Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 24 September 2020 at 3.00 pm

To be held as a virtual meeting.

The Press and Public are Welcome to Attend

Membership

Chief Superintendent Stuart Barton	South Yorkshire Police
Dr Nikki Bates	Governing Body Member, Clinical Commissioning Group
Jayne Brown	Sheffield Health & Social Care Trust
Nicki Doherty	Director of Delivery Care out of Hospital, Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children and Young People
Greg Fell	Director of Public Health, Sheffield City Council
Jane Ginniver	
Phil Holmes	Director of Adult Services, Sheffield City Council
Dr Terry Hudsen	NHS Sheffield CCG
David Hughes	Sheffield Teaching Hospitals NHS Foundation Trust
Alison Knowles	Locality Director, NHS England
Councillor George Lindars-Hammond	Cabinet Member for Health and Social Care
Laraine Manley	Executive Director, Place
Clare Mappin	The Burton Street Foundation
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
Alison Metcalfe	
Prof Chris Newman	University of Sheffield
Judy Robinson	Chair, Healthwatch Sheffield
David Warwicker	
Councillor Paul Wood	

Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

Sheffield's Health and Wellbeing Board started to meet in shadow form in January 2012 and became a statutory group in April 2013. The Health and Social Care Act 2012 states that every local authority needs a Health and Wellbeing Board. It is a group of local GPs, local councillors, a representative of Sheffield citizens, and senior managers in the NHS and the local authority, all of whom seek to make local government and local health services better for local people. Its terms of reference sets out how it will operate.

Sheffield's Health and Wellbeing Board has a formal public meeting every three months as well as a range of public events held at least once a quarter.

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. http://www.sheffield.gov.uk/home/public-health/health-wellbeing-board

PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you 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 Abby Brownsword on 0114 273 5033 or email abby.brownsword@sheffield.gov.uk

FACILITIES

N/A

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

24 SEPTEMBER 2020

Order of Business

1. Apologies for Absence

2. Declarations of Interest (Pages 5 - 8)
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. Covid-19: Rapid Health Impact Assessments (Pages 9 - 28)
Report of the Director of Public Health, Sheffield City Council.

5. Health Inequalities and Impact of Covid-19 on BAME Communities and How Health and Social Care Are Working With Communities To Tackle It (Pages 29 - 42)
Report of Brian Hughes, Deputy Accountable Officer, NHS Sheffield Clinical Commissioning Group and Executive lead for the Accountable Care Partnership, ACP, for the Impact of Covid-19 on BAME communities work stream.

6. Better Care Fund Update (Pages 43 - 52)

7. Terms of Reference (Pages 53 - 68)
Report of Greg Fell, Director of Public Health, Sheffield City Council.

8. Healthwatch Update
Verbal Update

9. Minutes of the Previous Meeting (Pages 69 - 74)

10. Date and Time of Next Meeting
The next meeting is on Thursday 10th December 2020 at 3pm.

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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

FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	20th September 2020
Subject:	The Impact on Health & Wellbeing in Sheffield of the Covid-19 pandemic and subsequent societal response to it.
Author of Report:	Eleanor Rutter (07917 240200) and Kathryn Robertshaw
Summary:	

Questions for the Health and Wellbeing Board:

- How can the Board ensure that the evidence base and recommendations of these impact assessments are acted on?
- Which groups and stakeholders do the board believe this report should be shared with?

Recommendations for the Health and Wellbeing Board:

- Note the full set of recommendations and endorse their delivery via appropriate governance structures.
- Incorporate the evidence base generated through this work, and recommendations produced as a result, into their on implementing the Joint Health & Wellbeing Strategy
- Consider using a future Strategy Development session to consider the findings of this work in more detail, and combine with the findings of work in other quarters to assess the impact of Covid-19.
- Support development and delivery of a communications strategy

Background Papers:

The Health Impact of the Covid-19 Pandemic in Sheffield -Rapid Health Impact Assessment - Framework and Guidance for Contributors. Received by the H&WB board in June 2020 and attached at appendix 1.

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

All

Who has contributed to this paper?

In excess of 100 people from commissioners, providers, voluntary sector organisations and community groups across the city.

The Impact on Health & Wellbeing in Sheffield of the Covid-19 pandemic and subsequent societal response to it.

SUMMARY

This paper describes the process of producing rapid health impact assessments relating to the Covid-19 pandemic, highlights key themes emerging from these assessments, and asks the Board to consider next steps for this work.

HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

Covid-19 has further exposed and widened existing health inequalities in Sheffield. This work seeks to identify key issues and make recommendations to address these, in order to reduce health inequalities resulting from the pandemic and in the future.

MAIN BODY OF THE REPORT

1. Introduction

Originating in the Wuhan province of China in December 2019, the Covid-19 pandemic reached Sheffield in February of 2020 where the first death was recorded in March. Early indications from other countries were that it was likely to have its most devastating impact on frail and significantly elderly people; evidence emerged soon after of its disproportionate impact on black and minority ethnic (BAME) groups. National lockdown was imposed on March 23rd; with its aim of limiting the spread of the virus, it took people away from their normal day-to-day social activities, allowing only the minimum considered vital to keep the country running.

Sheffield is a diverse city representing some of both the most deprived as well as affluent boroughs in the country and being home to people from more than 12 ethnic groups; BAME people representing around 20% of the population. It became clear, therefore that the impact of the pandemic was not going to be evenly spread across Sheffield, but that both the disease and lockdown were going to have the greatest impact on our already, most vulnerable communities.

At their April meeting, the Health and Wellbeing Board agreed to commission rapid health impact assessments to provide a systematic review of the impact on health and wellbeing in order to understand and document people's experience, aiming to be able to mitigate against the worst effects of second and subsequent waves and to provide an evidence base for recovery activities.

2. Process

A small steering group was established, led by Public Health. Key themes of particular concern were identified by stakeholders from across the city. A lead was identified for each theme who was encouraged to set up a task and finish group to gather together as much qualitative and quantitative intelligence as they were able within the short timescale. Theme leads met regularly to

share learning and iteratively develop the scope of each theme as it became evident that there was a great deal of overlap between them. The rapidity of the task was necessary if the work was to deliver its aim of learning prior to a second wave; this had an inevitable impact on the technical quality of some of the intelligence.

A community survey, which was designed to capture people's lived experience of the pandemic has received an excellent response rate (3,300 responses to date) and is due to close for analysis at the end of September.

3. Themes and key findings

Thirteen themes were identified for assessment; each one can be viewed as a 'mini' HIA in its own right. A report of this nature cannot do justice to the breadth and richness of information contained in each HIA which are available in their entirety or in three page summary versions to the board. To give a flavour of each theme, leads were asked to identify the three most important findings, which are documented below.

3.1. Active travel

- Traffic volume feel by 80%
- Increase in leisure cycling
- Public transport reduced to 50% usual volume

3.2. Employment

- 53,500 people furloughed – more in most deprived communities – some jobs will be lost when scheme ends
- 74% of self-employed people used the self-employment income support scheme which in our four most deprived communities was below the national average claim
- Business are facing cash flow problems and debt which will result in insolvencies and job losses

3.3. Health behaviours

- Evidence of weight gain and poor eating habits impacting socially disadvantaged groups the most (including poor oral health)
- Decreased physical activity overall
- Mixed picture on smoking – some responsive to quit messages, others report increased smoking
- Increased alcohol consumption
- Positive impact on breastfeeding rate
- Most people gambling less but problem gamblers gambling more.

3.4. Education

- Reduced educational attainment
- Negative impact on emotional wellbeing
- Some children especially SEND youngsters have had a positive lockdown in that their anxiety has reduced. Many families have had more time together and supported their children's learning.

3.5. Income and poverty

- Financial insecurity more widespread and more severe
- Demands on food banks increased four-fold
- Significant reduction in people accessing financial support advice in early stages, but now increasing rapidly

3.6. Loneliness and social isolation

- Increased social isolation experienced to some extent by all – greatest impact on social disadvantaged groups, those living alone and those with poor physical and mental health
- Socially isolated people reporting increased use of food, alcohol, smoking and drugs
- Social exclusion exacerbated by digital exclusion

3.7. Domestic abuse

- Increased time with 'abuser'
- Difficulty accessing support services
- Increased pressure on families and individuals so abuse is more frequent, escalating quicker and there is greater risk of serious harm

3.8. Access to care and support

3.8.1. Health Care

- Patients stayed away from their GPs and hospitals (including A&E attendances)
- Services unable to operate normally due to social distancing (including Cancer)
- High uptake of virtual GP/hospital consultations but not an option for all patients
- Rapid development of pragmatic solutions across agencies
- Mental health impact on physical conditions & vice-versa

3.8.2. Social Care

- Concern regarding consistent support for, and management of, care homes with regard to preventing Covid-19 infection

- Reconciliation of containing the spread of the virus with curtailment of human rights in relation to denial of contact for people
- Maintaining usual, as well as creating and delivering additional staff capacity at pace and at scale

3.9. Housing

- Lengthened exposure to unsuitable, overcrowded or unhealthy accommodation
- Inability to move away from dangerous or unhealthy living circumstances
- Opportunity to engage with partners to provide accommodation for homeless people

3.10. End of life

- Need for End of Life Care and bereavement support has increased and is likely to increase and persist
- Perceived inequities in end of life care potentially worsened by COVID-19 but based on limited objective evidence or intelligence
- Coordination and communication between health, care and third sector provided elements end of life care was needed, most notably engaging care homes

3.11. 'Long-Covid'

- Debilitating symptoms can last several months after infection, particularly in hospitalised patients
- High incidence of blood clots, cardiac and other longer-term complications
- Prolonged and complicated recovery is likely in patients discharged from intensive care

3.12. Mental wellbeing

- To follow

3.13. BAME

- Reporting separately

4. Crosscutting themes

Whilst the people and communities of Sheffield have shown themselves to be resilient and compassionate, and its workers, highly committed and agile, the pandemic has had a terrible impact across the city and particularly on our most vulnerable. Whilst examining the impact on specific, areas of concern, the themed reviews have highlighted a number of crosscutting issues which are described briefly here.

4.1. Inequalities

The key thread which dominates all the RIAs is how Covid-19 has exposed and widened the existing health and structural inequalities in our city. There has been a disproportionate impact of Covid-19

on different cohorts in Sheffield (e.g. BAME communities; people on lower incomes, carers, people with existing health conditions and disabilities) which must be reflected in commissioning and provision priorities going forwards.

4.2. Neighbourhood and Community

Throughout lockdown and beyond the community response (by the public, the voluntary sector and other local infrastructure) has been integral to supporting people in or close to their own homes when travel was limited (traffic volumes fell by 80%) and access to normal support networks was cut off.

