Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 31 March 2022 at 2.00 pm

Town Hall, Sheffield City Council

The Press and Public are Welcome to Attend

Membership

Dr David Black	Sheffield Teaching Hospitals NHS FT
Sandie Buchan	Sheffield CCG
Alexis Chappell	
Michael Crofts	
Councillor Jayne Dunn	
Greg Fell	Director of Public Health, Sheffield City Council
Dr Terry Hudsen	NHS Sheffield CCG
Brian Hughes	CCG
David Hughes	Sheffield Teaching Hospitals NHS Foundation Trust
Kate Josephs	
Councillor George Lindars-Hammond	Cabinet Member for Health and Social Care
John Macilwraith	
Sharon Mays	Sheffield Health & Social Care NHS Foundation Trust
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
Prof Chris Newman	University of Sheffield

Sheffield City Council

Judy Robinson	Chair, Healthwatch Sheffield
Toni Schwarz	
Helen Sims	Voluntary Action Sheffield
Helen Steers	Voluntary Action Sheffield
Councillor Alison Teal	
Simon Verrall	South Yorkshire Police
David Warwicker	

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

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

If you require any further information please contact Fiona Martinez on fiona.martinez@sheffield.gov.uk

FACILITIES

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

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

31 MARCH 2022

Order of Business

1.	**Apologies for Absence (5 mins)**	
2.	**Declarations of Interest (5 mins)** Members to declare any interests they have in the business to be considered at the meeting.	(Pages 5 - 8)
3.	**Public Questions (10 mins)** To receive any questions from members of the public.	
4.	**Working with the Integrated Care System (20 mins)**	
5.	**VCS Relationships (30 mins)**	(Pages 9 - 22)
6.	**HWBB Review - Proposal for Next Steps (20 mins)**	(Pages 23 - 54)
7.	**Taking Stock of the Joint Health and Wellbeing Strategy (15 mins)**	
8.	**Healthwatch Update (15 mins)**	
9.	**Minutes of the Previous Meeting (5 mins)**	(Pages 55 - 62)
10.	**Date and Time of Next Meeting** The next meeting is on the 30th June 2022, 2pm to 5pm, venue to be confirmed. **NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 30 June 2022 at 2.00 pm**	

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:	Mark Tuckett and Brain Hughes
Date:	31st March 2022
Subject:	Strengthening of statutory bodies strategic relationship with the Voluntary Sector in Sheffield
Author of Report:	Kathryn Robertshaw

Summary:

This paper provides an update to the Health and Wellbeing Board on the development of the strategic relationship between statutory bodies the and the Voluntary Sector in Sheffield

Since the discussion paper on this issue was brought to the HWBB in February 2021 Statements of intent have been agreed by both the HWBB and the Sheffield Health and Care Partnership (Appendix 1)

A set of actions to ensure intent becomes reality has been developed and is being taken forward by a working group. The group is made up of a broad range of VCS organisations as well as health and care commissioners and aims to bring together the various conversations and plans that were being developed in the city on this issue.

Questions for the Health and Wellbeing Board:

Health and Well-Being Board are asked to consider whether this provides sufficient assurance on progress against the Voluntary Sector Statement of Intent.

Recommendations for the Health and Wellbeing Board:

We need to be sure this action plan is a vehicle for change, rather than a process we move through. In particular this requires bold action to tackle the areas of concern outlined.

HWB Board are asked to debate the points outlined and:

- Note the areas of progress
- Outline any further points they wish the HCP to consider to secure a more strategic and equitable relationship with the voluntary sector in the city

Background Papers:

Statement of Intent and illustrative plan approved by Sheffield Health and Care Partnership Board June 2021 (Appendix 1)

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

The work has the potential to support delivery of all 9 of the strategy ambitions

Who has contributed to this paper?

Sandie Buchan (Executive Director of Commissioning Development
NHS Sheffield CCG)

Brian Hughes (Deputy Accountable Officer – NHS Sheffield CCG)

Kathryn Robertshaw (Deputy Director– Sheffield Health and Care Partnership

Helen Steers (Head of Health and Wellbeing - Voluntary Action Sheffield)

Mark Tuckett (Director Sheffield Health and Care Partnership)

Development of statutory bodies strategic relationship with the voluntary sector in Sheffield

1.0 SUMMARY

1.1 This paper provides an update to the Health and Wellbeing Board on the development of the strategic relationship between statutory bodies the and the Voluntary Sector in Sheffield

1.2 Since the discussion paper on this issue was brought to the HWBB in February 2021 Statements of intent have been agreed by both the HWBB and the Sheffield Health and Care Partnership (Appendix 1)

1.3 A set of actions to ensure intent becomes reality has also been developed and is being taken forward by a working group. The group is made up of a broad range of VCS organisations as well as health and care commissioners and aims to bring together the various conversations and plans that were being developed in the city on this issue.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 By working more closely with the VCS and having VCS organisations integral to health and care planning and provision we will be better able to reach and build connections with parts of our city which our statutory partners are less good at reaching. We know our VCS organisations are often very firmly rooted in their communities – both of geography and identify – and so have a trust and engagement with people that other providers could hugely benefit from.

2.2 It provides opportunity for decision makers to come together with people advocating for and providing support to those experiencing inequalities or experiencing inequalities themselves to work towards solutions and give people more opportunity to achieve good health outcomes

3.0 MAIN BODY OF THE REPORT

3.1 A discussion paper was considered by the Health and Wellbeing Board (HWBB) in February 2021. This paper explored ways in which the Health and Wellbeing Board and the voluntary sector in Sheffield, can develop their relationship to be more open, strategic, mutually supportive and sustainably funded as we begin to move towards recovery.

3.2 There was recognition at that time that discussions about the development of the relationship with the sector were taking place in different forums (e.g. Joint Commissioning, HCP and the HWBB) and that these needed to

be brought together. Recognising that this work is not just about commissioning, but about relationships and doing things in a different way.

3.3 This paper aims to provide an update to the HWBB Board on the progression of those conversations and the actions underway to develop the relationship with the VCS

3.4 In March 2021 the HWBB agreed its Statement of Intent for its relationship with the Voluntary and Community Sector.

3.5 In support of this, in June 2021 the Sheffield Health and Care Partnership agreed its Statement of Intent outlining its commitment to working differently with the VCS and providing an illustrative action plan (see Appendix 1)

3.6 The ten-year vision for Health and Care in the city was approved by the HCP partners at the end of 2021. There is a clear role for the Voluntary and Community Sector (VCS) within all three pillars of the vision:

On *inequalities*, the different models and modes of delivery are an invaluable asset in reaching and building connections with parts of our city and communities which our statutory partners are less good at reaching

On *integration*, the opportunities for fully realising the potential of holistic health, care and wellbeing stretches beyond connecting primary with secondary care, or health with social care, to also integrating voluntary services with statutory provision, as full partners

And on *people*, those both working in and volunteering for VCS organisations should be recognised as and identify with 'Team Sheffield'.

3.7 Voluntary Sector leaders are now key members of the Sheffield Outcomes Framework Board, enabling the establishment of service user and VCS experiences feedback into the outcomes framework dashboard. A proposal is being taken to the Outcomes Framework Board to ensure the dashboard is regularly shared with the HWBB.

3.8 Development of the Joint Commissioning Intentions has also ensured that the VCS were part of the consultation process. This engagement is planned to expand for future years. Good commissioning practice and also the role of VCS intelligence and data to City decision making are key to providing appropriate health and care for our population

3.9 A working group has been established to take forward and further develop the illustrative action plan outlined in the Statement of Intent. We need to be sure the action plan being developed by the working group to be a vehicle for change, rather than a process we move through. In particular

this requires bold action to tackle the areas of concern outlined. This group continues to develop and its membership includes a wide range of VCS organisations as well as commissioners from health and social care. The work of the group is focussed on five key areas:

- **Coordination and leadership**: investing in how a diverse VCS is connected, coordinated and led
- **Delivery**: recognise the 'otherness' and reach that the VCS brings to delivery and see VCS organisations as essential partners for delivery
- **Financial security**: support and enable longer term resilience and security for VCS organisations. This has been identified by the group as the most pressing area of work to focus on.
- **Voice**: listen, respect and respond to VCS organisations, both established and new and different voices
- **Shared learning and experience**: value, support, develop and connect people working across our health and care system, building on and sharing good practice about existing good connections and partnership between our statutory services and VCS.

