PLAN

2.1 **2nd May 2017 – Strategy Meeting**

- **Urgent Care Review**

  Urgent Care is seen as the most pressing issue in need of significant review and reform, both locally and nationally. The immediate focus is on A&E but all stakeholders realise there are many other components of the urgent care system in Sheffield. This session will consider the key issues facing the city and set a direction of travel for future work.

- **Public Health Strategy**

  Sheffield City Council Cabinet approved the organisation's Public Health Strategy on 15th March. The Strategy sets out the Council's approach to becoming a Public Health organisation, or one which operates in such a way as to maximise its impact on health outcomes and the reduction of inequalities. There is significant crossover with the Board's area of interest, and the strategy suggests the Board as a route to affect areas that the Council cannot influence on its own. The focus of this session will be on briefing the Board on the Strategy, and discussing the Board's role in implementation.

2.2 **8th June 2017 – Strategy Meeting**

- **Primary Care Review**

  Primary care is expected to be a major area of transformation for healthcare services in Sheffield over the coming years. This session will be focused on the Board's role as a system leader, ensuring understanding of the challenges involved and aiming for the development of a clear plan for the future of primary care in Sheffield. This is expected to be a major piece of work for the Board in 2017/18 and there is an expectation that a second session looking at this issue will follow later in the year.

2.3 **11th July 2017 – Strategy Meeting**

- **What is the Joint Strategic Needs Assessment telling us?**

  Sheffield's Joint Strategic Needs Assessment has been under review over the past year. It is moving to a new online, open data format, and will be

continually updated on an incremental basis, rather than being overhauled in full every three to five years. This process is scheduled to be completed in June 2017, and with the previous update of the JSNA having taken place in 2013 it is timely for the Board to discuss key messages from the data and consider what that means for strategy and the activity that flows from that. This will also be an opportunity to inform and shape the thinking that goes into the annual Director of Public Health report that will be published towards the end of 2017.

2.4 **31st August 2017 – Strategy Meeting**

- **Mental Health Services**

  Mental health is one of the six clinical priorities identified in the NHS Five Year Forward View. Shaping Sheffield, the city's health and care place-based plan, identifies four priorities in relation to this:

  i. Improved access for children, young people and adults to emotional and mental health wellbeing services, providing early intervention;
  ii. Expand method of access to mental health services through wider digital/IT opportunities and different talking therapy interventions being made available;
  iii. Mindful employer programme; and
  iv. Developing an integrated Primary Care Mental Health Service.

  This session will be focused on how to approach these priorities.

- **Primary Care Review – Follow Up**

  This session will follow up on the discussion in June, reporting back on activity since then and providing an opportunity to reflect further.

3.0 FUTURE DISCUSSION AREAS

3.1 The following areas remain as topics proposed for discussion by Board members that are yet to be placed on the Forward Plan. These represent possible future topics for discussion, and their presence on this list does not mean that they will definitely be placed on the Forward Plan in the future. They should be seen as suggestions that will be subject to a prioritisation process through the Board's Steering Group, and are split into four broad categories of:

- The health & care system;
- The future of public services
- Board reflection on strategy and supporting arrangements
- The wider determinants of health

3.2 Proposed topics are as follows:

3.3 **Health and care system**

- Accountable Care System – governance and implications for Sheffield
- Dementia Strategy
- IV Drugs – learning from other cities
- Sexual Health
- Social Prescribing
- Transitions from Young People to Adult Services

3.4 **The future of public services**

- Developing engagement across systems
- Moving towards a preventative approach to service delivery
- Public Service Reform

3.5 **Board reflection**

- Board Development Session
- Citizen voice and its representation on the Board
- Director of Public Health Report (Annual Item)
- Health & Wellbeing Outcome Framework & Indicators
- Joint Health & Wellbeing Strategy Review

3.6 **Wider determinants**

- Adverse Childhood Experiences
- Air Quality, Transport & Health Outcomes
- City for All Ages
- Community-based Contributions to Promoting Wellbeing
- Employment & Health
- Health & Wellbeing Inequality
- Housing Strategy
- Inclusive Growth
- Sheffield's Local Plan and Health & Wellbeing Outcomes
- Tackling Poverty & Links to Health & Wellbeing

4.0 QUESTIONS FOR THE BOARD

4.1 What do members see as priorities for the rest of the year?

5.0 RECOMMENDATIONS

5.1 Agree the forward plan to the end of August 2017.

SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 29 September 2016

PRESENT: Dr Tim Moorhead (Chair), Dr Nikki Bates, Councillor Jackie Drayton, Greg Fell, Alison Knowles, Councillor Cate McDonald, Dr Zak McMurray, Judy Robinson, Maddy Ruff and Dr Ted Turner

In attendance: Dawn Walton, Children Young People and Families and Peter Moore, Clinical Commissioning Group

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Julie Dore and Phil Holmes, Jayne Ludlam, Larraine Manley and John Mothersole.

