S H E F F I E L D C I T Y C O U N C I L

Sheffield Health and Wellbeing Board

Meeting held 27 July 2017

PRESENT: Councillor Cate McDonald (Chair), Cabinet Member for Health and Social Care

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

Dr Nikki Bates, Governing Body Member, Clinical Commissioning Group

Dr Alan Billings, South Yorkshire Police and Crime Commissioner

Jayne Brown, Sheffield Health and Social Care Trust

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

Greg Fell, Director of Public Health

Phil Holmes, Director of Adult Services, Sheffield City Council

Margaret Kilner, Sheffield Healthwatch

Alison Knowles, Locality Director, NHS England

Clare Mappin, The Burton Street Foundation

Peter Moore, Director of Strategy and Integration, Clinical Commissioning Group

Maddy Ruff, Accountable Officer, Clinical Commissioning Group

Prof. Laura Serrant, Sheffield Hallam University

Dr David Throssell, Sheffield Teaching Hospitals NHS Foundation Trust

In Attendance:

Rachel Dillon, Sheffield Clinical Commissioning Group

Kate Gleave, Sheffield Clinical Commissioning Group

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1. APOLOGIES FOR ABSENCE

Apologies were received from Jayne Ludlam, Dr Zak McMurray, John Mothersole, Professor Chris Newman and Judy Robinson. Margaret Kilner, Sheffield Healthwatch, attended as the appointed deputy in place of Judy Robinson.

2. DECLARATIONS OF INTEREST

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

3. PUBLIC QUESTIONS

There were no questions received from members of the public.

4. SHEFFIELD'S 2017/18 AND 18/19 DRAFT BETTER CARE FUND NARRATIVE SUBMISSION

The Board considered a joint report of the Executive Director Communities (now People Services), Sheffield City Council and the Chief Officer, NHS Sheffield Clinical Commissioning Group (CCG). Peter Moore, the Director of Strategy and Integration, Sheffield Clinical Commissioning Group introduced the report together with Rachel Dillon, Sheffield CCG.

The CCG and City Council were required to submit a plan for 2017-2019 to describe plans and targets by 11 September. The Health and Wellbeing Board would need to approve the narrative plan for Sheffield's Better Care Fund 2017/18 and 2018/19.

The Board was informed that the Better Care Fund was key to bringing about parts of the transformation the NHS, the Local Authority and local communities and was linked to public sector reform, place based plans and the Shaping Sheffield plan. There were challenges both at national and local level which related to Sustainability and Transformation Plans and integration. Nonetheless, Sheffield had remained clear to its outcomes. There had also been successes, including a pooled mental health budget, a pooled budget for equipment, the building of stronger relationships and the delivery of care through the development of community partnerships. The adoption of a neighbourhood model would mean that care could be delivered by groups of clinical and social care teams and allow earlier intervention and prevention and early diagnosis.

There were challenges around provider integration and the involvement of providers. There was also enabling work to be done in relation to infrastructure such as ICT. The financial position was also challenging and the Board had to be mindful of that and an example of a positive response was the planning of a pooled budget for mental health services. Sheffield was to receive an additional £24m non-recurrent funding in total over 3 years to spend on adult social care services. It was intended to progress the inclusion of provision for Children and Young People into the pooled budget from April 2018. There was also a plan relating to reducing delayed transfers of care out of hospital and in relation to management and governance. The ambition was to move to a more fully integrated system.

Members of the Board were asked to consider whether they were satisfied that the plans would progress the Board's ambition to transform the health and care landscape, reduce health inequalities and deliver better outcomes for Sheffield people; and to identify where there might be further opportunities for integration and joint working, in particular reference to commissioners and providers working together as an Accountable Care Partnership.

Members of the Board asked questions and commented on the issues and the comments and responses are summarised below:

It was hoped that with a less fragmented approach to commissioning of health and social care, there would also be less fragmented provision. The challenge was to use the existing resources more efficiently and not a reduction in the overall amount spent. There were some interventions, such as social prescribing, which provided benefit in other parts of the system, including secondary and tertiary care. However, at the present time, there was considered to be a capacity issue in relation in community provision and managing demand for social prescribing. It was thought that there should be cost effectiveness in all interventions.