Community hubs were established, often building on existing community assets to support food drops and wellbeing calls. Continuing to build on and invest in local assets and infrastructure and the VCF is a key recommendation of several of the RIAs. Investing in local areas and supporting none car based short trips not only supports the local economies but reduces pollution, supports increased social interactions and plays an important role in active lifestyles

4.3. Digital Inclusivity

Peoples access to, ability to use and motivation to use technology through the pandemic has had an impact on their access to support, ability to work and to study through the pandemic. People who were unable to engage with the new remote services being provided have missed out on support leading to widened inequalities in service provision. A significant number of people do not have access either to a telephone or the internet to undertake telephone or video appointments. Addressing this digital divide as a city comes through many of the reports as a key issue. Sheffield should be prioritising access to devices and broadband for our most disadvantaged people and communities (as well as working to improve people's skills confidence and motivation to use digital services.

4.4. Mental Health

Social isolation through Covid-19 and increased levels of stress and anxiety has led to the exacerbation of existing mental health conditions as well as leading to new problems arising. Over 60% of responders to a survey conducted by Sheffield Flourish reported that their mental health had worsened during the pandemic. This is unlikely to improve in the near future as there will inevitably be a period of adjustment through September and October (and beyond) as people return to work and school with ongoing uncertainty about future disruption through 2020/2021.

The pandemic has for many been and remains a traumatic event and has increased children's exposure to adverse incidents and increased levels of domestic violence. The need for improved access to mental health services and trauma informed care and support (across all sectors) has never been greater. It is anticipated that as unemployment increases and school and universities return latent demand for mental health support will begin to come through.

4.5. Access to Health and Care Provision

The pandemic has brought health and social care; statutory and voluntary services together and examples of excellent system working have come out of this period. New (remote) ways of delivering services have been developed, many of which will continue post-Covid. Anecdotal feedback has highlighted that non face-to-face contact can be very effective. However limitations in our ability to share information between different IT systems and between organisations has, at times, hindered delivery.

Access to remotely provided services has not been equitable; people with English as their second language or with sensory or cognitive impairments have often struggled to engage with remote services increasing existing inequalities of access during this time.

Staff working across the system will also need ongoing support; many are exhausted, trying to learn new ways of working and often working in isolation at home. The need to focus on staff wellbeing to ensure resilience in the workforce across all sectors, including independent providers is clear if we are to maintain services through the coming months.

4.6. Employment and Poverty

Financial insecurity is significantly more widespread and more severe since the beginning of the pandemic. Demand on food banks has increased and the number of people on Universal Credits has doubled in Sheffield. There has been a disproportionate impact in some areas of the city and in some cohorts. For example refugees and asylum seekers, women, younger people and people with disabilities are just some of the groups disproportionally affected by the financial impacts of Covid and the three most deprived constituencies have the most furloughed workers.

Levels of unemployment and poverty are expected to continue to increase over the coming months as the job retention scheme ends in October (53,500 employees in Sheffield have been placed on furlough). As a city we need to plan for this and ensure adequate levels of support and advice are available. We need to ensure uptake of benefits in all those eligible to do so, especially those which may never have had experience of using the benefits system before.

4.7. Communication and Engagement

The need for ongoing, consistent and culturally competent public health messaging is clear. There was decreased use of services throughout the period (Citizens Advice, health care, social care support) and although footfall is now increasing many people are still not accessing the services they need or would benefit from (either through fear or lack of awareness).

It is clear that messages need to be coproduced to ensure cultural appropriateness and will need to be delivered in multiple ways (need to move away from one size fits all wherever possible).

4.8. Limitations and Gaps

The information which has informed these assessments generally is limited to the last 3-4 months, which in many cases is too soon to see significant change. It is important that this work is ongoing to understand the full impact of Covid-19. Latent demand for support is starting to come through

and more is likely to surface as schools and universities return and the job retention scheme ends in October. Impacts on educational attainment, employment levels and physical health (particularly for people who have had Covid-19 or had other pre-existing conditions) are not yet able to be predicted or measured.

Not all voices are heard equally and impacts for some groups are not well known. In many cases there is poor (or no) data available to enable breaking down information to subpopulations or protected characteristics, often reliant on census data which is 10 years old. Improved data capture and use to better understand inequalities in access and provision of services is a gap which needs to be addressed going forwards.

Much feedback about the services provided through the pandemic is anecdotal; there is limited formal evaluation of the effectiveness of new services and delivery models at this stage. Although Sheffield Children's Foundation Trust has undertaken an extensive staff and patient survey of non face to face appointments (https://view.pagetiger.com/a-whole-new-world/2020).

Dental services and were not specifically covered by any of the reports.

5. Individual theme recommendations

A total of 83 individual recommendations have been made so far (Mental Health theme awaited and BAME reporting separately). The complete list is included at appendix 1. Different task and finish groups have taken different approaches to recommendations and thus whilst some are duplicates of each, they are broad in their reach and vary in their style. They can be summarised as follows:

- New (short term) actions in response to pandemic (50%)
- Implement existing plans (30%)
- Big ideas/cross-cutting themes (20%)

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

The findings and recommendations from this report need to be shared with the people and organisations that are able to bring about change in the relevant areas. We need to ensure that they are incorporated into work going forwards, including implementation of the Health and Wellbeing strategy.

QUESTIONS FOR THE BOARD

- How can the Board ensure that the evidence base and recommendations of these impact assessments are acted on?
- Which groups and stakeholders do the board believe this report should be shared with?

RECOMMENDATIONS

The Board are recommended to:

- Note the full set of recommendations and endorse their delivery via appropriate governance structures.
- Incorporate the evidence base generated through this work, and recommendations produced as a result, into their on implementing the Joint Health & Wellbeing Strategy
- Consider using a future Strategy Development session to consider the findings of this work in more detail, and combine with the findings of work in other quarters to assess the impact of Covid-19.
- Support development and delivery of a communications strategy

Appendix 1

The Health Impact of the Covid-19 Pandemic in Sheffield

Rapid Health Impact Assessment - Framework and Guidance for Contributors

Context

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

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

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

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

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

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

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

Framework

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

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

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

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6. **Objectives**

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

7. **Methods and Sources of Intelligence**

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

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

8. Key Lines of Enquiry

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

9. Scope

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

10.Timeline

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

11.Contributors

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

12.Links

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

13.Recommendations

Points to consider:

- How can we/the city prevent or mitigate any negative impacts?
- How might our services/approach flex to meet the needs identified here to aid recovery?
- What are the good things happening that we want to keep? How could we do this?

- If there's no such thing as business as usual any more, what are the opportunities for more radical change?
- Other work that is in the planning or early implementation stage, that might add substantial information to his HIA that may change the recommendations or mitigations we currently believe to be appropriate?
- What more do we need to know?

Appendix i

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

Appendix ii

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

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

5th June 2020

Appendix 2

Rapid Health Impact Assessments – summary of recommendations across all themes

Theme	Recommendations
Active travel	For the City to harness Active Travel
	To continue to support bus services and public transport in the medium to long term
	To improve data collection and evidence of localised investment benefits
	To invest in local areas that support none car based short trips
Employment	How the city should define economic success, considering outcomes other than growth, such as health and wellbeing
	Work with communities of Sheffield, for example via voluntary and community sector organisations, to ensure what matters to people is considered in the development of the renewed strategy
	The Universal Basic Income trial
Health behaviours	Seek to influence high-level strategic conversations about recovery and next steps for the city
	Existing public health strategies must be implemented and investment maintained or in some cases increased to enable maximum impact amongst high risk populations
	Accelerate efforts to develop culturally competent health promotion and disease prevention programmes.
	Policy leads and commissioners need to ensure the voices of all communities are heard in the development of strategies and interventions; in particular the BAMER community, those experiencing socio-economic disadvantage and those living with disabilities.
	Enhance messaging around the connection between a range of health behaviours and physical health and mental well-being.
	Ensure that gambling is reflected as a contributory factor in relevant strategies including for poverty, mental wellbeing and other addictions
Education and skills	Continue to provide a wide range of support and advice to schools and families and make sure those services are Covid secure
	Continue clear communications with schools, providers and other settings – including developing a resource library so that schools can access key documents
	Maintaining the school enquiries and complaints service
	Maintaining links with DFE and Ofsted to ensure schools have the latest information and guidance
	Ensure Sheffield schools have access to any grants from government for summer schools and additional catch up lessons
	Learn Sheffield will also continue to support schools
	Provide support needed for children at key moments of transition
	Ongoing support to families from the SEND team. This includes focussing on the process and resource for assessment of needs so that schools can understand the impact on learning and put appropriate provision in place. This will require support from those with greater expertise e.g. Educational Psychology, specialist teachers, locality SENCOs
	Encouraging schools to targeting resources for catch up for all pupils but especially those with SEND or those who are in a vulnerable group where the gap has widened
	Development and training on catch up curriculums so that schools ensure that they address needs beyond the teaching and learning e.g.: managing mental health and

	trauma
	It is also likely that even next academic year there will be a combination of home learning and face to face teaching in schools. It is important that the LA acts to share best practice across our schools as to the best way to support our young people in this new learning environment. For example when children return, schools could build a display/symbol/stories about the period of home learning. Schools could become the hub for recovery within their community.
	Continue to provide a wide range of support and advice to schools and families and make sure those services are Covid secure
Poverty and income	Ensure a collective, city-wide approach to developing responses
	Plan for poverty and demand for support services to increase
	Build on and nurture good partnership working on the ground
	Prioritise making digital access available to disadvantaged people and communities in the city
	Increase take-up of benefits and support in the city. Also explore introducing 'financial healthchecks' for households in response to the crisis.
	Plan, predict and disseminate widely: we should focus on how this work can continue to evolve and inform wider activities across the city, as well as future responses.
	Seek to influence high-level strategic conversations about recovery and next steps for the city
Loneliness and social isolation	Invest in the VCF sector to build Resilient Communities **a.** *Short term:* Build more capacity in the VCF workforce to undertake more 'check and chat' call **b.** *Longer term:* Create an environment for people in their communities to become leaders: i. Recruit, develop and support more people to peer support each other ii. Support people to develop social activities (digital and COVID-19 safe face to face) – a reason to get together with meaning and purpose to people eg knitting, sporting memories **c.** *Short to medium term:* The pandemic saw a community response in way we haven't before, we need to support mutual aid groups to flourish and find a place post the immediate crisis
	Workforce and the system recognise that Loneliness (separator or lack of social connection) is trauma in children and adults. All staff across the system need to be trained to recognise this
	Help people and families manage the risk of covid so that they are not too frightened to re-engage in their life
	Reduce digital exclusion
	Support small community and volunteer led building and activities to reopen or start activities in a sustainable and covid safe way
	Support people to develop the tools to manage living by themselves (needs to connect to the work of the mental wellbeing HIA
Domestic and sexual abuse	Invest in services for all those impacted by domestic abuse – victims / survivors, children and perpetrators, and increase capacity where needed to ensure needs are met
	Ensure there is adequate provision of good quality, safe, appropriate emergency accommodation with specialist support
	Improve responses from agencies and employers
	Prevent domestic and sexual abuse in the future by increasing understanding of the