3.10 There are already examples in the city where the VCS are taking a leading role bringing investment into the city and leading change in health and care provision. For example, the investment (secured through a bid led by Voluntary Action Sheffield) by the Kings Fund Healthy Communities Together Fund to support a piece work to improve connections between communities and the health system particularly where health inequalities are highest, to improve the prevention and management of diabetes.

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

4.1 This paper provides an update on the early work to develop the relationship with the VCS. Board will need to continue to engage with the development of this and consider its role in challenging other bodies to do the same.

5.0 QUESTIONS FOR THE BOARD

5.1 Health and Well-Being Board are asked to consider whether this provides sufficient assurance on progress against the Voluntary Sector Statement of Intent.

6.0 RECOMMENDATIONS

6.1 HWB Board are asked to note and debate the points outlined below:

- Note the embedding of the VCS in strategic conversations across health and care.
- Note the establishment of a working group and its key areas of focus.
- Note the proposal that the Sheffield Outcomes Framework be brought to HWBB on a regular basis.
- Outline any further points they wish the HCP to consider relating to how they are developing a more strategic relationship with the voluntary sector in the city

Appendix 1 – Statement of Intent and illustrative plan approved by Sheffield Health and Care Partnership Board June 2021

Statutory Bodies – VCS relationship

Since the inception of the Sheffield Health and Care Partnership (SHCP), we have been in full agreement about the importance of the Voluntary and Community Sector (VCS) and the critical role it plays within our health and care system. This relationship has developed over time, with Voluntary Action Sheffield (VAS) joining the SHCP as a full member in Summer 2018 and the following year, funding of £50,000 per annum agreed for a 3-year period to support the integration within the city's health and care infrastructure and the broader development of the VCS.

Pre-covid, our conversations had already turned to the next steps in strengthening this relationship and how to ensure the sustainability of critical VCS services. The events of the past 12 months have showcased the flexibility and added value, with which the VCS enhances our statutory service provision. As a result though, our VCS finds itself under significantly increased pressure, and there are real concerns about the short to medium term sustainability of critical services which we have come to rely on as a city. One example of this is the increase in activity at Manor and Castle Development Trust: they would typically be supporting 440 people at any one time, whereas by February 2021 they were supporting 1170 people, with the same resources and no additional capacity, leaving their staff and services at breaking point.

As stated in our draft 10-year vision:

The VCS in Sheffield is already a key part of our health and care system, whether through commissioned services or through the support provided to individuals and communities using charitable funding. *Given this key role we need to support its long-term future. Although a number of VCS organisations in Sheffield have been in existence for longer than some of our statutory partners, sustainability and funding remain common challenges. Funding processes have been known to stifle progress and effective ways of working, whilst our VCS representatives have described the tension between our strategic and planning intentions to work with the sector in a supportive and strategic way, and how services are procured and contracts are established. This is reflected in a wider concern about the extent to which the appetite for a strategic relationship with the VCS is embedded in the culture across and throughout our organisations.*
The VCS can be recognised as disruptors, challenging the status quo and thinking differently about the delivery of better outcomes with and within communities. Simply sub-contracting elements of service delivery risks understating thus undermining the benefits which can be achieved, and perpetuates an assumption that VCS services are simply cheaper alternatives to statutory providers. If we are serious about working with communities, community reference groups will need to share the same status as clinical reference groups as service plans are developed; with a shared focus on the social determinants of health alongside medical models of healthcare.

There is a clear role for the VCS within all three pillars of our draft vision:

- On *inequalities*, the different models and modes of delivery are an invaluable asset in reaching and building connections with parts of our city and communities which our statutory partners are less good at reaching

- On *integration*, the opportunities for fully realising the potential of holistic health, care and wellbeing stretches beyond connecting primary with secondary care, or health with social care, to also integrating voluntary services with statutory provision, as full partners

- And on *people*, those both working in and volunteering for VCS organisations should be recognised as and identify with 'Team Sheffield'.

We have a good story to tell in Sheffield, which is starting to be recognised beyond our own city (the University of Birmingham is currently undertaking some research based on the positive stories they have heard about the role our VCS organisations have played as part of Sheffield's COVID response). We need to build on this.
The table below has been developed through collaboration between the CCG, Sheffield City Council, VAS and the SHCP core team. It outlines their initial views on what we must, should and could do to maximise the full benefit of a strong and integrated VCS for our Sheffield citizens, thus strengthening our strategic relationship and recognising the value of the 'otherness' which the VCS brings. Five key areas are covered:

- **Coordination and leadership**: investing in how a diverse VCS is connected, coordinated and led

- **Delivery**: recognise the 'otherness' and reach that the VCS brings to delivery and see VCS organisations as essential partners for delivery

- **Financial security**: support and enable longer term resilience and security for VCS organisations

- **Voice**: listen, respect and respond to VCS organisations, both established and new and different voices

- **Shared learning and experience**: value, support, develop and connect people working across our health and care system, building on and sharing good practice about existing good connections and partnership between our statutory services and VCS.

The table below is included in this paper for illustrative purposes, to share with SHCP Board the range of thinking and options currently under consideration. It is fully expected that these will be adapted to reflect wider and evolving views, including those of SHCP members beyond the CCG, City Council and VAS. As firmer proposals are developed, we will take them to EDG and, where appropriate, to Board. We have identified a number of actions, which we believe should be implemented within the next 12 months – these are listed below and are presented for SHCP Board approval.

This paper also reflects, and brings together, similar conversations currently taking place at both the Health and Wellbeing Board and the Joint Commissioning Committee. The actions proposed below contribute directly to the Health and Wellbeing Board's recently endorsed 'Statement of Intent for VCS Relationship'.

<u>In the next 12 months we will, as a minimum:</u>

Coordination and leadership

- Embed VCS leadership in our future place partnership model of working
- Agree what our shared investment in VCS leadership (through VAS and other coordination and leadership organisations) and aligned expectations for this money, so that it can have greater impact

Delivery

- Implement the diabetes project, led by the VCS and with all partners playing a full role
- Working with Primary Care Networks and community care teams, develop an employment model for care coordination posts, which fully integrates VCS organisations
- In line with our ambitions around prevention and community-based care and support, assess the level of risk currently being held (and contained) within the VCS to agree actions which will either:
    i. minimise escalation to statutory services,
    ii. enable individuals'/families' continued support in community-based settings or
    iii. support a managed transition to clinically-led care
- Reframe the way we work with the VCS: shift away from a transactional relationship based around funding distribution, to one which delivers better services in partnership with our communities

Financial security

- VAS, SCC and the CCG to identify specific ways through which longer term financial security could be achieved and implement those changes

Voice

- Recognise Sheffield Healthwatch as our experts and independent champion for voice and influence (in our governance, in our discussions, and through specific improvement work)

Shared learning and experience

- The implementation of our reciprocal mentoring programme at EDG
- Expansion of system leadership development, including across voluntary sector providers