It was considered that the Board would be assisted if there were appropriate metrics relating to the progress and impact of integration. Whilst the ambition for change presented in the draft narrative to the plan could be supported, the plan also required greater precision.

There was agreement that the term 'integration' should be something as seen from the perspective of the citizen and not an organisational viewpoint.

It was necessary for the Board to keep sight of what it wished to achieve and to demonstrate leadership, using the Better Care Fund to enable the use of resources where needed in the community and through providers.

There were examples of good practice in relation to the self-care strategy, where patients were enabled and supported to take on those tasks in relation to which they felt comfortable relating to their own health and wellbeing. In relation to patient satisfaction, outcomes were thought to be better if patients were properly involved.

Whilst issues of culture and cultural change had been put forward, it was acknowledged that it was difficult to define what was meant by the term 'culture' and therefore difficult to say how it might be changed. There were issues relating to clinical and professional boundaries which needed to be taken into account.

The main emphasis and audience for the narrative plan needed to be considered. Factors such as the implications for risk and the risk management associated with the movement of resources from one area to another might need to be more clearly detailed. Similarly, the factors specific to Sheffield may need to be more clearly set out.

There was acknowledgement that the issues for Sheffield's population were also contained in the Joint Strategic Needs Assessment and the State of Sheffield report, which gave a snapshot of the City. Moreover,

the changes brought about through the Accountable Care Partnership and Better Care Fund should also become apparent in those documents.

As regards the intended audience for the narrative document, the Better Care Fund Plan was to be submitted to NHS England and it was a subset of the Shaping Sheffield Plan. The guidance in relation to the Better Care Fund required it to be 'signed off' by the Board, although it was not specific as to the detail. There was a balance and choice for the Board as to whether it wished to see a highly detailed document or a narrative one, which might be high level or easier to follow.

The Better Care Fund might also be seen as a catalyst for change in terms of building partnerships and relationships. The plan might be considered to set the tone and expectations for integration of health and social care. This included the use of the plan to think about the Board's ambitions relative to the present state of things. As part of that thinking, the detail of the plan and issues such as public accountability would be considered.

There needed to be more in the narrative specifically about Sheffield and there were links to the content of the Public Health Strategy, which was to be considered by the Board later at this meeting. Whilst there were a number of different strategies, the Board would need to be clear about whether those strategies were sufficiently joined up. The right metrics needed to be worked upon. It was recognised that there had been sizable change in the past two years in the extent to which organisations were beginning to work together and understand their respective issues. This type of cultural change took time, but it was important to take into account risk, limitations and dynamics in organisations and the extent of public buy-in and understanding.

At its forthcoming development day, the Board might look at questions of leadership to enable cultural change and how strategies could be co-produced with patients and employees.

Appropriate metrics relating to the Better Care Fund might include measurement of what was being achieved and other aspects including cultural change and influence that the plan was bringing about. This included evaluation from the patient's perspective of their experiences. Actual health improvement may not be easy to measure and proxy measures might need to be utilised. Reference could be made to the JSNA, to clarify which of the populations in the City the plan was to target. There were various methods of measuring and evidencing the extent of achievement and change and these could include quantitative and qualitative measures, such as numbers, expenditure and patient voice by asking patients how they might articulate change. The measures could be based around the outcomes, themes and priorities in the plan.

It was **RESOLVED** that:

1. Approval is given to the narrative of the Better Care Fund plans;
2. the Health and Wellbeing Board delegates final approval of the Better Care Fund submission to NHS England to the lead executive officers in the Council and the CCG.
3. the Health and Wellbeing Board receives an update on progress at its public meeting in November 2017.

5. URGENT PRIMARY CARE

The Board considered a report of the Director of Strategy and Integration, Sheffield Clinical Commissioning Group concerning Urgent Primary Care. The item was presented by Kate Gleave, Sheffield CCG.

The report stated that the Clinical Commissioning Group's Strategy for Urgent Care articulated a need to improve urgent care services, in recognition of national policy to improve access and because people found the existing service arrangements confusing and difficult to use appropriately.