	dynamics of abuse and the impact of trauma, and by branding Sheffield as a city where we foster healthy relationships
	Work with organisations such as the Local Government Association to raise national issues
Access to health and care services (Healthcare)	We therefore strongly recommend that this RHIA document be made available to sub-population subject matter experts in order for an impact rating to be allocated against each development area (for example, voluntary sector, carer/patient groups, condition support groups). Transparency: Subject-matter experts should be requested to contribute to detail around impact and mitigating actions which could be implemented to ensure equity across our population. One potential approach would be to implement a website dedicated to consultation with all groups whereby major health and social service changes would be required to be reviewed. Individual groups would be responsible for providing a response for the population they represent. An ICS level approach would ensure consistency and avoid duplication of effort. Such a resource would be valuable in many areas beyond health and social care.
	Develop MDS for protected characteristics via an ICS model for minimum data collection which can be replicated at each individual place level.
	Seek to influence high-level strategic conversations for future system integration and provision of integrated patient services.
	Building on new ways of working and lock-in the benefits. ICS should monitor to ensure post-pandemic developments are consistently and equitably implemented across the South Yorkshire and Basset Law Region.
	Address digital exclusion Establish digital access points in GP practices/schools/suitable venues. We recommend that service providers, including adult health, child health, community services, and social services collaboratively develop a plan to implement digital service points patients can easily access .
	Identify and implement appropriate off the shelf or bespoke Apps.
	Expand Community Services
	Primary Care Networks (PCN) Implementation and development of new roles to support personalisation and the value of non-medicalised interventions should be acknowledged and developed
	Increase Rates of 'hear/see and treat' via Yorkshire Ambulance Service
	Ensure equitable access to face-to-face appointments
	Review and respond to evidence developed during the pandemic e.g. on use of technology
	Implement a programme to embed patient self-care within clinical pathways
	Personalised Care: Action should be taken to identify the system level work already in train and as a result agree and respond to any gaps, particularly in regard to provision across the protected characteristics populations.
	Homelessness - Implement learning from the citywide partnership work supporting rough sleepers and the homeless during COVID. Robust joined-up communications would have a significant positive impact with regards to supporting the majority of vulnerable people across the city.
Access to health and care services (social care)	In relation to care homes ensure the whole health and social care system works together to achieve the best outcomes for individuals. This needs to include supporting providers and balancing an approach that combines effective measures to contain the pandemic with respect human rights.
	Ensure that the whole system partnership approach cemented during the pandemic is

	maintained into business and usual working and included within the strategy review of all Adult Social Care Services.
	Enable discussions, which including individuals and their advocates at each stage, to use the learning from the pandemic around alternative approaches and locations for service delivery to create tailored responses to care needs.
	Promote nurture and support community led initiatives to facilitate a broad range of informal care and support activities within localities and neighbourhoods building upon the excellent work of the VCF sector linked to localised demographic need.
	Adopt a health and social care whole system approach to the identification and provision of assistive technology to help meet health and social care needs across the city
	Utilise and consolidate the upsurge in the use of virtual communication channels and tools to achieve the right levels of contact with people who have care and support needs to monitor ensure their wellbeing
	Create additional resilience within services in preparation for the anticipated upsurge in Covid-19 cases through Autumn and into Winter. Specifically ensure the appropriate care and support staffing capacity to ensure excess demand can be met across all sectors, including independent providers.
	Increase data capture and conversations to better understand and tackle inequality in access and provision of service delivery, particularly where this is felt by BAME people and within BAME communities.
	Learning from the experiences of delivery partners working across the health and social care sector during this crisis to redesign processes and practice that previously inhibited the ability of the system as to deliver holistic joined up and straightforward care and support to people who need it throughout a person's pathway.
Housing and Homelessness	Immediate: Reinstate Choice Based Lettings and associated activities
	Immediate: Review and modify communications strategies in light of the 'new normal'
	Longer term: Adopt and adapt governance structures to embed true partnership working into all housing projects and programmes going forward
	Longer term: Ensure frontline workers have the tools to provide a person-centred approach to services
	Longer term: Identify gaps in order to provide a complimentary suite of housing options
	Longer term: Modify relevant project initiation processes to ensure it is business-as-usual to embed service users at the centre of service development
End of Life	Consider retaining or reinitiating the response to persisting and future increases in need for end of life care, most notably in care homes but also in acute hospital, community services and specialist palliative care in the event of further Covid-19 wave and NHS phase 3 response
	Continue to enable development of Care Home, adult social care and Primary and Community Care Communities of Practice as a means of training, reflection and support via relevant means, enhancing representation from adult social care within future command and control and decision making bodies
	Support maintenance of alternative approaches to end of life care enhancing communication with the general public to support understanding of and access to the range of options
	Maintain and further develop a representative, citywide end of life care group
	Develop Sheffield End of Life Intelligence collaboration
	Implement a Compassionate City/public health approach to end of life care.
	Consider the findings of the '*Supporting adults bereaved in Sheffield: bereavement*

	care pathway, gaps in provision and recommendations for improved bereavement care (August 2020)' report. Support delivery of recommendations through the end of life group and Compassionate Cities approach where appropriate.
Long-Covid	Seek to validate the estimates in this work with Sheffield, HES data.
	The H&WB to take a full report from the Sheffield Long-Covid group at its next meeting.
Mental Wellbeing	To follow
BAME	See separate report

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Brian Hughes, Deputy Accountable Officer, NHS Sheffield Clinical Commissioning Group and Executive lead for the Accountable Care Partnership, ACP, for the Impact of Covid-19 on BAME communities work stream
Date:	24 September 2020
Subject:	Health inequalities and impact of Covid-19 on BAME communities and how health and social care are working with communities to tackle it
Author of Report:	Clive Clarke, Chair of the Impact of Covid-19 on BAME communities strategy group, and North East & Yorkshire Regional Director of Inclusion (formally Deputy Chief Executive, SHSC) and Jane Ginniver, ACP Deputy Director – Development

Summary:

This summary paper with the attachments highlights the work that was commissioned by the ACP Executive Delivery Group (ACP EDG), to engage and co-production with a variety of stakeholders, staff, BAME staff network chairs, community representatives and staff side, across health and social care domains , NHS Trusts Sheffield Social Service, the voluntary independent and faith sector, primary care, care homes and public health Sheffield to :

1) Support all organisations to ensure that BAME staff are “safe” and have access to a risk assessments

2) That reports such as the Public Health England report and it’s recommendations are given due consideration, and that proposals and actions are co-produced as to how the city wishes to take this actions forward.

The second of two reports was presented to the ACP EDG on 27 August 2020 and included four recommendations , all supported by the ACPEDG to be led by Brian Hughes. (Attached Appendix 1).

To note: Recommendation 2 included three urgent priorities, the ACP EDG discussed the priorities and agreed to them in principle and requested a further two were added to include Attendance at the ACP EDG meeting by "community representatives "and Cultural awareness training. The five priorities would be developed by various group members into proposals to be presented to the ACP EDG later in September/October 2020.

The recommendations and actions directly read across into the various report that have been produced in relation to the impact of Covid-19 on the BAME communities and the Black lives Matter movement. Sheffield's actions (Appendix 2) read across the actions from the Fenton, PHE Beyond the Data, on the impact of Covid on the BAME communities, as well as the NHS People Plan Phase 3 planning guidance and knowledge we have learned from the Annual NHS staff experience survey.

Questions for the Health and Wellbeing Board:

The Board are asked:

1) Comment on the work done to date
2) Are there any other areas that the Board feel need to be pursued as a priority
3) How can the board be kept up to date with this aspect of inequalities work steam?

Recommendations for the Health and Wellbeing Board:

1) Note the summary document with the appendices.
2) Recognise that work is ongoing, the next deadline is the production of proposals of detailed action focused proposals, to go back to the Executive Delivery Board
3) Note the work to address the national recommendations
4) Note that this work will be feed into the new formed Race Equalities Commission as supporting evidence of good practice in the city to address the disparities of risk to Covid19 in workplace settings for Black, Asian and Ethnic Minorities.
5) Request report back in the next 6 months

Background Papers:

* Public Health England reports
Risk and outcome of Covid-19, and
Beyond the Data, Understanding the impact of Covid-19 on BAME communities
* the NHS People Plan
* Phase 3 Planning Guidance

ACP BAME Strategic Group: our identified priorities

ACP Executive Delivery Group 27th August 2020

Author(s)	**Clive Clarke & Jane Ginniver**
Sponsor	**Mark Tuckett**

1. Purpose

This paper follows last month's 'Black Lives Matter' paper, when EDG discussed the opportunities available to us as a system to drive real change in this area, and in line with the 7 recommendations made within the recent PHE report '*Beyond the data: Understanding the impact of COVID-19 on BAME groups*'. There was a request for Clive Clarke (SHSC) to continue to lead this work, and to return this month with specific proposals around:

- Recommended process changes, which will have an impact on addressing institutional cultural issues
- Focused actions that we can start quickly, building on the work of the BAME Strategic Group and its subgroups
- What we should do as a city, not strictly limited to health and care, but including other areas that have an impact on health and care (eg housing)
- How we can use our collective influence beyond Sheffield

This paper, and the priorities outlined in Paper Bi, outline those actions which we propose to implement across the ACP and address the above 4 points.

2. Is your report for Approval / Consideration / Noting

For approval and consideration

3. Recommendations / Action Required by Accountable Care Partnership

Key questions for EDG:

1. Do you support the priorities identified within Paper Bi? Is there anything you feel we should change / remove / add?
2. Do you agree with and support the 3 urgent priorities outlined in section 4? NB: progressing these priorities will have capacity implications for some staff and these need to be considered.
3. Who will be the dedicated EDG Lead for this work?
4. The priorities identified will have implications for ACP partner organisations, as some of them require organisational-specific actions to connect with the ACP-wide action (eg Action 2b re the recruitment of NEDS – we can facilitate some generic recruitment campaigns and events across the ACP, however there will also need to be a focus on implementing this action within organisations). Do EDG members commit to taking these actions back into their organisations to secure organisational commitment and sign-off?