	We must…	*We should…*	*We could…*
Coordination and leadership	1. Invest in additional capacity within VAS and the wider VCS to coordinate VCS and specific community of interest connections, with decision-making at a city and locality level to support more effective "place based" arrangements 2. Tackle inequality in leadership, including investment in BAME leadership to bring more voices to influence. 3. Coordinate the various conversations and funding streams into VAS and the wider VCS and focus on outcomes.	1. Invest in other organisations doing this leadership 2. Support the VCS to coordinate network activities – map out current infrastructure funding and put on a recurrent basis (at least 3 year contracting arrangements) where possible.	
Delivery	4. Make continued investment to support wellbeing across the city, e.g. a small grants pot to enhance services and support from the statutory sector, or to wrap around individuals and communities in a way the statutory services do not and targeted to address inequalities, with an expectation that e.g. 50% of the fund is invested through BAME/community led groups to generate a levelling up effect. 5. Understand the collective cash input into the sector through grants and commissioned services to understand gaps and/or duplication 6. Capture the outcomes achieved through the work with the sector	3. Invest in capacity within organisations to allow the VCS to shape local partnerships 4. Have an expectation that each SHCP partner invests 1% of its turnover in the VCS in Sheffield 5. Consider further investment in managing the impact of COVID-19 to ensure longer term infrastructure funding commitment. 6. Develop more capacity within Social Prescribing organisations to support hospital rehabilitation and recovery services.	1. Develop capacity within VAS to have a greater role in connecting commissioning to VCS delivery in identified areas e.g. Autism or COVID recovery. 2. Each (non-VCS) SHCP member to identify a tricky problem on which it will work with VCS partners to find and invest in alternative practices and solutions. During 2021/22, we will implement changes in light of the recommendations that arise from this work

Financial Security	7. Make a public commitment of support to the VCS 8. Not financially penalise VCS organisations in Sheffield as a result of Covid 9. Prioritise business continuity through financial arrangements, and commit to taking every opportunity to foster collaboration not competition 10. Make timely decisions and take timely action to reduce financial insecurity for organisations and their staff 11. Fully fund all contracted activity (a lot of VCS activity is currently cross-subsidised from charitable activity funds). 12. Work with voluntary and community based organisations with longer term, secure funding arrangements - in the immediate term, we will ask VAS, SCC and the CCG to identify specific ways through which this longer term security could be achieved. Annually renegotiated budgets and contracts will become the exception rather than the norm.	7. Join up commissioning so an administrative layer isn't added to the VCS burden 8. Recognise and understand the complexity of VCS funding – e.g. ZEST funding for weight management, swimming pool, adult education – each relies on the other and one decision impacts on the whole organisation, yet decisions are taken in isolation 9. Use joint commissioning to bring decisions together and make them work for the VCS 10. Change perceptions of value – people, assets, skills, continuity of service, wider support for and investment in communities to enable resilient support. It isn't just about the £ and saving or spending money 11. Refer to good examples of where this is done well to achieve excellence (e.g. Preston and Wigan) 12. Develop more VCS led interventions that support people with multiple, complex support needs that currently fall between services, resulting in inefficient demands being placed on statutory services.	3. Decide how to invest more in the VCS, without strings around outcomes and to enable a leadership role in community led approaches.
Voice	13. Bring people's voices and what matters to them to the heart of improving health and social care	13. Embed understanding of theory and experience the practice of engagement in CPD, training and career progression	4. Commit to testing ideas about service redesign to meet local population health priorities e.g. diabetes,

	14. Invest consistently in capacity of organisations to engage with need – small and flexible 15. Recognise Healthwatch's unique position as the independent champion 16. Create the expectation for all SHCP papers that they explicitly include a section on voice 17. Invest in the long term [5 year minimum] to build relationships, trust and confidence. 18. Involve in problem *setting* as well as problem *solving* 19. Understand voice's role *across* design, commissioning, management and evaluation of services ***and*** in wider discussion, outside specific services, in system changes and identifying what makes for well-being. 20. Be more consistent as a system in how we do it 21. Listen to people who are rarely heard and test for "blind spots". 22. Develop and support models which resource the co-ordination of voice, ***as well as*** resourcing organisations to participate. 23. Create/ continue the space for VCS organisations to engage with and be heard by our statutory partners (e.g. the SHCP BAME Communities Group)	14. Embed the role of the VCS in supporting communities to engage with and support devolved decision making in localities 15. Shift to a 'Radical Help' model to change the relationships from service provider and service user to collaborative relationship 16. Position civic society and communities at the heart of what we do – participants not consumers 17. Visibly base decisions in communities and need, not in commissioning silos e.g. bring together home care, employment, developing community assets; align different policies to achieve multiple and *connected* goals 18. Invite Healthwatch Sheffield to join our SHCP Board and fund it to do more. 19. Clarify and strengthen the connection between our *Improving Accountable Care Forum* at the Board and Executive Team. 20. Surface, hear, consider and resolve longstanding and emerging challenges that Healthwatch and other voice-based organisations and fora have identified as areas for improvement 21. Widen the membership of the SCC VCS Steering Group to develop this into a place-level meeting	dementia, young people's mental health 5. Use the Local Area Co-ordination Network (lacnetwork.org) in a defined area (PCN or community with an established organisation like Zest / SOAR etc.) or with a specific service e.g. a Doncaster peer support group has re-shaped their mental health crisis care service

	24. Focus on sharing intelligence between SHCP partners 25. Understand what the Community needs / and how it wants to be supported e.g. refugees		
Shared learning and experience	27. Adopt a strategic approach to our current system leadership provision (e.g. Leading Sheffield) to ensure impact is maximised across and within all organisations	22. Commit to activity to understand the VCS offer within organisations and drive that from a top level to embed activities 23. Establish peer mentoring 24. All senior leaders spend a day with a VCS organisation each year as part of their learning and development	6. Establish a "job exchange" scheme for staff working in our health and care system to experience working with and in VCS organisations; and vice versa

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell Director of Public Health, Sheffield City Council
Date:	31st March 2022
Subject:	**Health and Wellbeing Board Review – Proposal for Next Steps**
Author of Report:	Lucy Darragh Dan Spicer, 273 4554

Summary:

This paper outlines the proposals for the future direction of the Health and Wellbeing Board, following a period of review and refresh carried by the Board between December 2021 and February 2022. The proposal enclosed considers changes to Health and Wellbeing Board meetings and the implications for current Board members. It provides an opportunity for the Board to reflect on the key findings from the review and comment on the proposed next steps. The key changes are:

- Maintaining formal committee meetings to fulfil statutory functions, but loading up the agenda with more intelligence, updates and change proposals and dedicating time at one of these meetings to look back at the previous year and look forward to the next;
- Replacing the current strategy development sessions with three half-day conference-style events per year, with a broader invite list, focussed on specific themes/priorities decided on by the Board; and

- The HWBB Steering Group to still meet in its current form but shift its role to being primarily about designing the conference events and making them effective and engaging, rather than forward planning.

These changes are intended to address the issues identified through the review, and to provide renewed energy, impetus and focus to the Board's work.

Questions for the Health and Wellbeing Board:

1. Do these proposals take into account the key considerations of Board members when thinking about the HWBB's future direction?
2. Do these proposals make sense in light of NHS and Council governance reforms, as well as wider contextual changes, e.g., 'living with Covid' plans, changes in Sheffield's partnership landscape?
3. Do the proposals give the urgency needed to ensure that the HWBB can have the most significant impact on health inequalities in Sheffield?

Recommendations for the Health and Wellbeing Board:

The Board are asked to:

1. Note and agree the framework for the future of the Board set out in this paper
2. Note and agree the framework for future membership, and agree to further work to identify appropriate NHS members, and members with a focus on children and young people
3. Agree to receive a final revised set of Terms of Reference for the Board at their June 2022 meeting based on these proposals, ahead of putting these to Full Council for approval and incorporation into the Constitution

Background Papers:

- HWBB Review and Refresh – Discussion Paper (*February 2022 Strategy session)*
- Health & Wellbeing Board: Review and refresh (*December 2021 Strategy session*)

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

All nine ambitions have been considered, with this paper relating specifically to the 'Delivering on ambitions' section of the Health & Wellbeing Strategy.

Who has contributed to this paper?