2. DECLARATIONS OF INTEREST

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

3. PUBLIC QUESTIONS

3.1 Public Questions Concerning Sustainability and Transformation Plans

3.1.1 Mike Simpkin asked the following questions concerning the South Yorkshire and Bassetlaw and Sheffield Local Sustainability and Transformation Plan:

3.1.2 1) What was the role of the Health and Wellbeing Board in relation to the Sustainability and Transformation Plan (STP) given that it will not meet in public again until April?

2) Where was the South Yorkshire regional dimension being publicly discussed?

3) Given the size of the funding gap for Sheffield, how will the STP be financed, especially if the South Yorkshire and Bassetlaw footprint was not successful in obtaining transformation funding? To what extent does the STP require financial reallocations between health and social care organisations within Sheffield and the wider sub-region?

4) Details of the STP were not expected to become available for another two weeks when some sort of consultation process will begin. Yet the timetable appears to demand that 2 year contracts will be signed before the end of the year. What was the nature of these contracts?

3.1.3 Greg Fell, Director of Public Health, responded that with regard to the role of the Health and Wellbeing Board, the NHS planning guidance was clear that there was not an expectation that Health and Wellbeing Boards would sign off the Sustainability and Transformation Plans. Health and Wellbeing Boards did not

override the existing governance arrangements of constituent organisations at this stage. Alison Knowles, NHS England stated that the role of the Board was to have responsibility for setting the strategy for health and wellbeing in the Sheffield and therefore to ensure that the STP was something which would help to drive that strategy forward and would not be to the detriment of the strategy for the City.

3.1.4 With regard to where the regional dimension relating to South Yorkshire was being publicly discussed, Greg Fell stated that the NHS wished to make sure that various parts of the health and social care system owned the STP before going to the public. However, no one expected that there would not be wider consultation prior to any change.

3.1.5 The STP was a plan and organisations may choose not to implement some elements of that plan. The plan for Sheffield was progressing, whilst the South Yorkshire plan was quite light on detail at this stage. With regard to discussion about the plan for South Yorkshire and Bassetlaw at regional level, there was not a similar forum at the regional level. People in each area would be discussing the plans. Discussion was taking place regarding the Sheffield plan.

3.1.6 Alison Knowles confirmed that discussions relating to the STP were happening at each of the five areas in South Yorkshire and Bassetlaw, and included individual health Trusts, Clinical Commissioning Groups and Health and Wellbeing Boards. There would be open and public discussion about the STP. In addition, if there were proposals for significant change, there was a statutory requirement to engage and consult. A team was working on the engagement relating to the Plan. The five chairs of Healthwatch organisations in the region were to meet with Sir Andrew Cash, the Chief Executive of Sheffield Teaching Hospitals NHS Trust, including with regard to engagement.

3.1.7 Tim Moorhead, Co-Chair of the Board, stated that a significant amount of work had been done in relation to financing of the STP and with regard to allocation of resources between health and social care organisations. Peter Moore, Clinical Commissioning Group, stated that there was a place based plan and resources would be considered for the City as a whole. Consideration would be given to where providers of services incurred costs in delivering those services and the related opportunities such as how money might follow the patient. Work was being undertaken at present with regard to how funding could be provided which would meet patient need.

3.1.8 Maddy Ruff, Clinical Commissioning Group, stated that the NHS had set a deadline of 23 December for contracts to be signed off and work was being progressed with key providers and contracting intentions were to be produced with providers based on the Sheffield Plan, to which all organisations were signed up. There were also other areas specific to providers which were outside of the Sheffield Plan. Discussion took place at the Clinical Commissioning Group Board with regard to contracting intentions.

3.1.9 A South Yorkshire Joint Scrutiny Committee had met to examine some areas, including specialist children's services and stroke services, which was considered to be positive and consideration would be given to whether issues relating to the

STP might also be submitted to that forum for early discussion.

4. SUSTAINABILITY AND TRANSFORMATION PLANS AND SHAPING SHEFFIELD

4.1 The Board considered a report of the Director of Public Health and the Integrated Commissioning Programme Director concerning the development of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) and Sheffield Local STP. Greg Fell, the Director of Public Health, introduced the report and confirmed that the existing statutory bodies had responsibility for governance relating to the Plan and the Board was requested to note the current position as regards the STP and Sheffield Place Based Plan and to provide robust challenge as appropriate.

4.2 The STP would be used to deliver what people wanted to be done in Sheffield, including better care, enabling people to be healthier and an NHS which ran more efficiently. A coalition of different organisations would work together to achieve those aims.

4.3 Members of the Board asked questions and made comments and responses were provided, as summarised below:

4.4 The Plan documents should make sure to mention children and young people as well as adults, for example in relation to mental health. The programme relating to children and young people was developing and there was an emphasis on increasing the proportion of children in the City who were school ready. There were also positive developments relating to dental health for young children and immunisation.

4.5 There were inequalities relating to health in Sheffield. For example, many people did not go to their GP and there was evidence of people dying early when they might have received treatment for their health condition. A problem was how people might be encouraged to seek help when they were aware of symptoms. Action did need to be taken to help people who did not access health services. In some circumstances, investments may have to be made on wider determinants of health which would impact upon inequalities, such as work to increase the numbers of school ready children.