The Strategy recognised that local urgent primary care and services needed to be reorganised and the CCG had considered how this might be achieved with a view to agreeing a set of options for the delivery of services on which to consult from September 2017. The report summarised the case for change and the principles upon which the options had been based and it outlined the timescales involved.

The Board was informed that engagement with patients had found that patients did not always access urgent care based on the level of need and patients were confused as to what services to use and when. There was inequality and a differing experience and knowledge of services depending on where people lived in Sheffield. People were not always treated by the most appropriate service and there were issues relating to systems not operating cohesively and with regard to communication. The cost of travel on public transport was a barrier for some people, as were language issues.

The Board was asked to consider whether it could confirm that the objectives of the Urgent Primary Care review and redesign were in line with its own objectives; whether the Board would support and inform the formal public consultation; and whether the Board supported disproportionate re-investment into the areas of greatest need.

Members of the Board made comments and asked questions with reference to the questions outlined above and these are summarised below:

A question was asked about the consequences of moving financial resources if there was disproportionate re-investment into the areas of

greatest need. The response to this was that the NHS would usually make the same service offer to everyone. In this case, it had been identified that greater resource could be deployed to where need was greater and the need/demand was something which could be shown geographically and was highlighted in relation to urgent care. Such an intervention and investment in those communities would provide the best value for money and it would lead to improved health outcomes.

It would be considered helpful to communicate what changes to urgent care provision would mean for people and for particular groups of people. There was support for differential investment based on a clear understanding of need and there would also need to be transparency and consistency with regards to services which were available. The Board might also look at engagement in a similar way and apply disproportionate effort or investment to mobilise people and also ensure that they had a voice.

It was not intended that capacity for planned care would be adversely affected by the proposed changes to improve access to urgent care. The approach which had been taken recognised the relationship between planned and urgent care.

The Board would inform the options relating to consultation. There was no ability to give the perfect level of urgent care and therefore, it was proposed to provide a generic offer and also a more specific one for those communities which had particular circumstances, for example people who were homeless. There was also a wish to make sure patients with ‘urgent’ care needs received triage in a timely manner and were transferred to appropriate ‘planned’ care as soon as possible and also to ensure that there was capacity in primary care for a patient to be seen the same day or urgently. Whilst there were many fragmented services in the NHS, patients wished to see continuity of care.

It was confirmed that the issue would be submitted to the Board for further consideration and, at this point in time, the Board was being asked to confirm that it supported consultation in relating to urgent care. It was important to properly frame questions in the consultation and address uncertainty with regards to need and to recognise that there might be a range of different public opinion.

It was considered that proportionate re-investment would be a suitable approach and that there should be clarity as to what was meant by greatest need and in relation to where investment would be made.

The Board RESOLVED to:

1. Note the plans and intentions with regard to consultation on Urgent Primary Care as outlined in the report of Director of Strategy and Integration now submitted;

2. Confirm that the objectives of the Urgent Primary Care review and redesign are in line with its own objectives; and

3. Support proportionate re-investment into the areas of greatest need.

6. PUBLIC HEALTH STRATEGY

The Board considered a report of the Director of Public Health concerning the Public Health Strategy. The City Council's Cabinet agreed a Public Health Strategy at its meeting on 15th March 2017. Greg Fell, the Director of Public Health, explained that the strategy aimed to describe the Council's ambition to redress inequalities and, specifically, the 25 year difference in healthy life expectancy through the totality of its functions.

A key feature of the strategy was a focus on the concept of Health in All Policies in order to make explicit and increase health gain from policies and service areas that are not traditionally considered as "health" related. There was also an acknowledgement that to deliver such an approach, it would be necessary to change the way the organisation thinks and does its business. The four objectives of the Strategy related to: health inequalities, health in all policies, health protection and healthy lifestyles. There were 10 specific areas within the Strategy upon which the Council would initially focus as set out in the Strategy.

The Health and Wellbeing Board was asked to consider how this approach could be developed.