Lucy Darragh

Dan Spicer

HWBB Steering Group

All Board members

Health and Wellbeing Board Review - Proposal for Next Steps

1.0 SUMMARY

1.1 This paper outlines the proposals for the future direction of the HWBB, taking into account the key findings of those discussions. These proposals concern key changes to HWBB meetings:

- Maintaining formal committee meetings to fulfil statutory functions, but loading up the agenda with more intelligence, updates and change proposals and dedicating time at one of these meetings to look back at the previous year and look forward to the next;
- Replacing the current strategy development sessions with three half-day conference-style events per year, with a broader invite list, focussed on specific themes/priorities decided on by the Board; and
- The HWBB Steering Group to still meet in its current form but shift its role to being primarily about designing the conference events and making them effective and engaging, rather than forward planning.

1.2 The paper also outlines the implications of these proposals, and other contextual factors, on current HWBB members.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 The HWBB needs to work in an effective way, in order to be able to deliver on its goal of closing the gap in healthy life expectancy in Sheffield. This is particularly the case given the upcoming changes to local NHS structures and the HWBB needing to be able to articulate Sheffield's health and wellbeing needs and priorities at a wider system level.

2.2 The proposals detailed in this paper should help to tackle health inequalities in the following ways:

- Bringing in a broader range of voices and more diverse insight into health and wellbeing priorities set out by the Board;
- Providing opportunity for decision makers in the city to come together with people experiencing health inequalities, working towards co-produced solutions; and
- Where possible, providing the opportunity for the HWBB to get out of its normal meeting settings and "into communities".

3.0 BACKGROUND

3.1 In December 2021, the HWBB started a process of review and refresh in light of an identified need to refocus its efforts as we emerge from the immediate crisis period of the Covid-19 pandemic.

3.2 A series of other key implications on future Board activity were also identified:

- the upcoming changes to local NHS structures, as per legislation currently proceeding through parliament;
- changes to Sheffield City Council's governance arrangements, of which the Health & Wellbeing Board is a part; and
- work being undertaken by Sheffield City Partnership to develop a new City Strategy.

3.3 To support this refresh and review, Board members took part in a dedicated discussion at December's strategy development session and also had a one-to-one interview with a member of Sheffield City Council's Strategy & Partnerships team.

3.4 Both December's strategy development session and the 1:1 interviews asked Board members a series of open questions to support thinking about the issues involved in considering the Board's future direction.

3.5 These discussions were centred around five main themes:

- The scope of the Board's work
- The functions it carries out
- The methods it uses to do this
- The membership of the Board and who participates in discussions
- The relationship it has with other bodies in Sheffield and beyond

3.6 Following the completion of the 1:1 interviews, the key findings were presented back to the HWBB in February's strategy development meeting, with this paper setting out the proposed next steps based on feedback from that meeting.

4.0 KEY FINDINGS

Scope

4.1 There was broad agreement that the Board should be focused on addressing health inequalities in Sheffield, looking beyond NHS and social care services to encompass all determinants of health and wellbeing. However, this was not matched by a sense that this is clearly set out and collectively owned by Board members.

4.2 There was a strong view and broad agreement that the Board must be a body that has a meaningful impact on Sheffield and be able to demonstrate positive change. However, there was not clear consensus on what impact means for the Board, and how it could or should be measured.

4.3 It was clear that the Board should have an all-age approach, as reflected in the Strategy, but concern that it can tend to focus on adults.

Functions

4.4 There was general agreement that the Board discharges its statutory duties in relation to the Joint Strategic Needs Assessment, Pharmaceutical Needs Assessment, Joint Health and Wellbeing Strategy, and encouraging integrated working, well.

4.5 There was also agreement that the Board's functions are not restricted to these, and that it should also be a strategic place for coordination and for systems leaders to get out of silos and bring things together. There was also a sense that the HWBB should be able to represent health and wellbeing priorities in other forums, including up to the ICS in the future, with a strong view on the importance of engagement and knowing the place.

Methods

4.6 There was a sense that the way HWBB meetings are organised at the moment (with the separate formal and informal strategy development sessions) are good in principle but don't really seem to be working the way they have set out to do.

4.7 There was also agreement that the Board should be a place that engages in challenging conversations, as envisaged in the Joint Health & Wellbeing Strategy, but that so far this has not happened to the intended degree.

4.8 Linked to the discussion about impact, it was reflected that the Board is not very good at tracking and following up actions and decisions being made and suggested that there should be a regular conversation about how Sheffield is doing in relation to the Board's priorities. This would help to build accountability into the Board's work.

4.9 Some Board members reflected on how it could be ensured that coproduction and codesign is a feature of the Board's work, with the voices of residents influencing how things progress.

Membership

4.10 There was agreement that an all-age Board needs to have a membership that reflects this, and concern that the current membership does not do this.

4.11 There was broad agreement on the need for clarity on the precise role of Board members, and what they are expected to deliver as "system leaders". For example, whether they should bring expertise from a particular constituency, or whether they should bring some influence over their organisation or other Boards they are a member of.

4.12 There was a view expressed that the Board is too dominated by Sheffield City Council and the Clinical Commissioning Group, and that there should be an aim to widen membership across the city and its organisations, to allow for a greater diversity of views.

4.13 However, there was also a sense that a widened membership might mean the Board would become too unwieldly and less effective as a partnership. The idea of having a

smaller ‘core’ membership to fulfil statutory duties, and a wider and more flexible invite list to address other functions was suggested several times.

4.14 There needs to be a strong position on deputies, ensuring that informed substitutes are available if someone is unable to attend.

Relationship to other bodies

4.15 There was a lack of clarity identified in how the various strategic partnerships in Sheffield fit and work together, and a desire for this to be set out.

4.16 It was also noted that the health and wellbeing conversation should be represented in those other spaces, to reflect the Board’s ‘all determinants of health’ approach. This could be facilitated by HWBB members who also attend other strategic partnerships.

4.17 It was suggested that the Board doesn’t have a strong enough link to groups that are tasked with driving progress, to ask what impact is being made against the Joint Health and Wellbeing Strategy.

4.18 There was a strong view that the HWBB’s future relationship with the ICS in South Yorkshire will be extremely important and provide an opportunity for city leaders to take a collective understanding of Sheffield’s health and wellbeing needs into wider discussions. However, this review and refresh is needed to ensure that the HWBB has a strong enough individual position, to take full advantage of this relationship.

5.0 PROPOSED CHANGES TO HWBB MEETINGS

5.1 Based on the findings outlined above and subsequent feedback from February’s strategy development session, this paper proposes that, in the future, the HWBB splits its functions into three distinct parts:

- formal committee meetings;
- conference-style events focused on specific priorities;
- the Board’s steering group.

5.2 The biggest change here is that the conference-type events will replace the strategy development sessions in their current form, though there will be some implications for the formal committee meetings and the HWBB steering group’s role too.

Formal committee meetings

5.3 The four formal public meetings per year will continue, using these to fulfil the Board’s statutory functions as is currently the case.

5.4 These meetings will also be used to give the Board the opportunity to receive and discuss engagement and intelligence, input into change proposals, and see progress reports on key pieces of work.

5.5 One of these meetings each year will be used to look back at what has been achieved that year, refresh the Board’s mission, and set priorities for the year ahead.

Conference-type events

5.6 Strategy development sessions will end in their current form and be replaced by three significant half-day conference-style events a year.

5.7 These events will be focused on specific themes or priorities from the current Strategy, to be decided upon by the Board at the annual look back/look forward discussion at the formal committee meeting (see above).

5.8 To give a sense of what these could like, the following examples are suggested:

- A conference on 'Housing and Health' based on ambition four – "Everyone has access to a home that supports their health"; or
- A conference on 'Early years' or 'The first 1001 days' based on ambition one – "Every child achieves a level of development in their early years for the best start in life"; or
- A conference on 'Tackling loneliness and social isolation' based on ambition eight – "Everyone has the level of meaningful social contact that they want".