Are there any Resource Implications (including Financial, Staffing etc.)?

N/A

ACP BAME Strategic Group: our identified priorities

August 2020

1. Introduction

This paper follows last month's 'Black Lives Matter' paper, when EDG discussed the opportunities available to us as a system to drive real change in this area, and in line with the 7 recommendations made within the recent PHE report '*Beyond the data: Understanding the impact of COVID-19 on BAME groups*'. There was a request for Clive Clarke (SHSC) to continue to lead this work, and to return this month with specific proposals around:

- Recommended process changes, which will have an impact on addressing institutional cultural issues
- Focused actions that we can start quickly, building on the work of the BAME Strategic Group and its subgroups
- What we should do as a city, not strictly limited to health and care, but including other areas that have an impact on health and care
- How we can use our collective influence beyond Sheffield

Following the identification of the priorities outlined in Paper Bi, we mapped the actions we are proposing against the recommendations contained within various national level documents, including; the Public Health England's report 'Beyond the Data', the NHS People Plan 2020-21, the guidance for 'Implementing Phase 3 of the NHS Response to the COVID-19 Pandemic' and the requirements of the NHS Workforce Race Equality Standard (WRES), to identify any gaps and check our plans against recommended good practice. This mapping can be viewed in the tabs of Paper Bi.

2. Context

Paper Bi outlines the priorities that have been developed to date following conversations at the BAME Strategic Group and its subgroups (Staffing and Communities). In addition to these priorities, we are mindful of the following contextual factors, which impact directly on this agenda:

2.1 *The establishment of a Race Equality Commission (REC)*, which the ACP has pledged formal support for (following the July ACP Board discussion). Clive Clarke will be our formal link with the REC, and we intend to submit our plans to the REC as part of their call for evidence. We also urge the ACP partners to submit their own organisational plans as evidence of intent. The REC intends to conclude in Summer 2021.

2.2 *There remains a strong possibility of a considerable increase in covid-19 infections over the coming months:* The disproportionate impact this will continue to have on our BAME populations will place an increased urgency on addressing the actions highlighted in Paper Bi; while we have made significant headway in addressing the long-standing trust deficit between BAME communities and our statutory bodies over recent months, this is still very fragile and will be tested through our response to a second wave. We must demonstrate that we have learned lessons.

A combination of flu and covid could be catastrophic not only for our service provision, but also in those communities and populations where they are likely to hit hardest. We need to make a concerted effort to work differently and ensure that as many of our poorest and deprived citizens take up their access to flu jabs as possible.

2.3 *The Phase 3 planning work* is focussing our NHS organisations on the return to as near 'normal' service provision as possible. As we do this, we need to work with and listen to our BAME staff and communities. As services change as a result of positive advancements that have been made throughout the covid period, we need to also change the way that we develop these services and co-produce with members of the public. We need to listen to their fears and work with them to design the solutions.

2.4 *There is a lot of activity in this area across the ICS, regionally and nationally,* we need to ensure that we are connected with this wider activity and that our ACP plans enhance, rather than duplicate, other work taking place. There is already increased pressure on our EDI leads, and we need our agenda to help alleviate this workload by sharing good practice and only doing things once, rather than multiple times, across the ACP. This will involve working with the ICS in particular to identify and agree those things that are best developed and implemented at place.

3. Priorities

Paper Bi details the priorities that have been identified as the core actions that the BAME Strategic Group will drive over the next 12 months. A few notes on this action plan:

3.1 This is not intended to be a final set of actions. It will continue to evolve to reflect the views of our BAME staff and communities, and the continually changing environment and challenges that we face. However, the content of the 'our narrative' column reflects challenges that have developed over many years and do need to be addressed with some urgency, so while the order that we address these in may change, we would not expect the priorities themselves to change.

3.2 We have tentatively proposed professional roles to lead each priority. At this point these are only proposals and we have not consulted with people in these roles. Please let us know as soon as possible if they need to change, and propose others who should be involved who are not currently included. We will start to contact specific people w/c 6th September.

3.3 As mentioned above, these priorities have been developed through the BAME Strategic Group and its subgroups, through listening to the priorities raised by their members. They therefore have the needs of our staff, our citizens and our organisations at their heart. We then mapped these priorities against the recommendations made through a number of external, national reports; the 7 recommendations from the PHE report 'Beyond the Data' (known as the 'Fenton recommendations), the NHS Long Term Plan and the NHS People Plan 2020/21; and checked that there were no gaps in our planning. We feel it is important to note that our ACP priorities are not driven by external factors.

3.4 Not included within the priorities in Paper Bi, is a request of our ACP organisations. In order to make a tangible difference to the experiences and health outcomes of our BAME staff and citizens, we need to collectively and individually recognise the value of the contribution of Organisation Development (OD) in; promoting respect and dignity, recognising people's experiences, and encouraging conversation across all staff and between organisations and citizens, to create genuine parity of esteem and leading to the culture change that we aspire to. Equality, Diversity and Inclusion is typically classed as a HR function, responsible for upholding our legal responsibilities; by refocusing the emphasis to align with an OD emphasis on culture change, we believe we will have a greater impact more quickly.

4. Our Most Urgent Priorities

Paper Bi outlines a range of priorities, which are all important. However, some of these are particularly urgent, and / or will generate information and create new ways of working that will facilitate some of the other priorities. We have identified the following 3 priorities as those which we believe should be progressed as soon as possible:

i) Action point 1 in Paper Bi: relating to the collection of data relating to staffing, patient outcomes and health inequalities

ii) Action points 5a and 5c, focusing on working with our BAME communities to maximise the uptake of flu vaccinations amongst the eligible populations

iii) Actions 4a and 4b, to commission services with and for our BAME communities differently.

5. Next Steps

5.1 Clive Clarke is about to start a 6-month secondment with NHSE/I regionally as Director of Inclusion. As part of this secondment he has requested, and been granted, the flexibility to spend 0.5 days per week focusing specifically on driving this agenda across our ACP. This is a great investment for us – in addition to having access to significantly more of Clive's time, he will also be able to share the good practice taking place across the 4 ICS's in our region and connect us more closely with regional and national work, and raise the profile of the work we are doing. Clive will also be the formal ACP link with the Race Equality Commission, as agreed at ACP Board in July 2020.

5.2 We would like a dedicated EDG Lead for this work, in line with the short-term priorities for other ACP work, and to return to EDG approximately every 10-12 weeks to share progress and seek input.

5.3 We will continue to develop the priorities through ongoing conversations with organisations, BAME staff and communities. This will include the confirmation of named leads for each action and agreed timescales.

6. Questions for EDG

1. Do you support the priorities identified within Paper Bi? Is there anything you feel we should change / remove / add?
2. Do you agree with and support the 3 urgent priorities outlined in section 4? NB: progressing these priorities will have capacity implications for some staff and these need to be considered.
3. Who will be the dedicated EDG Lead for this work?
4. The priorities identified will have implications for ACP partner organisations, as some of them require organisational-specific actions to connect with the ACP-wide action (eg Action 2b re the recruitment of NEDS – we can facilitate some generic recruitment campaigns and events across the ACP, however there will also need to be a focus on implementing this action within organisations). Do EDG members commit to taking these actions back into their organisations to secure organisational commitment and sign-off?

#	Focus area	Our narrative	What does success look like?	Who should own and lead this challenge?	Who else will need to be involved want to work with?	Link to external sources
1	**Data**	We will collate data across the ACP which provides clear measurement of our progress in addressing structural inequalities. This will include measurement of staffing data, patient outcomes, in addition to updating existing data on health inequalities.	Data will be used as an evidence base to develop and drive priorities across the city.	Data Leads	Sam Kyeremateng, Shahida Siddique, John Soady, Chris Gibbons, EDI Leads	Fenton Report NHS LTP
2	**Leadership**	a) We will develop leaders across our ACP partners (at all levels) who are culturally aware, and representative of our local communities. All leadership development will routinely monitor and analyse BAME participation rates, and take positive action to increase participation, including addressing talent pipeline issues. Places on organisational leadership development programmes will be reserved for BAME staff.	Leadership across our ACP will be more diverse, with culturally aware leaders confident in having conversations around colour and challenging inappropriate behaviour.	OD Leads	Paula Ward, Maddy Desforges / VAS representative, Jane Ginniver, Simon Richards	Fenton Report
		b) We will actively promote the recruitment of BAME NEDS to our statutory organisations, and to bring the voices of diverse Sheffield communities into our board rooms.	Our executive teams will have membership which reflects the city's population, ensuring that decisions are reflective of, and take account of, a wide range of perspectives.	As above	As above + Shahida Siddique	Fenton Report NHS People Plan

		c) We will support our city's community organisations to develop confident and visible leaders, who are able to use their existing talents, skills and knowledge to represent their communities on an equal footing within the health and care sector	A leadership development programme / programmes specifically for staff across Sheffield's community organisations, supported by our ACP partners, will lead to increased engagement with Sheffield's communities across health and care.	Communities Group Co-Chairs		Fenton Report
3	**Staffing**	a) All ACP partners will communicate their commitment to tackling racial abuse and harassment of their staff and make tangible efforts to invest in the psychological contract, ensuring that all BAME staff across our ACP partners feel valued, and have equality of opportunity in all aspects of their employment.	Staff survey feedback will improve in all areas for BAME staff and the gaps between BAME and white staff feedback in all areas will close. WRES data for NHS organisations will show that the disparity in disciplinaries between BAME and white staff has closed.	EDI Leads	Liz Johnson, Bo Escritt, Lucy Ettridge, Mark Bennett	Fenton Report NHS People Plan
			Each organisation will have a Charter that clearly states that racial abuse and harassment is not acceptable and will not be tolerated. This will apply to the abuse and harassment by service users as well as from staff members.			Fenton Report NHS People Plan
		b) We will identify where the blockages are in the talent pipelines, which are preventing advancement of our BAME staff into senior positions. This will be infomed by both the quantitative data achieved through the action point above, as well as through qualitative data collected through conversations across our partner organisations	The development, through co-production, of targeted programmes of support which have a tangible impact on increasing diversity at all staffing levels.	OD and HR Leads	Rita Evans, Maddy Desforges / VAS representative, Jane Ginniver, Simon Richards	Fenton Report NHS People Plan