The Board was asked to consider a number of questions, namely: whether priority areas identified in the Strategy were the right areas to be focusing on, and if there were any that were of more immediate interest; were there other areas we should be looking at; what role the Health and Wellbeing Board could play in maximising the impact of the strategy; how the Health and Wellbeing system in Sheffield could build upon this direction to improve wellbeing in the city; and how the Health and Wellbeing Board could work with the Council's Scrutiny function to support the delivery of the Strategy?

Members of the Board asked questions and commented on this item of business, as summarised below:

There was a significant amount of activity in addition to the Public Health Strategy, including in relation to smoking cessation and prevention and air quality. The Strategy also had links to the Joint Strategic Needs Assessment and the Annual Report of Director of Public Health.

The Board expressed a number of different observations about the respective merits of having a broad strategic document as opposed to one which covered greater detail about activity, projects and operational matters.

It was consider that, whilst the Public Health Strategy was broad, it might be useful to identify where it could influence (and where it would not) and for the Board to consider some of the ten priority areas in greater detail and what organisations other than the Council were expected to contribute in this regard. It would also be helpful to say, if the priorities as set out in the Strategy were achieved, what was expected to happen to indicate that these were indeed the right priorities and how would we know that we had made a difference.

In relation to a work and health strategy, the three main issues were firstly, employability (i.e. ensuring that people could get back into work) and this was in progress; secondly, the health of people who were in work but poorly (sickness management); and thirdly, looking at those people who were both in work and well to make sure that issues of poor environments in the workplace were addressed.

The Strategy document identified that childhood experiences and inequalities in educational attainment were a key determinant of health outcomes. The Board may also consider how the ten priority areas would be brought back to the Board in future.

There would be further discussion about the detail of activity outlined in the Strategy and it was acknowledged that the Strategy would need both to describe the means by which there would be accountability and be more explicit in some areas, including in relation to education, communities and neighbourhoods and inequalities. Specific issues such as tobacco control and air quality would be brought to the Health and Wellbeing Board for consideration in the future.

The strategy was an “all age” strategy and it was considered that investment in children was the best thing to do in terms of its value. The timeframe of the strategy was two years (2017-19) and progress would be reviewed at the end of the two years, which would be subject of consideration by the Board. Whilst the Council did not control other organisations in the City, the strategy had a role in influencing and setting a direction for Sheffield in respect of public health. The Strategy would also be submitted to the CCG in September 2017 and might also be presented to other organisations.

It was RESOLVED that the report and Public Health Strategy 2017-19 be noted and that the Director of Public Health be requested to submit a report to the Board having reviewed progress relating to the Strategy after March 2019.

7. SHEFFIELD HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

The Board considered revised the Terms of Reference for the Board and were asked to comment as appropriate.

It was expected that deputies would be in attendance at meetings of the Board on an exceptional basis and agreed that this should be made clear in the Terms of Reference at paragraph 3.2.

In terms of the authority of representatives, it was accepted that each of the organisations represented on the Board were sovereign and that some decisions or representations would need to be made in accordance with the governance arrangements of individual organisations.

It was RESOLVED that:

1. the Terms of Reference of the Board are amended as follows:

    - The addition at paragraph 3.2 of the words “in exceptional circumstances” following the words “… attend a meeting and vote in place of the member.”

    - The addition at paragraph 3.5 of the words “and/or representations” after the words “It is accepted that some decisions”

2. The revised Terms of Reference are circulated to Members of the Board.

8. HEALTH AND WELLBEING BOARD FORWARD PLAN

The Board considered its forthcoming Work Programme as circulated.

The Board RESOLVED:

1. to note the Programme as submitted and the expected times and dates of Strategy Meetings (from 2pm to 5pm) and those Meetings of the Board to be held in public (from 3pm to 6pm).

2. to note the addition of cancer services to the list of topics for future consideration.

9. MINUTES OF THE PREVIOUS MEETING

It was RESOLVED that the minutes of the meeting of the Board held on 30 March 2017 be approved as a correct record.

10. DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Wellbeing Board would be held on Wednesday 27 September 2017, starting at 3.00pm.