5.9 These events could also be run in partnership with other bodies – e.g., work with the Economic Partnership on an event themed around inclusive growth and health, with outputs for both boards to consider.

5.10 These events will have broad attendance, linking in Board members as key decision makers in the city with a service user perspective from organisations, individuals and experts in the field who can bring a diverse range of insights into the discussion.

5.11 This bringing of different perspectives together to discuss the challenges Sheffield's health and wellbeing faces will support the development of new solutions. It will be critical to ensure that attendance is representative of the city as a whole, as appropriate for the issue at hand, and to ensure that everyone attending these events speaks on the same terms and with the same expectations of being heard.

The HWBB steering group

5.12 The Steering Group will continue to meet monthly, with its focus being on ensuring the Board is talking about the right things, in the right way.

5.13 It will maintain its ownership of the HWBB's forward plan, but will also take responsibility for designing the conference events to ensure that they are engaging, meaningful, and impactful for attendees and the city.

6.0 WHY WE ARE PROPOSING THESE CHANGES

These changes are intended to respond to or deliver the following:

- Responding to feedback that the current meeting format hasn't worked out the way it intended to do, this would shift the style of meetings outside of the formal committees.

- It would give the Board the opportunity to prioritise its attention for a given year, giving it something tangible to focus on underneath the Joint Health and Wellbeing Strategy
- It would provide a way for the voices shaping conversations to be more representative of the city as a whole.
- It would provide a clearer way in for lived experience and other expertise, without this being concentrated in a small number of people.
- It would allow Board resources to be focused on a small number of higher quality, high impact events, rather than spreading this out over monthly meetings.
- It will free up Board member time.
- It will provide space to add fresh impetus and energy into the formal Board meetings.
- It would provide a clear signal of change and refresh to the Board's work as we look forward beyond Covid.

7.0 CHANGES TO HWBB MEMBERSHIP

7.1 In light of this proposal and wider membership issues, we would also expect some changes to the Board's membership.

7.2 Due to not being yet clear on both Council and ICS governance arrangements, it is not yet possible to make firm recommendations in this area. However it is possible to set out the parameters of the discussion that needs to take place, and commit to bringing back a firm proposal to the next public meeting.

7.3 Any changes to the Board's membership will need to reflect the following points:

- They should not lead to an overall increase in the size of the Board
- There must be an increase in the proportion of voices with a focus on children and young people
- All statutorily required members must be retained
- There should be an expectation that Board members bring either subject matter expertise, organisational influence, or both, and members should be selected on this basis

8.0 CO-CHAIRING ARRANGEMENTS

8.1 The existing co-Chairing arrangements have been a valued symbol of the Board as a partnership. However, it is not clear who the appropriate replacements for CCG Governing Body members will be, once the CCG ceases to exist, and in particular the Chair of the Governing Body in their role as co-Chair of the Board.

8.2 It is suggested that work should be undertaken, alongside that to identify appropriate future local NHS representation, to decide the most appropriate future chairing arrangements. The preference would be for maintenance of the co-Chairing arrangement; however this will depend on identifying an equivalent non-Executive role

from an NHS perspective. If this cannot be identified it is suggested that chairing of the Board will be the responsibility of one of the Elected Member representatives.

9.0 ROLE OF MEMBERS AND DEPUTIES

9.1 For these changes to work, it will require commitment from Board members to ensure all perspectives are part of all discussions. This means there will need to be an expectation that Board members prioritise formal committee meetings and conference events, with a nominated deputy to attend in their place if necessary.

9.2 In addition, it will be important for Board members to play a strong role in promoting the mini-conference events, identifying relevant people to attend and contribute, and taking action away for delivery.

9.3 It is critical to understand that if the Health & Wellbeing Board is to have an impact, it will be through and because of the actions, of individuals and organisations, that result from its discussions, and it is the responsibility of all to deliver on this.

10.0 QUESTIONS FOR THE BOARD

10.1 Do these proposals take into account the key considerations of Board members when thinking about the HWBB's future direction?

10.2 Do these proposals make sense in light of NHS and Council governance reforms, as well as wider contextual changes, e.g., 'living with Covid' plans, changes in Sheffield's partnership landscape?

10.3 Do the proposals give the urgency needed to ensure that the HWBB can have the most significant impact on health inequalities in Sheffield?

11.0 RECOMMENDATIONS

11.1 The Board are asked to:

a) Note and agree the framework for the future of the Board set out in this paper

b) Note and agree the framework for future membership, and agree to further work to identify appropriate NHS members, and members with a focus on children and young people

c) Agree to receive a final revised set of Terms of Reference for the Board at their June 2022 meeting based on these proposals, ahead of putting these to Full Council for approval and incorporation into the Constitution

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Health & Wellbeing Board: Review and refresh

Introduction & Summary

This paper sets out briefly developments in the context around the Health & Wellbeing Board, covering:

- the key aspects of upcoming changes to local NHS structures, as per legislation currently proceeding through parliament;
- changes to Sheffield City Council's governance arrangements, of which the Health & Wellbeing Board is a part; and
- work being undertaken by Sheffield City Partnership to develop a new City Strategy.

It then highlights implications for the Health & Wellbeing Board, poses some questions for the board to consider, and makes recommendations towards a review and refresh of the Board. Key implications for the Board are identified as:

- Potential for strengthened accountability and influence in relation to NHS services, but with the potential need to work across South Yorkshire as well as at place level to maximise these;
- The need to review membership with both NHS and Council reforms in mind, at a minimum;
- A revitalised SCPB providing a need to consider how the Board relates to other partnership structures to maximise impact; and
- All of the above providing an opportunity to carry out a stock take of the Board's work and consider whether changes need to be made.

It should be emphasised that this paper represents the start of a process that will take place over the next few months. It aims to prompt discussion and get Board members thinking about the issues involved in considering the Board's future direction. It is not expected that these questions will be resolved in one meeting, but instead will be addressed through a longer process.

Board members will also be invited to participate in 1-1 interviews to support a review of the Board as well look ahead to the NHS reforms, and this paper also seeks to provide context for those. It is anticipated that this will be complete to inform a refresh of the Board's Terms of Reference to be discussed at the March 2022 committee meeting.

Changes to NHS Structures

The Health and Care Bill currently working its way through parliament will put on a statutory footing arrangements that have been developing since the publication of the Five Year Forward View, known as Integrated Care Systems. The Board has been briefed on and discussed these developments previously, but for the purpose of this paper the following are the key elements of this reform:

- They are "geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services" (Kings Fund, 2021).
- They are part of an aim to shift the NHS way of working away from competition towards collaboration.
- They will see the creation of two new bodies:
    - An **Integrated Care Board**, responsible for producing a **five-year system plan** for health services, and allocating the NHS budget and commissioning services accordingly; they will take on the functions of Clinical Commissioning Groups and are expected to also take on some functions that NHSE currently perform. Its membership will be consist of non-executive directors and nominations from NHS trusts, local authorities and primary care, with an Independent Chair;
    - An **Integrated Care Partnership**, responsible for developing and leading an **Integrated Care Strategy** and planning to meet health, public health and social care needs. It will share some membership with the Integrated Care Board, and have representatives from local authorities, Healthwatch and other partners.
- The Integrated Care Strategy produced by the ICP must have regard to the Joint Strategic Needs Assessments produced in each area covered by the ICS.
- In turn, the five-year system plan produced by the ICB must have regards to the Integrated Care Strategy, and the Joint Health & Wellbeing Strategies produced by the Health & Wellbeing Boards in the area.
- To support this requirement, the legislation sets out that:
    - ICBs must consult with Health & Wellbeing Boards on whether the proposed plan takes proper account of local Joint Health & Wellbeing Strategies;
    - They must publish a statement of opinion on this from each Health & Wellbeing Board consulted, and their annual report must review the steps taken to implement Joint Health & Wellbeing Strategies;
    - NHSE must publish an annual performance assessment of how well each ICB is discharging its duties, consulting relevant Health & Wellbeing Boards in doing so.
- Four fundamental purposes have been set out for ICSs:
    - Improve population health and healthcare
    - Tackle unequal outcomes and access
    - Enhance productivity and value for money
    - Help the NHS to support broader social and economic development
- Place-level partnerships (such as the Sheffield ACP) remain important, and where much of the actual work of integration is expected to take place. Both national and local discussions have indicated that a strong emphasis will be placed on the principle of subsidiarity and the primacy of place based arrangements for the integration of care.