c) We will tackle and minimise unconscious and conscious bias on recruitment panels, through the mandatory presence of at least one BAME member of every panel for recruitment to posts above Band 8a, or the equivalent (c £50k pa) in other parts of the system.	Our staff across all partners, and in all role types, will reflect our local populations at all levels.	Recruitment leads	Fenton Report NHS People Plan
d) We will work within an agreed set of principles that include using positive action to achieve a diverse and representative workforce.	All organisations will agree to use positive action (to choose the individual from an under-represented group in a tie break situation); scrutinise current recruitment policies and practices; ensure that all panel members are appropriately trained, develop a shared 'Best Practice Guide' for using representative recruitment panels, etc. NOTE: These principles will need to be drawn up in collaboration.	As above	Fenton Report NHS People Plan
			Fenton Report NHS People Plan
e) We will actively promote the breadth of health and social care careers across our BAME populations, including the promotion of alternative (non-degree) routes into professions such as AHPs and nursing.	Our staff across all partners, and in all role types, will reflect our local populations at all levels.	As above	Fenton Report NHS People Plan

		f) We will support the creation and continuation of a City-wide group for all Chairs of BAME Staff Network Groups.	A group is established and meets on a regular basis. The group enables networking between all network chairs and promotes greater collaborative working across all organisations. The group may wish to pursue shared activities and events for the benefit of all organisations' BAME staff network groups.	ACP Place-based workforce lead Staff Network Chairs	Fenton Report NHS People Plan
		g) We will ensure that all BAME staff working across our ACP partners have access to a dedicated staff network.	Staff will feel supported and able to discuss concerns and issues in a safe environment, with a connection to senior leadership teams to escalate any specific matters, which will improve the feedback from staff on progress against addressing inequalities.	As above	Fenton Report NHS People Plan
	Commissioning	a) We will commission differently by working with our BAME organisations, recognising their expertise and experience in knowing the needs of the organisations and how to achieve specific outcomes, they will have freedom, flexibility and more sustained funding to enable them to do so.	We will have greater impact on better health and wellbeing outcomes as organisations have the freedom to adapt their approach to context, circumstances and changing priorities.	Comms Leads	

		b) We will commission services that meet the needs of our population, and commission more services for those with the greatest health needs - this will include working specifically with our BAME communities. Develop constructive relationships and work with our citizens to understand what they need, then commission accordingly.	Better health outcomes and improved relationships, engagement and levels of trust with our BAME populations	CCG Directors of Commissioning		
5	**Communications and Engagement**	a) We will ensure that any conversations around improving health inequalities and improving engagement, will include those people who we are talking about (or their representatives) in the conversation from the beginning.	The health inequalities gap will start to close, this will be measured by specifics such as 80% take-up of flu vaccinations amongst the eligible populations in our most deprived communities.	Comms Leads	Shahida Siddique, other comms leads, Sarah Hepworth	Fenton Report
		b) We will adopt and invest in targeted approaches to involve people in our work who experience the greatest health inequalities and have the poorest health	BAME communities will feel empowered, with opportunities to have a say and influence decision-making			NHS LTP
		c) We will work with Sheffield citizens to understand the barriers to accessing health and care services, and feeling comfortable in doing so. We will respond through changing the way we deliver services.	The health inequalities gap will start to close, this will be measured by specifics such as 80% take-up of flu vaccinations amongst the eligible populations in our most deprived communities.	Public Health	Shahida Siddique, Adele Ro	Fenton Report

Recommendations from 'Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities'

#	Recommendation	Addressed through ACP Action #
1	Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.	1
2	Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.	NA
3	Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.	2a, 2b, 2c, 3b, 3c, 3d, 3e, 3f, 3g, 4a, 4b, 5a, 5b, 5c
4	Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of COVID19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.	NA (Completed across ACP)
5	Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.	5a, 5b, 5c
6	Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities	4a, 4b, 5a, 5b, 5c
7	Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.	4a, 4b

NHS People Plan 2020/21

We are the NHS: action for us all'

Actions below taken from Chapter 3 'Belonging in the NHS', pp23-25

#	Action	Deadline	Responsibility (in plan)	Link to ACP Action Plan
1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and labour markets.	By October 2020	Employers	3b, 3c, 3d, 3e
2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table	From September 2020	Employers	NA
3	Publish progress against the model employer goals to ensure that the workforce leadership is representative of the overall BAME workforce		Employers	NA
4	51 per cent of organisations to have eliminated the ethnicity gap when entering into formal disciplinary processes	By the end of 2020	Employers	3a
5	All organisations should review their governance arrangements to ensure that staff networks are able to contribute to and inform the decision-making process	By December 2021	Employers	3f, 3g
6	Publish competency frameworks for every Board-level position in NHS providers and commissioners. These frameworks reinforce that it is the explicit responsibility of the chief executive to lead on equality, diversity and inclusion, and of all senior leaders to hold each other to account for the progress they are making	By March 2021	NHS England and Improvement	2b
7	Support organisations to achieve the above goal [4], including establishing robust decision-tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks		NHS England and Improvement	NA
8	Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics	From September 2020	NHS England and Improvement	1

NHS Long Term Plan

Action required to tackle health inequalities in latest phase of COVID-19 response and recove

#	Action	Link to ACP Action Plan
1	Protect the most vulnerable from COVID-19	5a, 5c
2	Restore NHS services inclusively	4a, 4b, 5a, 5b, 5c
3	Develop digitally enabled care pathways in ways which increase inclusion	NA
4	Accelerate preventative programmes which proactively engage those at risk of poor health outcomes	4a, 4b, 5a, 5c
5	Particularly support those who suffer mental ill-health	NA
6	Strengthen leadership and accountability	2a, 2b, 3a, 3b
7	Ensure datasets are complete and timely	1
8	Collaborate locally in planning and delivering action	5a, 5b, 5c

Better Care Fund 2019-20 Plan
Year-End Submission

Health and Wellbeing Board Meeting

24 September 2020

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Sheffield City Council

NHS Sheffield Clinical Commissioning Group

Better Care Fund

What is the Better Care Fund?

- The better care fund is a national programme that requires Local Authorities and CCGs to pool defined budgets through a section 75 arrangement to support the integration of care.

- In Sheffield our Better Care Fund goes beyond the minimum contributions and our programmes extend to include many other areas of work that benefit from joint decision making and are commissioned through pooling budgets.

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Priorities for 2019/20

- **Urgent Care** – Blended contract arrangements, supporting the improvements required to reduce avoidable hospital attendances and admissions.
- **People Keeping Well** – Expanding the service offer to prevent onset of ill health and maximise independence
- **Active Support and Recovery** – Further development of a city wide intermediate care offer to sustain the reduced DTOC position
- **Ongoing Care** – Market develop and service integration.
- **Mental Health** – Improving early access to support
- **Independent living (Equipment)** – maintain an effective service whilst delivering service efficiencies.
- **Capital** – Maximising opportunities through effective utilisation of DFG.

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Better Care Fund Plan

The Better Care Fund Narrative Plan, describes how Sheffield commissioners will work towards a single budget for health and social care.

Ambitions of Better Care Fund

- Ensure service users have a seamless, integrated experience of care, recognising that separate commissioning can be a block to providers establishing integrated services
- Achieve greater efficiency in the delivery of care by removing duplication in current services
- Be able to redesign the health and social care system, reducing reliance on hospital and long term care so that we can continue to provide the support people need within a reduced total budget for health and social care.

Next steps

- Building on the 2017-2019 narrative plan, the Joint Commissioning Committee will drive forward the development and delivery of the Joint Commissioning plan.

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2019 Better Care Fund Plan

- The minimum contribution for the Better Care Fund is £74 million of the total Better Care Fund is £399 million.
- Draft plan and budget brought to HWB in June 2019
- Final Plan Submitted in September 2019 following publication of guidance and approval of Chairs
- Plans were delivered as expected subject to amendments required during March 2020 due to the Covid-19 Pandemic.

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2019/2020 Budget

Funding Sources	Budget
DFG	£4,502,097
Minimum CCG Contribution	£40,755,897
iBCF	£25,723,334
Winter Pressures Grant	£2,705,263
Additional LA Contribution	£97,420,082
Additional CCG Contribution	£227,652,801
Total	£398,759,474

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Performance Measures

Year	Readmissions of 90 days	Non elective admissions	Delayed Transfers of Care	Residential Admissions
2018/ 19 Plan	774	27,749	17,130	774
2018/19` Actual	732	28,206	26,244	732
2019/20 Plan	768	45,235*	7,237	774

*2019/20 increase relates to growth and HWB footprint, the mapped footprint has made the target a bit more achievable in theory, increasing by around 11k. So, by the end of Q2 19/20 - activity was 3% better than plan; 28,206 vs 28,289. If only looking at individual quarters however, activity was 2.5% better than plan; 13,923 vs 14,223.

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Making a difference

Non-Elective Admissions

As at the end of March 2020 ,the final outcome was 0.3% under target and an improvement of over 5% on the previous year. The Enhanced Care Home Programme and Joint Commissioning of Community Support has enhanced the step up step down offer to the system, which was enabled by maturing PCN's and close working with VCS partners.

As we've now got the 'HWB footprint' target, which is quarterly, Q1 was 1.6% higher than target and Q2 was 2.0% lower (both slightly revised since last month, given data updates) and Q4……

DTOC

As at the end of March 2020, there were 7,237 delayed days recorded, 48.6% fewer than at this point last year. Whilst the target in 2019/20 was challenging it was consistently met, although the challenge will be to maintain the current low levels of DTOC when the target is reintroduced in quarter 2 of 2020/21. The impact of Covid-19 and the unknown deterioration of long term conditions during lockdown, alongside expected winter illness, will present a challenge to the Sheffield system.

Residential Admissions

On a rolling 12 month basis to the end of March 2020, there were 774 admissions compared to the target of 729. This equates to 815 admissions per 100,000 of the population compared to the target of 768. The measure is, therefore, was not met. Each placement was reviewed to ensure it was appropriate and support package in place to meet the individual need and an alternative non-residential placement could not have effectively have been provided.

Reablement Measure

Performance as at the end of March 2020 was 81.2% compared to the target of 80%, therefore, achieved its target, with people remaining in their usual residence after 91 days.

Successes and Challenges

Successes in 2019/20:

- **Joint Commissioning of Health and Social Care** – the Joint Commissioning Committee have provide Councillor and Governing body leadership, to support the implementation of the better care fund plan and progress further ongoing transformation plans;
- **Integrated Workforce (approach to training/upskilling)** – Team around the person, based within a residential care setting, enabled stronger relationships with providers, health and social care. Facilitating transfer of skills and more proactive assessments to determine longer term needs.