4.6 The Plan broadly referenced voluntary and intermediary groups and it could be more specific so as to include people who were volunteers, in voluntary and community organisations, in workforce programmes. It was also acknowledged that the voluntary, community and faith sector and Healthwatch were particularly effective in relation to involvement and engagement and it was suggested that the Board support the establishment of a working group on that issue.

4.7 Whilst the link between economic and health factors was mentioned in the Plan, there was a risk that the Plan became focussed too much on health services. Such factors as employment and health might be included to a greater degree in the Sheffield Local STP. Business and education sectors would need to be included in engagement to discuss such issues as sickness and wellbeing,

employment and apprenticeships. Attention should also be given to the inclusion of black and minority ethnic communities.

4.8 Work and health were included in the Plan and a bid had been submitted to the Government's Work and Health Innovation Fund with regard to a project which aimed to get people with certain health conditions back into employment. A report would be submitted to the next Strategy meeting of this Board regarding employment and health. The Transforming Sheffield Programme Board representing the Chief Executives of Sheffield's health and social care organisations would consider the STP and with regard to support and sponsorship for the Sheffield based Plan, the Chief Executives of both the Council and Teaching Hospitals Trust were members of that Board.

4.9 It would be considered how broader commercial interests might be included within the STP and how investment in Sheffield might be used to stimulate the local economy and keep employment and business in the City.

4.10 A comment was made that the Plan as it was written did not translate into a picture of transformation. Whilst success measures were good, it was not apparent how much change they might bring about. Although there was an opportunity to bring about transformative change, there was nothing in the Plan which said how it could be achieved. It would be important to identify how barriers which had prevented delivery could be removed.

4.11 Governance was potentially a difficult issue and it might prevent the health and social care community from delivering its ambitions. Health and social care organisations did not share risk and operated in silos and this represented a barrier. Whereas, patients should be considered before organisations. The requirement for each organisation to balance a budget or achieve financial control targets did not help them to share risk. The governance issue should be identified as a potential risk.

4.12 Organisational boundaries presented a problem and on reflection, some plans had not been fully transacted because barriers were in place. However, the governance was something which had to be worked through and some difficult things had been achieved within existing governance arrangements. It was possible that NHS England could attempt to improve this situation where risks were identified, so that health and social care organisations were able to do bold things.

4.13 Describing what success looked like in the Plans was a challenge and might be achieved by looking at outcomes to understand what was understood by transformation in reality and on the ground. For example, improving children's readiness for school could be measured by how well they were potty trained and whether they displayed good behaviour on entering school.

4.14 A memorandum of understanding had been agreed and signed by providers which would enable services and resources to move from one organisation to another. This needed to be tested but it could form the basis of a different model of governance. The Chief Executives of Health and Social Care organisations had

agreed to the Plan and they would be held to account. The idea of a single balance sheet had also been agreed. How this translated into contracting intentions was something which was being done through co-commissioning with the local authority in respect of children's and mental health services.

4.15 A combination of primary care, community care services and the voluntary sector would be utilised to help deliver and more might be done by community services which may have otherwise been done in hospital settings. It was thought that the STP needed to say more about primary care, community care and social care.

4.16 General Practice was an important part of developing a strong and sustainable model of primary care for the City and the CCG had published a Primary Care Strategy and Practices were positive about the model of neighbourhood working to support people in staying well.

4.17 Areas to focus on included: inequalities; health and work; governance, including in relation to the use of financial resources and how these were accounted for, decision making and risk; primary and social care; raising the profile of things which were already happening; and recognising barriers and challenging them.

4.18 In relation to measures of success, there were some City-wide issues which might be considered, including children's health and wellbeing, employment and equality as well as indicators of behaviours between organisations. The plan also needed to add value to existing initiatives. Successful engagement was also an important factor. Success might also be defined by the extent to which issues which prevented change, including system governance, were addressed collectively.

4.19 It was considered that the construction of the plan was an iterative process. The next step was the submission of the detailed plans and an approach to engagement and communications would also need to be in place by that point in time.

4.20 **RESOLVED:** That the Health and Wellbeing Board:

(1) notes (a) the context in which the Sustainability and Transformation Plan (STP) is being developed, and the challenging timescales that have been set; (b) that many of the constituent parts of the plan reflect plans that are already in train – both at South Yorkshire and Sheffield level; (c) that the plan represents an opportunity to transform service provision in a way that better enables us to meet the three goals of improved heath & wellbeing, improved service quality, and improved efficiency; and

(2) notes the points raised during the Board's consideration of the plan at this meeting and as outlined above, including its consideration of improvements to the way the plan is being developed that will enable greater involvement and engagement of groups not currently involved and elements of the plan or process that need to be made more visible and explicit.

5. MINUTES OF THE PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Health and Wellbeing Board held on 31 March 2016 be approved as a correct record.

6. DATE AND TIME OF NEXT MEETING

The next meeting of the Health and Wellbeing Board would be held on 30 March 2017.