From the above, the following points are worth highlighting in particular:

- There is potential for a complex web of local and national accountabilities, with potential for conflict between the demands of both levels

- Local accountability is to all Health & Wellbeing Boards across the ICS area, not just Sheffield
- The legislation positions accountability to a degree coming through Health & Wellbeing Boards, but it is not clear how this relates to the local authority statutory requirements around Scrutiny
- There is a stronger requirement for the NHS to account to Health & Wellbeing Board than is currently the case
- For the first time the NHS will have population health, and expectations around contributing to local social and economic development, as outcomes to deliver against

Sheffield City Council Governance Changes

Following the result of the governance referendum in May this year, Sheffield City Council is in the process of shifting from a Leader and Cabinet model of governance (in which the Council's Leader is supported by a Cabinet of Executive Members with responsibility for decision making in specific portfolios, with the remaining elected members scrutinising and holding to account) to one focused on Committees (in which **all** elected members take part in decision making through thematic committees). This has three potential implications for the Health & Wellbeing Board: firstly, in its capacity as a committee of the Council; secondly, in terms of the Council's statutory responsibilities around scrutiny and how these interact with the Board's role in holding local NHS services to account; and thirdly, in terms of membership, with a different approach required for the places currently occupied by Executive Members.

The precise approach to this change is still being developed; however the Board will retain its existing responsibilities in relation to the JSNA, PNA, Joint Health & Wellbeing Strategy, and in relation to encouraging and integration of services, principally through the Better Care Fund. Discussions are underway as to how existing arrangements, including the Joint Commissioning Committee, are retained and built on in this area. It will be a decision for individual partners as to whether any decision-making responsibilities are delegated to the Board, though as things stand this is not anticipated. However, it is important that the Board remain sighted on developments in this space as the relationship with formal decision-making structures within the Council remains important.

Sheffield City Partnership Board and a new City Strategy

Over 2021, Sheffield City Partnership Board has focused its discussions on the recovery of the city from the impact of Covid-19. This work has developed into a plan to produce a new City Strategy, setting a clear vision and direction for Sheffield, shared across all partners in the city.

While this work is still forming, two key aspects seem likely to emerge with implications for the Health & Wellbeing Board and its work:

1. The development of a new City Strategy is intended to provide a single guiding view of the future of Sheffield that is shared across all partners and partnerships, and there may be a need to consider the Joint Health & Wellbeing Strategy in this context. Specifically a City Strategy with a strong focus on health & wellbeing would be welcome, but may also give cause to consider how a Joint Health & Wellbeing Strategy can add to and support this, rather than duplicate;
2. Supporting this, it is possible that a small number of priority areas to focus on will be identified, with appropriate structures required to develop plans and drive progress; were one of these areas to be the health & wellbeing of the population, it would be appropriate to consider what this Board's role in that regard should be.

Issues for the Board to consider

Reflecting on the above, this paper now sets out a number of issues the Board needs to consider, covering:

- The scope of the Board's work
- The functions it carries out
- The methods it uses to do this
- The membership of the Board and who participates in discussions
- The relationship it has with other bodies in Sheffield and beyond

In reading this paper, it should be borne in mind that these issues are interconnected, and identifying the right way forward for the Board involves a negotiation across all of them.

The scope of the Board's work

Since 2016, the Board has set its scope as "all the determinants of health", with NHS and social care services numbered among those. Through the nine ambitions set out in the Health & Wellbeing Strategy, it can be described as aiming to maximise the impact of all institutions in Sheffield on reducing health inequalities in the city. This has not always been straightforward, and conversations within the NHS and care system have generally been easier to engage in. This reflects the very different experience, knowledge and understanding that Board members bring to discussions: where the Board looks at (for example) housing and health, significant effort needs to be expended on established common ground and understanding before more practical work. The question of "how do we engage in this topic?" becomes a challenge in itself.

It is notable that the changes to the NHS described above come with a commitment to focus on population health as well as healthcare, and beyond this a commitment to contribute to social and economic development. Beyond this, the Covid-19 pandemic has also made clear the impact of socio-economic inequalities on health, and the consequential need to address them. With this in mind, it would not seem appropriate or timely to shift away from all determinants of health to focus purely on NHS and social care integration and delivery.

However, the Board may wish to reflect on where it can exert the most influence, especially in the context of a future with a comprehensive city strategy and potentially re-energised partnership framework in place. If the Board sees itself as having the job of maximising the impact of all institutions in Sheffield on reducing health inequalities in the city, what is the best way to approach this? Should the Board focus on ensuring local NHS and care services have the broadest possible impact on health & wellbeing, with a population health approach foremost in that, while playing a challenge role in other areas (such as transport), asking for demonstration of health considerations and impact? Or should it still seek to work more broadly? In addition, how does the Board ensure there is a clear link between the high level vision and strategy for Sheffield that the Board has set out, and operational delivery by partners?

The functions the Board carries out

Broadly the Board carries out its statutory functions (publishing the Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment, agreeing a Joint Health & Wellbeing Strategy for Sheffield, supporting integration of health and care services and overseeing the Better Care Fund) effectively. However in Sheffield (as in other places) the Board has attempted to go beyond this, to

act as a system leader in relation to health and wellbeing, to act as sponsor of the principle of health and wellbeing in all policies, and to challenge partners and support improvement in Sheffield around this.

The principle tools in this work are the Joint Health & Wellbeing Strategy and the Joint Strategic Needs Assessment. As Sheffield starts to emerge from the Covid-19 pandemic, it would be appropriate to consider whether these need to be updated to reflect the impact of that event, and any changes to priorities that result from that. It should be expected that the Joint Health & Wellbeing Strategy remains the Sheffield strategy for health improvement.

There is a challenge and support angle to the Board's work. Challenge: to institutions and organisations to set out how their plans, strategies or interventions act to improve health and wellbeing in Sheffield, even where this is not the primary aim (for example in relation to transport infrastructure); and support: to ask, where work to address health and wellbeing and inequalities is being developed or undertaken, how can partners round this table support and help deliver the biggest possible impact.

In addition, the changes to NHS arrangements indicate a potentially stronger accountability role for the Board in relation to NHS and social care services. How the Board carries out this function will also need to be considered alongside the above. In particular the Board could consider how to challenge the ICS to ensure delivery of NHS and social care services improves health and wellbeing through the approach to delivery, as well as the care itself. It could also build into this exploration of how other organisations or sectors could support the ICS in this work.

The methods the Board uses

The Board splits its time between formal Committee meetings, held quarterly and through which the statutory business of the Board is conducted, and informal Strategy Development sessions, in which more open discussions are held focusing on the challenges identified in the Heath & Wellbeing Strategy.

Following the publication of the current Joint Health & Wellbeing Strategy, the Board committed to using its Strategy Development sessions to convene broad conversations focusing on the ambitions in the Strategy, inviting appropriate people from outside the Board to contribute to understanding and working through the way forward for Sheffield.

In practice, there have not been as many of these types of discussion as intended, especially in terms of broadening participation beyond Board members. This is partly down to the impact of the pandemic on capacity to support the Board, and the impact of meeting remotely, but not wholly.

It is the case that broad workshop sessions such as those intended take time and effort to make work well, and the approach to date has focused on the limited amount of resource the Board has directly, and the goodwill and confidence in the value of the time on the part of participants.