Challenges for 2020/21:

- **Good quality and sustainable provider market that can meet demand –** the fragility of the care home market became apparent in March 2020 when the Covid-19 pandemic commenced. Further work is required during 2020/21 to establish clear plans to ensure longer term sustainability and quality in care home settings;
- **Integrated electronic records and sharing across the system with service users** – digital transformation programmes have taken longer to implement than planned. Sharing care records across organisations and the third sector is ongoing development.

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HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	16th September 2020
Subject:	Health & Wellbeing Board Terms of Reference
Author of Report:	Dan Spicer

Summary:

The Health & Wellbeing Board's Terms of Reference commit the Board to reviewing them annually. This paper provides a summary of discussions on this issue and makes recommendations for some minor amendments to the Board's Terms of Reference, along with recommendations for working practices.

Questions for the Health and Wellbeing Board:

Do the Board agree with the proposed changes set out in this paper?

Recommendations for the Health and Wellbeing Board:

The Board are asked to discuss, amend and if appropriate approve the proposed changes to the Terms of Reference.

Following this the Board are asked to agree to submit the resulting revised Terms of Reference for consideration by Full Council at the next opportunity.

Background Papers:

- The existing Terms of Reference are appended to this paper.

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

This paper seeks to ensure that the Board is appropriately constituted to address all ambitions in the Health & Wellbeing Strategy.

Who has contributed to this paper?

This paper has been informed by discussions at Board meetings and with the Board's Steering Group.

HEALTH & WELLBEING BOARD TERMS OF REFERENCE

1.0 SUMMARY

1.1 The Health & Wellbeing Board's Terms of Reference commit the Board to reviewing them annually. To meet this requirement, the Board and its Steering Group have reflected on a range of related issues, including the discussion on the recent Marmot and PHE reports on health inequalities at their last public meeting.

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

1.3 It also makes proposals for the Board's ways of working, reflecting the Steering Group's view that some of the issues raised cannot be addressed through relatively minor structural changes to the Board.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 This seeks to ensure that the Board continues to be fit for purpose in delivering on its goal of eliminating health inequalities in Sheffield, reflecting the differing ways health inequalities are caused, present and impact on the full range of communities and groups in the city.

3.0 SUMMARY OF KEY ISSUES AND DISCUSSIONS

3.1 The consensus is that the Board continues to develop in the right direction, but that there remain some areas for improvement or adjustment. These areas are as follows, with proposed changes to the Board's Terms of Reference in response set out in the following section:

Role of the Board in leading the system, and the role of Board Members

3.2 It remains clear that Board's role is strategic leadership of the health and wellbeing system in Sheffield, setting high level strategic aims based on the evidence in the Joint Strategic Needs Assessment, and then working to ensure that these are reflected in what the system actually does.

3.3 However, there was discussion over the mechanisms by which the Board ensures strategy is translated into action. This focused particularly on whether the Board has a role in "holding organisations to account" for delivery against the Joint Health & Wellbeing Strategy. Outside of the Board's statutory responsibilities in relation to the Clinical Commissioning Group and Council Commissioning Plans, Board members were not comfortable with this characterisation of the Board's role.

3.4 Instead, the Board's and Steering Group's discussions focused on the Board's role as one of collective leadership and responsibility, in which Board members

are active in reflecting on Board discussions, implementing (or encouraging the implementation of) changes in response in their organisations or sectors, and championing the Board's work in forums outside of Board meetings.

3.5 It is proposed that the language in the sections of the Terms of Reference on "Role and Function of the Health and Wellbeing Board" and "Role of a Health and Wellbeing Board member" be updated to reflect this view.

Representation

3.6 The issue of whether those around the table in Board discussions adequately represent the population of the Sheffield was discussed at length at the Board's June public meeting, as part of the Board's reflections on the Marmot Review 10 Years On, and the two PHE reports on the disparities in the impacts of Covid-19.

3.7 The Board reflected on this question further in their July Strategy Development session. Key points from their discussion were:

- Attempting to address the issue of representation with the Board membership risks a tokenistic approach, whilst only partially addressing the underlying issues;
- It remains important to ensure those in positions of responsibility in key city organisations are involved in discussions and own the outcome of them; and
- It is vital that the Board find a way to address this issue adequately, so that the voice and experience of all communities in Sheffield are included in discussions and reflected in the strategy that results from them.

3.8 The Board's Steering Group discussed this during August, and propose the following to address these points:

- To consider again whether it would be appropriate to expand the Board's membership to include from a BAME community organisation, or representative voice-based organisation or group;
- To formally commit to running Strategy Development Sessions as workshops focused on a specific issue or challenge, and taking the discussion out to a community that is directly affected in order to facilitate engagement on their terms (once guidance in relation to social distancing allows);
- To instigate a Citizens Panel, recruited to be representative of the city, who would have an open invitation to participate in these workshop sessions;
- For Board members to take on an active engagement role, seeking out interested groups to engage on the issues the Board is looking at and

bringing back what they hear into discussions, either personally or by inviting others to attend;

- Building on the engagement work Healthwatch have done by developing an approach that ensures the outcome of Board discussions is clearly communicated out to participants and communities.

3.9 Some of these suggestions would require some changes to the Board's ways of working, which sit outside the Terms of Reference. Others would appropriately be reflected in the Terms of Reference, as part of the Board's governance arrangements or as part of the role and requirements of Board Members.

Membership, and whether necessary perspective is included

3.10 The Board discussed whether the perspectives around the table adequately reflected the ambitions set out in the Strategy, with a particular focus on:

- **Children & Young People:** noting that a third of the ambitions in the Health & Wellbeing Strategy are focused solely on children and young people, the Board agreed that it would be appropriate to reflect this better in the voices around the table, though there was not clear consensus on the appropriate person to fill this role would be;
- **Housing:** housing, and in particular homelessness and rough sleeping, has been a focus of Board discussions pre-lockdown, and the issue has only increased in salience. It was agreed that Board discussions require expert housing input to reflect this;
- **Clinical Commissioning Group Membership:** due to restructures and other changes, the defined places reserved for some Clinical Commissioning Group officers are now out of date;
- **Deputies:** Board members are expected to have deputies nominated to substitute for them when necessary, and it remains the case that not all Board members have this formally arranged. To address this, and to use this as an opportunity to expand the potential set of voices involved in meetings, the Steering Group are suggesting that a review of Deputies be conducted by the Chairs and agreement reached on who these should be;
- **Board Size:** Concerns have been expressed about the size of Board and whether this allows for focused discussions in which all members contribute, especially in light of potential additions described above. The Steering Group agreed in their discussion to explore whether all existing places on the Board are necessary.

How the Board works to maximise the impact of the above

3.11 In reflecting on the Board's discussions, the Steering Group have discussed a number of possible changes to the Board's ways of working to support the above. These need not be incorporated into the Board's Terms of Reference but are included here to invite Board Members' views and offer an opportunity to suggest additions:

- Chairs to canvass Board Members at the end of meetings for changes they will make or actions they will take away as a result of discussions, to encourage proactive responses;
- In addition to the Citizens Panel, developing a more fluid approach to invitations to strategy discussions;
- Add to this by drawing a clearer distinction between public, formal committee meetings and strategy development sessions, with the latter seen as "events hosted by" the Board, rather than Board meetings;
- More methodically incorporate life experience into board discussions, through arranging for individuals with experience of the subject matter to tell their stories as part of the scene setting for discussions.

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

4.1 Based on the above, the following are proposed as changes to the Board's Terms of Reference, broken down by section:

Role and Function of the Health and Wellbeing Board

4.2 Alter paragraph 1.5 from:

> "The Board will be ambitious for Sheffield and hold organisations in Sheffield to account for the delivery of the Board's vision for the city. It should enable organisations to work in an integrated way, for the purpose of advancing the health and wellbeing of people in Sheffield." to read:
>
> "The Board will be ambitious for Sheffield and will demonstrate leadership, as well as supporting and encouraging organisations in Sheffield to collaborate, in delivering the Board's vision for the city. It will ensure organisations work in an integrated way, for the purpose of advancing the health and wellbeing of people in Sheffield."

4.3 Alter paragraph 1.8 from:

> "The Board will own and oversee the strategic vision for health and wellbeing in Sheffield, hold all partners and organisations to account for delivering against this by taking an interest in all associated strategies and plans and when appropriate requesting details on how specific policies or strategies help to achieve the aims of the Joint Health & Wellbeing Strategy." to read:

"The Board will own and oversee the strategic vision for health and wellbeing in Sheffield, leading all partners and organisations in delivering against this by taking an interest in all associated strategies and plans and when appropriate requesting details on how specific policies or strategies help to achieve the aims of the Joint Health & Wellbeing Strategy."

Membership

4.4 Membership as set out in paragraph 2.1 to be amended as follows:

- To add a member to provide an additional voice on issues affecting children & young people, to be agreed by the Chairs in consultation with the Steering Group;
- Under NHS Sheffield Clinical Commissioning Group, amend "Accountable Officer" to "Place-Based Lead Officer"
- Under NHS Sheffield Clinical Commissioning Group, amend "Director of Strategy" to "Appropriate CCG Director"
- To consider adding an additional place for a VCS organisation, to be reserved for someone from a BAME community organisation, or representative voice-based organisation or group

Governance

4.5 Amend paragraph 3.2 from:

"**Attendance at meetings and deputies:** In order to maintain consistency it is assumed that Board members will attend all meetings. Each member must name 1 deputy, who should be well briefed on the Board's purpose and activities, fulfil the same or similar function in their primary role (as opposed to being from the same organisation), and attend meetings and vote on behalf of the member when they are absent." to:

"**Attendance at meetings and deputies:** In order to maintain consistency it is assumed that Board members will attend all meetings. Each member must agree a Deputy with the Chairs, who should be well briefed on the Board's purpose and activities, fulfil the same or similar function in their primary role (as opposed to being from the same organisation), and attend meetings and vote on behalf of the member when they are absent."

4.6 Insert new paragraph 3.8:

"The Board shall maintain a Citizens' Panel, recruited to be representative of the city, who shall have an open invite to Strategy Development workshops."

Meetings, agendas and papers

4.7 Alter paragraph 4.1 from:

"The Board will normally meet quarterly in public, interspersed with private strategy development meetings. There will be no fewer than 2 meetings per financial year, with a maximum of 32 weeks between meetings." To:

"The Board will normally meet quarterly in public, and host workshops focused on the development and implementation of the Joint Health & Wellbeing Strategy in other months. There will be no fewer than 2 meetings per financial year, with a maximum of 32 weeks between meetings."