These sorts of sessions are essential to taking a whole system approach to addressing some of the challenges and ambitions set out in the Strategy. If the Board are confident this is the right method to use, it is necessary to think through how they are resourced accordingly. This does not have to be about resources that the Board control directly; it should also involve an understanding that preparing high quality Board discussions is a priority for officers working within partner organisations. If this is the approach it will be essential for Board conversation to deliver value in return, in terms of supporting the development of responses to city challenges.

Critical to delivering value in this way will be a commitment on all sides to engaging in challenging discussions about where Sheffield needs to improve and what it can learn from elsewhere, as well as where we have good work to build on. An alternative approach could be to focus on the formal statutory committee business side of the Board's work, and explore other routes for the strategic, system-wide partnership development.

The membership of the Board and who participates in discussions

With the coming changes to NHS structures and Council governance, it will be necessary to review the Board's membership. While it is expected that CCG officers will transfer to the ICS in a lift-and-shift model, and that there might a reasonably straightforward approach to Elected Member representation, there are a number of other areas where thought must be given to future arrangements.

First among these is the current co-Chairing arrangement, whereby ownership of the Board is shared across the Council and CCG. Under the ICS, there will not be a direct equivalent in the governance structure of the Sheffield CCG Chair of the Governing Body; if the Board value the co-Chairing arrangement and the statement this makes about the Board as a joint venture, consideration will be to be given to how this should be addressed for the future.

This is also an opportunity to take stock of other aspects of the Board's membership. When the previous review of the Board was conducted in 2016, it was agreed to invite membership from NHS provider trusts, but to make these clinical and non-Executive voices, rather than executive leadership. It may be appropriate to revisit this view and consider whether this is still the right approach to take.

This opportunity to sense-check the membership of the Board extends to other areas too, such as housing voice, or engagement from the two Universities. It also provides a welcome opportunity to consider afresh what steps could be taken to ensure the Board represents the city of Sheffield in all aspects.

The relationship the Board has with other bodies in Sheffield and beyond

Recent developments point to the need to think clearly about how the Board relates to a range of other bodies in Sheffield, as follows:

- **Sheffield City Partnership Board**: as noted above, SCPB is in the process of developing a new City Strategy for Sheffield, and the approach to this may have implications for how the Board approaches its work. There will always be a role for HWBB to represent the case for addressing health inequalities to other forums (such as around economic development; transport; sustainability), but (for example) if a new City Strategy were to focus strongly on health and wellbeing or quality of life for residents of Sheffield it would be necessary to consider what this Board's role in that should be, how to avoid overlaps and use resources effectively, and how a refreshed Joint Health & Wellbeing Strategy should look in that context.
- **Other Health & Wellbeing Boards in South** Yorkshire: as discussed, there are strengthened lines of accountability for the NHS to Health & Wellbeing Boards set out in the draft legislation. However it must be remembered that this will operate across South Yorkshire, and there is a resulting need to coordinate across the four Health & Wellbeing Boards to maximise the ability to influence the ICS.

- **Scrutiny**: as noted, the Council's approach to its statutory Scrutiny role following the coming shift to a Committee model is not yet clear. The Board may need to consider its role in this place, and/or its relationship with joint health scrutiny functions at a South Yorkshire level.
- **Children's Health & Wellbeing Transformation Board**: the Health & Wellbeing Board is an all age Board, and there has been a long-standing uncertainty in the relationship between it and the Children's Health & Wellbeing Transformation Board. There may be an opportunity to resolve this question as part of this process; this may in turn raise further questions for membership of the Board.
- **The Sheffield Health and Care Partnership**: as the place-level partnership for health and care collaboration in the city.

Next Steps

This paper and the Board discussion resulting from it represent the first step in engaging Board members in an iterative process to review and refresh the Board ahead of the NHS and Council Governance reforms being implemented in March and May 2022 respectively. In addition to this session, we will also be engaging 1:1 with Board members to get their views in more depth over the coming month, as well as inviting ICS leaders to a Board meeting in the new year to discuss the future relationship in more depth. The intention is to bring a formal proposal for consideration to the Board's March 2022 public meeting.

Questions for the Board to consider

1. What are the key considerations that the Board would like taking into account as this work develops?
2. How do the Board want to address the changes made necessary by NHS and Council reforms?
3. What changes, if any, should we be considering to ensure the Board has an impact on health inequalities in Sheffield?

Recommendations

The Board are recommended to:

1. Confirm their commitment to addressing all determinants of health as the frame for future work
2. Commit to reviewing ways of working to ensure the Board is driving reductions in health inequalities in Sheffield and can engage effectively in new NHS and Council structures
3. Commit to a review of the Board's Terms of Reference, including membership, with a focus on addressing all determinants of health, and working well with and influencing the new ICS following its formal establishment, to be received at the Board's March 2022 meeting
4. Commit to a review of the Health & Wellbeing Strategy reflecting on the changed context set out above, to be received at the Board's March 2022 meeting
5. Agree to receive an update of the Joint Strategic Needs Assessment at a meeting later in 2022, and consider at this point whether to conduct a full refresh of the Joint Health & Wellbeing Strategy

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HWBB Review and Refresh – Discussion Paper

This paper summarises the key points from the Board's December 2021 meeting, and the series of 1:1 interviews conducted with Board members during December and January. It then draws from this:

- areas where the way forward seems clear for the Board to consider and respond to; and
- areas for further discussion, where a steer from the Board would be useful in drawing up firm proposals

The Board are asked to consider and discuss the questions posed as a result of these. The outcome of that discussion will inform the development of a formal proposal to be tabled at the Board's March public meeting.

Summary of Recommendations

Recommendations are made to the Board as follows, using the established categories of Scope and purpose, Functions, Methods, Membership, and Relationships with other bodies.

Scope & Purpose

1. The Board should develop a clear mission statement (with underpinning principles), rooted in the overarching aim of the Joint Health & Wellbeing Strategy, and that is collectively owned and understood by all Board members, and is regularly refreshed to ensure this remains the case

2. The Board should actively assess the impact it is having through an annual report reflecting on what has changed as a result of Board discussions

Functions

3. The Board agree that they have four functions to fulfil, covering:

    a. Statutory duties as laid out in legislation;
    b. System leadership around health & wellbeing, including driving progress on certain agendas;
    c. Providing support and challenge to policy and decision makers in areas that impact on health & wellbeing
    d. Representing Sheffield and its approach to improving health & wellbeing for Sheffielders to ICS decision makers; and

Methods

4. The Board set out an understanding of the types of discussion they expect to engage in, and task the Steering Group with explicitly considering this in drawing up the Board's Forward Plan.

5. The Board reflects on how best to use the time available across a given year, and in particular the appropriate balance between public formal committee meetings and more informal workshop development sessions.

6. The Board should dedicate one meeting per year to refreshing ownership of its mission, understanding the impact of its work over the previous year (and beyond), and agreeing the areas it will focus on over the coming year. This should link to the publication of the annual report proposed in Recommendation Two.

7. Board members commit to support those developing work on behalf of the Board to bring open, challenging discussions that aim to pinpoint:

    a. what the real world experience is for people in the area in question;
    b. what is good and can be built on;
    c. where challenges are that need addressing;
    d. what the evidence says about how to do this; and
    e. what we can learn from elsewhere.

8. The Board re-commits to delivering on the recommendations of the Engagement Working Group, including ensuring that engagement work conducted by all partners including Healthwatch and VCS organisations is fed into Board discussions, and to exploring how else the Board could connect with the communities and people of Sheffield.

Membership

9. The Board should consider whether there would be benefits it establishing a minimal, core membership based on statutory requirements to address statutory duties, with a broader and more flexible invite list for the other functions described in this paper.