Role of a Health and Wellbeing Board member

4.8 No amendments are proposed to this section, but the Board may wish to reflect on the points raised above.

Engagement with the public and providers

4.9 No amendments are proposed to this section, but the Board may wish to reflect on the points raised above.

5.0 QUESTIONS FOR THE BOARD

5.1 Do the Board agree to delegate to the Chairs the task of identifying an appropriate additional representative on issues affecting Children & Young People, in consultation with the Steering Group?

5.2 Do the Board agree to create an additional place for a VCS organisation, to be reserved for someone from a BAME community organisation, or representative voice-based organisation or group?

5.3 Do the Board agree with the proposed changes set out in this paper, subject to any further discussion resulting from answers to questions 1 and 2?

6.0 RECOMMENDATIONS

6.1 The Board are asked to discuss, amend and if appropriate approve the proposed changes to the Terms of Reference.

6.2 Following this the Board are asked to agree to submit the resulting revised Terms of Reference for consideration by Full Council at the next opportunity.

APPENDIX

Sheffield Health and Wellbeing Board

Terms of Reference

Approved by Full Council 6th February 2019

1. Role and Function of the Health and Wellbeing Board

1.1 The Sheffield Health and Wellbeing Board (the Board) is established under the Health and Social Care Act 2012 as a statutory committee of Sheffield City Council (the Council) from 1 April 2013. However, it will operate as a multi-agency board of equal partners.

1.2 The Board will develop and maintain a vision for a city free from inequalities in health and wellbeing, taking a view of the whole population from pre-birth to end of life.

1.3 The Board will be the system leader for health & wellbeing, acting as a strong and effective partnership to improve the commissioning and delivery of services across the NHS and the Council, leading in turn to improved health and wellbeing outcomes and reduced health inequalities for the people of Sheffield.

1.4 In doing this, the Board will take an interest in all the determinants of health and wellbeing in Sheffield and will work across organisational boundaries in pursuit of this.

1.5 The Board will be ambitious for Sheffield and hold organisations in Sheffield to account for the delivery of the Board's vision for the city. It should enable organisations to work in an integrated way, for the purpose of advancing the health and wellbeing of people in Sheffield.

1.6 The Board is statutorily required to carry out the following functions:

- To undertake a Joint Strategic Needs Assessment (JSNA)[1];
- To undertake a Pharmaceutical Needs Assessment (PNA)[2];
- To develop and publish a Joint Health and Wellbeing Strategy (JHWS) for Sheffield[3]
- To provide an opinion on whether the Council is discharging its duty to have regard to the JSNA, and the JHWS, in the exercise of its functions[4];
- To review the extent to which the Clinical Commissioning Group (CCG) has contributed to the delivery of the JHWS[5]; to provide an opinion to the CCG on

[1] Section 116 Local Government and Public Involvement in Health Act 2007 (the LGPIHA 2007)
[2] Section 128A National Health Service Act 2006 (the NHSA 2006).
[3] Under Section 116A LGPIHA 2007
[4] Under Section 116B LGPIHA 2007
[5] Under Section 14Z15(3) and Section 14Z16 NHSA 2006

whether their draft commissioning plan takes proper account of the JHWS[6]; and, to provide an opinion to NHS England on whether a commissioning plan published by the CCG takes proper account of the JHWS[7];

- To support joint commissioning and encourage integrated working and pooled budget arrangements[8] in relation to arrangements for providing health, health-related or social care services;
- To discharge all functions relating to the Better Care Fund that are required or permitted by law to be exercised by the Board; and
- To receive and approve any other plans or strategies that are required either as a matter of law or policy to be approved by the Board.

1.7 In addition to these the Board will also take an interest in how all organisations in Sheffield function together to deliver on the Joint Health & Wellbeing Strategy.

1.8 The Board will own and oversee the strategic vision for health and wellbeing in Sheffield, hold all partners and organisations to account for delivering against this by taking an interest in all associated strategies and plans and when appropriate requesting details on how specific policies or strategies help to achieve the aims of the Joint Health & Wellbeing Strategy.

1.9 The Board will continue to oversee the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of its statutory duty to encourage integrated working between commissioners. This will include signing off quarterly and annual Better Care Fund submissions

2. Membership

2.1 The membership of the Board is as follows:

- Sheffield City Council:
  - Cabinet Member for Health & Social Care
  - Cabinet Member for Children & Families
  - Cabinet Member for Neighbourhoods & Community Safety
  - Chief Executive
  - Director of Adult Social Services
  - Director of Children's Services
  - Executive Director for Place
- Sheffield NHS Clinical Commissioning Group
  - Governing Body Chair

[6] Section 14Z13(5) NHSA 2006
[7] Section 14Z14 NHSA 2006
[8] In accordance with Section 195 Health and Social Care Act 2012. This includes encouraging arrangements under Section 75 NHSA 2006.

    - One other Governing Body GP
    - Accountable Officer
    - Medical Director
    - Director of Strategy
- Other Commissioners
    - Senior Representative from NHS England
- Providers
    - Accountable Care Partnership Programme Director
    - NHS Provider – Clinical Representative
    - NHS Provider – Non-Executive Representative
    - VCF Provider
    - VCF Organisation
    - Blue Light Service
- Independent Voice
    - Chair of Healthwatch Sheffield
    - Director of Public Health
    - University

2.2 Other representatives from the wider health and wellbeing community in Sheffield may be invited to attend the Board from time to time to contribute to discussion of specific issues.

2.3 Any changes to personnel will be approved through Full Council on an annual basis.

3. Governance

3.1 **Chair:** The Board will be co-chaired by the Council Cabinet Member for Health & Social Care and the Chair of the CCG, with chairing of meetings generally alternating between them.

3.2 Attendance at meetings and deputies: In order to maintain consistency it is assumed that Board members will attend all meetings. Each member must name 1 deputy, who should be well briefed on the Board's purpose and activities, fulfil the same or similar function in their primary role (as opposed to being from the same organisation), and attend meetings and vote on behalf of the member when they are absent.

3.3 **Quorum:** 1 Elected Member of the Council & 1 other Council Representative (Elected Member or Officer), 1 CCG Governing Body GP and 1 other CCG Representative, 1 Provider Representative, and 1 Independent Voice Representative, with an in-meeting majority for Commissioners.

3.4 **Decision-making and voting:** The Board will operate on a consensus basis. Where consensus cannot be achieved the matter will be put to a vote. Decisions will be made by simple majority: the Chair for the meeting at which the vote is taken will have the casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chair.

3.5 **Authority of representatives:** It is accepted that some decisions and / or representations will need to be made in accordance with the governance procedures of the organisations represented on the Board: however, representatives should have sufficient authority to speak for their organisations and make decisions within their own delegations.

3.6 **Accountability and scrutiny:** As a Council committee, the Board will be formally accountable to the Council. Its work may be subject to scrutiny by any of the Council's relevant scrutiny committees

3.7 Relationship to other groups: The Board has formally agreed a protocol with the city's Safeguarding Boards. The Board will seek to develop close relationships with the city's Accountable Care Partnership and Sheffield City Council's Scrutiny Committees, as part of its work to hold the health and wellbeing system to account. It will also develop relationships with other bodies in the city such as the Sheffield City Partnership Board and Safer & Sustainable Communities Partnership, especially where the agendas of such bodies overlap with the Board's.

4. Meetings, agendas and papers

4.1 The Board will normally meet quarterly in public, interspersed with private strategy development meetings. There will be no fewer than 2 meetings per financial year, with a maximum of 32 weeks between meetings.

4.2 Dates, venues, agendas and papers for public meetings will be published in advance on the Council's website.

4.3 The co-Chairs will agree the agenda for each meeting, supported by an officer subgroup

4.4 Agendas and papers will be circulated to all members and be available on the Council's website 7 days in advance of the meeting

4.5 Minutes will be circulated to all members, and published on the Council's website as soon as possible after the meeting

4.6 It is expected that those who write papers will work collaboratively with others to provide a city-wide perspective on any given issue.

5. Role of a Health and Wellbeing Board member

5.1 All members of the Board, as a statutory committee of the Council, must observe the Council's code of conduct for members and co-opted members. Other responsibilities include:

- Attending Board meetings whenever possible and fully and positively contributing to discussions, reading and digesting any documents and information provided prior to meetings
- The membership of the Health & Wellbeing Board is constructed to provide a broad range of perspectives on the development of strategy. With this in mind, members are asked to bring the insight, knowledge, perspective and strategic capacity they have as a consequence of their everyday role, and not act simply as a representative of their organisation, but with the interests of the whole city and its residents at heart.
- Fully and effectively communicating outcomes and key decisions of the Board to their own organisations, acting as ambassadors for the work of the Board, and participating where appropriate in communications/marketing and stakeholder engagement activity to support the objectives of the Board, including working with the media
- Contributing to the development of the JSNA and JHWS

- Ensuring that commissioning is in line with the requirements of the JHWS and working to deliver improvements in performance against measures within the public health, NHS and adult social care outcomes frameworks
- Declaring any conflict of interest, particularly in the event of a vote being required and in relation to the providing of services
- Acting in a respectful, inclusive and open manner with all colleagues to encourage debate and challenge.

6. Engagement with the public and providers

6.1 Healthwatch Sheffield is the Board's statutory partner for involving Sheffield people in discussions and decision-making around health and wellbeing in the city. It is expected that the Healthwatch Sheffield representative(s) will clearly ensure Sheffield people's views are included in all Board discussions, with Elected Members, and other Independent Voice members also having a role in this regard.

6.2 Formal public meetings will be held quarterly, with members of the public invited to ask questions. An answer may take the form of:

- An oral answer
- A written answer to the member of the public, circulated to the Board and placed on the Council's website
- Where the desired information is contained in a publication, a reference to that publication.

The Board's chairs retain the right to restrict the length of time given to answering public questions at any meetings held.

6.3 The Board will work with Healthwatch Sheffield to engage with the public on the issues affecting health and wellbeing in Sheffield through a range of means, ensuring the output from this engagement is linked to the Board's Forward Plan, and is fed into and reflected in Board discussions. This work will:

- Provide an avenue for members of the public to impact on the Board's discussions and work;
- Engage the public and/or providers in the development of the Joint Health & Wellbeing Strategy;
- Develop the Board's understanding of local people's and providers' experiences and priorities for health and wellbeing;
- Communicate the work of the Board in shaping health and wellbeing in Sheffield;
- Develop a shared perspective of the ways in which providers can contribute to the Board's delivery.

6.4 The Board will maintain a website with up-to-date information about its work and send out regular newsletters.

7. Review

7.1 These Terms of Reference will be reviewed annually.

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 25 June 2020

NOTE: This meeting was held as a remote meeting in accordance with the provisions of The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020.

PRESENT: Councillor George Lindars-Hammond (Chair) – Cabinet Member for Health and Social Care, SCC
Chief Superintendent Stuart Barton - District Commander for Sheffield, South Yorkshire Police
Councillor Jackie Drayton - Cabinet Member for Children and Families, SCC
Greg Fell - Director of Public Health, SCC
Terry Hudsen - GP Governing Body Chair, Sheffield CCG
Brian Hughes - Deputy Accountable Officer, Sheffield CCG
David Hughes - Medical Director, Sheffield Teaching Hospitals
Claire Mappin - Managing Director, Burton Street Foundation
Judy Robinson - Chair, Healthwatch Sheffield
David Warwicker - Governing Body GP, Sheffield CCG
Sara Storey – Interim Director of Adult Services, SCC
Mark Tuckett - Director, ACP
Maddy Desforges - Chief Executive Officer, Voluntary Action Sheffield

Also present were Eleanor Rutter - Consultant in Public Health, SCC (in respect of Minute No. 5) and Lucy Davies – Healthwatch Sheffield (in respect of Minute No. 6).

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Karen Curran, John Doyle, Alison Knowles, Laraine Manley, John Macilwraith, Zak McMurray, Chris Newman and Lesley Smith.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest made.

3. CHAIR'S MESSAGE OF THANKS

3.1 On behalf of the Health and Wellbeing Board, the Chair noted that it had been 6 months since the last meeting of the Board and this virtual meeting was an indication that we were now returning to a new normal. Staff from all organisations and partners had been brilliant working through the crisis, not just

the NHS, but care workers, carers, care home staff and Council staff. The Board was recommitting to the Health and Wellbeing Strategy, launched last year, which aimed to end health inequality in Sheffield.

The pandemic was not over, but thanks to the continuing efforts of all those involved, doing what was needed to get Sheffield through, and create a pathway to a better city and healthier population.

4. PUBLIC QUESTIONS

4.1 There were no public questions.

5. COVID-19: RAPID HEALTH IMPACT ASSESSMENTS

5.1 Eleanor Rutter joined the meeting and explained that prior to the Covid-19 pandemic, there had been a 20 year gap in life expectancy and the pandemic and lockdown had impacted most on the most vulnerable. The Health and Wellbeing Strategy had previously committed to closing the gap and it was now more of a challenge. There was a need to carry out additional work.

5.2 The Covid-19 Rapid Health Impact Assessments were a collection of small impact assessments. Rapidity was essential and getting as many responses as possible immediately, in order to get intelligence out as soon as possible.

5.3 Much of the data was qualitative – what was being experienced at the moment. This was an asset based approach and Sheffield was responding in an incredible way. The compassionate city approach with organisations being agile and flexible in their approach. It was hoped that the data would feed into recovery and help to shape where Sheffield wanted to be in the future.

5.5 A small steering group had been established and a list of around 12 themes from a wide group of partners had been established. Task and Finish Groups had been set up to coordinate the data and 1st drafts had been received from all. Feedback was encouraged on the approach and content.

5.6 Judy Robinson praised the report and noted the need to keep moving forward. She asked whether the work was being completed in line with Community Participatory Research Principles (CPRP) and, when looking at the data, would the impact on care homes be included? Eleanor responded that the work was being done in line with CPRP with a community based questionnaire which gathered data quickly and an initial report would be made to the board in July. The most vulnerable groups were represented within the data, but special reference to care homes would be useful. Discrimination and marginalisation was included along with access to services by geography.

5.7 Brian Hughes supported and endorsed the approach, the work needed to be done quickly, the initial data in July would be valuable to shape responses. Eleanor noted that all data was being shared between organisations.

5.8 A question was raised regarding coordination of the response. There was a need to ensure people were not overwhelmed. Eleanor stated that they were being careful to coordinate with other organisations and were trying to work together with the CCG as much as possible. This was a live piece of work and there was a second focus on cross cutting themes, also looking at protected characteristics.

5.9 Terry Hudsen said he was excited by the pace at which the work had been done and hoped that it would pave the way for more real time intelligence and data going forward. The key areas were broadly right, but what assurances could be made to ensure cultural sensitivity was maintained. Eleanor responded that an update would be supplied in writing.

5.10 Sara Storey said that it was also important to understand the experience of those with learning difficulties and dementia etc. and how to better support them, along with the experiences of those living in care homes. What was the next step with the intelligence? The pace of the work was impressive, but what would be done with the intelligence gathered. The same pace would also be needed to look at what needed to happen next. Eleanor stated that it was hoped the data would feed in to help with recovery and hopefully help to close the gap in healthy life expectancy.

5.11 Stuart Barton made an offer to share data that had been collated by South Yorkshire Police which was gratefully accepted.

5.12 **RESOLVED:** That, the Board:

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

6. HEALTHWATCH UPDATE

6.1 Judy Robinson and Lucy Davies presented the report which provided an update on the work of Healthwatch. Since the outbreak of COVID 19, Healthwatch had produced reports drawn from its inquiry service, feedback from individuals and from partner organisations. It had been a challenge to obtain information from some services.

6.2 There were both positive and negative stories regarding support packages during the pandemic and there was a need to take stock and ensure that all needs were being met.

6.3 There were different experiences of care homes, it was not always possible to access residents, but there were positive steps being taken to establish virtual inspections.

6.4 The Healthwatch survey report was due at the end of July. There was a need to ensure that engagement was at the centre of reorganising services. It was hoped

to make service users feel empowered and add their experiences to shape services in the future and ensure that all voices were brought together. Diversity and representation in decision making were key.

6.5 Communication to disadvantaged communities was to be made using volunteers and there was a need to think about the messages and how they were delivered.

6.6 It was hoped to develop virtual inspections and feed in to Council processes, it was hoped to include virtual contact with the residents. The challenge was to engage with residents as this was usually done face to face.

6.7 Jackie Drayton stated that the comments highlighted the inequality of the impact of Covid-19 and the importance of clear communication and asked if there had been and comments from children or young people. Lucy Davies noted that there had not been much input from children or young people.

6.8 **RESOLVED:** That the report from Healthwatch Sheffield on the impacts of Covid-19 be noted.

7. HEALTH INEQUALITIES AND COVID-19

7.1 Greg Fell presented the report which summarised the key findings of three recent reports considering health inequalities in England:

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

7.2 It reflected on the Sheffield position in relation to these, and how they interacted with the current crisis. It also reflected on work underway that was aiming to consider how Covid-19 was impacting on Sheffielders, and how this would contribute to addressing some of the issues raised in the reports, in the short term.

7.3 Greg Fell stated a key headline is that impact of Covid-19 is disproportionate on BAMER communities, due to structural inequalities, and that the response was the Health and Wellbeing Strategy, there was a need to focus on doing and then measure the outcomes. The Marmot report was a little weak on the community aspects. There were many assets in Sheffield and the Marmot report should not be taken in isolation. There was a need to build inequality impact assessments. The Board Terms of Reference needed to be discussed by the board to ensure they were still fit for purpose.

7.4 Terry Hudsen noted that the report brought together complex information and was easy to understand. Health inequality was a cross cutting theme in the strategy. Did the strategy need to be more explicit regarding inequalities such as protected

characteristics. The focus should be on prevention. Community led engagement was needed with a focus on cultural sensitivity in the responses. A list of protected characteristics was needed to ensure there were no blind spots, but there is also a need to go beyond protected characteristics to consider layered inequality.

7.5 Councillor Jackie Drayton said that it was good to see the reports together and the board should be looking at how to commit to delivering the recommendations of the Disparities in the risk and outcomes of COVID-19 report. Ethnicity recording should be carried out by the Council as a matter of course. Communications were very important, how we use the information and how we write tender documents in the future needed to be looked at. There was also a need for BAME experiences to be listened to.

7.6 Judy Robinson stated that there was a need to focus and keep things in balance. A practical approach could be for the Health and Wellbeing Board to meet in other locations.

7.7 Greg Fell explained that location was one of the factors being looked at, but that hygiene factors needed to be taken into account. It was hoped that and increased settlement would be available from the Government to offset some of the costs of Covid-19. Sheffield City Council had done the right thing by overspending the public health budget to counter the disease.

7.8 Mark Tuckett noted that the report was helpful and that the Board also needed to reflect on its own make up with regards to the BAME community.

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

- Are there any other areas of work that should be explored as part of the work to address health inequalities in Sheffield, both pre-existing and those created and exacerbated by Covid-19? *The Terms of Reference of the Board should be looked at to ensure they met the current needs of the city.*
- How work to address questions of representation and engagement in relation to the Board's work be approached? *Reports needed to be shorter and pithier and it would be necessary to deal with issues in a more rapid way.*

(2) The content, conclusions and recommendations of the Marmot report, and the PHE reports, be noted;

(3) The Board recognise that work is ongoing to understand the impact of Covid-19 in Sheffield and how this impacts on different groups, with short term actions being put in place as these deliver intelligence;

(4) The Board recommit to delivering the Health & Wellbeing Strategy, recognising that the ambitions within it remain the building blocks of healthy lives for Sheffielders, and that the challenge in and importance of delivering on them is greater in the context of the pandemic;

(5) The Board commit to delivering at the local level the recommendations laid out in the second PHE report, where we have the powers to do so;

(6) The Board agree that responding to the challenges outlined above is not the responsibility of one organisation but of the whole city;

(7) The Board use the opportunity of the delayed Terms of Reference review to reflect on questions of representation and ways of working to ensure that the strategies it develops and delivers on reflects the concerns and interests of all Sheffielders, reflecting on this at their July Strategy Development Session and bringing proposals in response to the next Public Committee Meeting, and;

(8) The Board commit to working with all city partners and other bodies in the city on addressing the disparities in the impacts of Covid-19, health inequalities in general, and the root causes of these, in the short and long term, especially recognising the vital role of the VCS, BAME and Faith sector organisations and leads in this approach.

8. MINUTES OF THE PREVIOUS MEETING

8.1 **RESOLVED:** That subject to Maddy Desforges being added as being present, the minutes of the Health and Wellbeing Board held on 30th January 2020 be approved as a correct record.

9. DATE AND TIME OF NEXT MEETING

9.1 It was noted that the next meeting of the Health and Wellbeing Board would take place on Thursday 24th September 2020 at 3pm.

On behalf of the Board, the Chair thanked Nicki Doherty for her contribution to the Health and Wellbeing Board and wished her luck in her new role.

The Chair also thanked those present for their attendance.