10. The Board should adjust membership to include more places for organisations or constituencies with a focus on children and young people, including but not limited to:

    a. Education & Skills
    b. Early years
    c. Children's NHS and social care

11. The Board should engage with ICS leadership to discuss the most appropriate adjustments to membership to account for the shift in structures, governance and responsibilities in the NHS locally.

12. The Board should agree to reserve a place for each of the Chairs of the Sheffield City Council Adult Health & Social Care, and Education, Children & Families Committees.

13. The Board should agree to revisit chairing arrangements once arrangements with the ICS have been clarified.

14. The Board should change current membership arrangements as follows:

    a. The two places reserved for a clinical and non-executive voice from NHS Providers should be re-allocated to Chief Executives of NHS Providers
    b. The places for the Executive Member for Communities and Executive Director of Place should be removed, and the place for a social landlord should be reinstated.
    c. Arrangements for deputies should be clarified, with members expected to identify an appropriate individual from their organisation to attend on their behalf when they are unable to.

15. The Board should consider any other changes to the membership that might be beneficial.

16. In making the above changes, the Board should actively seek to broaden representation in its membership.

Relationships with other bodies

17. The Board actively engage in the development of the City Strategy, seeking to ensure that health & wellbeing is properly embedded in it, and that the Health & Wellbeing Strategy connects well and serves to support delivery.

18. The Board should engage with other partnerships to explore how to influence agendas being developed elsewhere, to ensure identification of potential win-win opportunities leading to maximum impact on health & wellbeing in Sheffield, and to reduce duplication.

19. The Board maintain an ongoing dialogue with the ICS to build an effective relationship for future delivery.

December Board Discussion – Key Points

The December 2021 Health & Wellbeing Board meeting was dedicated to reflecting on the changing context around the Board and its work, and considering the need to review and refresh the Board as a result. This section sets out the key points raised in that session, using the areas set out in the discussion paper for that meeting as a starting point:

- Scope and purpose
- Function
- Methods
- Membership
- Relationships

Full notes of the meeting and the breakout groups held within it are at Appendix A for reference.

Scope and purpose

- There was broad agreement that the Board should be focused on addressing health inequalities in Sheffield, looking beyond NHS and social care services to encompass all determinants of health and wellbeing.
- However, this was not matched by a sense that this is clearly set out and collectively owned by Board members.
- There was also a view that many of the discussions the Board has don't reflect that focus, with too much time spent on commissioning and not enough on outcomes.
- It was clear that the Board should have an all-age approach, as reflected in the Strategy, but concern that it can tend to focus on adults.
- Some Board members felt that the Board should have a role in engaging and communicating with Sheffield, especially in terms of positive changes.
- There was a strong view and broad agreement that the Board must be a body that has a meaningful impact on Sheffield, both in terms of being able to demonstrate positive change, and ensuring resources committed to the Board are valued.
- However there was not clear consensus on what impact means for the Board, and how it could or should be measured.

Functions

- There was agreement that the Board discharges its statutory duties in relation to the Joint Strategic Needs Assessment, Pharmaceutical Needs Assessment, Joint Health and Wellbeing Strategy, and encouraging integrated working, well.
- There was also agreement that the Board's functions are not restricted to these, and that it should also:
    - Provide space for systems leaders to get out of silos and bring things together
    - Be a strategic place for coordination, that has an overview of the system
    - Represent health and wellbeing priorities for Sheffield up to the ICS in the future, with a strong view on the importance of engagement and knowing the place

Methods

- There was agreement that the Board should be a place that engages in challenging conversations, as envisaged in the Joint Health & Wellbeing Strategy, but that so far this had not happened to the intended degree.

- It was also seen as important that the Board was able to invite people in to provide that challenge, including citizens and service users.
- The Board reflected on the distinction between their statutory duties and that work, and whether there could or should be a formal split between the two, allowing for a more flexible approach to non-statutory work. This could take the form of a minimal Board to meet statutory requirements for exercising duties, and a much larger group for engaging in strategy development.
- Relatedly, some Board members asked how it could be ensured that coproduction and codesign could be a feature of the Board's work, with the voices of residents influencing how things progress.
- In relation to the difference between statutory and non-statutory work, it was noted that the Board has a "budget" of time for a given year of 33 hours. 12 of these are spent on formal public committee meetings, and 21 on more informal strategy development: is this balance right?
- It was also asked how Board members could be more involved in shaping the Board and its work, ways of working, culture and behaviour, to create more buy-in.
- Linked to the discussion about impact, it was suggested that there should be a regular conversation about how Sheffield is doing in relation to the Board's priorities, to build accountability into the Board's work.

Membership

- There was broad agreement on the need for clarity on the precise role of Board members, and what they are expected to deliver. This touched on:
    - Whether they should bring expertise from a particular constituency, or whether they should bring some influence over their organisation, or other Boards they are a member of; and
    - Whether they should have an interest in health outcomes, or be able to have some influence over them.
- There was agreement that an all-age Board needs to have a membership that reflects this, and concern that the current membership does not do this.
- There was a view expressed that the Board is too dominated by Sheffield City Council and the Clinical Commissioning Group, and that there should be an aim to widen membership across the city and its organisations.
- There needs to be a strong position on deputies, ensuring that informed substitutes are available if someone is unable to attend.

Relationships with other bodies

- It was noted that Board members also attend other strategic partnerships, and that the health & wellbeing conversation should be represented in those spaces.
- There was a lack of clarity identified in how the various strategic partnerships in Sheffield fit and work together, and a desire for this to be set out.
- It was suggested that the Board doesn't have a strong enough link to groups that are tasked with driving progress, to ask what impact is being made.
- There was a suggestion that a stronger link to the Health & Wellbeing Outcomes Board could be useful in this, with potential for a formalised relationship.
- There was some agreement that the Board needs to establish a constructive relationship with ICS structures, potentially working with other South Yorkshire Health & Wellbeing Boards in doing this.

Feedback from Interviews

A series of 1:1 interviews were conducted with Board members during December 2021 and January 2022. This section sets out the key points that came out of these interviews, which expand on, differ from, or add emphasis to the comments outlined above.

A full write up of the interviews is at Appendix B for reference.

Purpose, role and impact

- Most HWBB members agreed that the Board is **not very clear on its overall remit or focus**, or at least, has lost its connection to purpose over the last couple of years.
- When asked what the HWBB's purpose and scope *should* be, there was however general consensus among Board members: the Board should be about **improving health and wellbeing for Sheffield's population as a whole**, focusing on 'all the determinants of health' and going beyond its statutory functions to leading and setting strategic direction for the city.
- One aspect which members keep coming back in the interviews was **impact**, with most agreeing that, as it stands, it is difficult to see what difference the Board is making.
- Opinions on **what success should look like** did, however, vary considerably between different members. Some thought that the Board needs to be better at setting, delivering and then reporting back on priorities. Meanwhile, others believed that the Board should focus more on using 'soft power' to seek assurance that things are happening, influencing and convening, and putting challenge into the system.

Function and ways of working

- Many Board members agreed that the way the meetings are organised at the moment - with the separate formal and informal strategy development sessions - are good in principle but **don't really seem to be working the way they have set out to do**.
- Reflecting on other partnerships they are involved in, members gave various suggestions for improvement, including the idea of having a few **delivery workstreams focusing on specific priorities** as well as exercises to encourage the Board to **think through issues through the lens of individuals** experiencing health inequalities.
- Members also spoke the HWBB's role in **influencing other areas that deliver on health outcomes,** and that there needs to be a way to build this into its workplan.
- Many HWBB members liked the idea of the meetings being oriented more closely on **particular themes.** This would allow the Board to bring in the right people to talk on that theme and members will be able to figure out what insights they should bring into the discussion.
- Importantly, Board members reflected not just on the format of HWBB meetings but also on the **content of the discussions**. The ability of the Board to constructively challenge, have honest and tough conversations, as well as draw out conclusions and follow through on these, were all emphasised as being important.

Membership, engagement and the role of Board members

- While some members emphasised the need to **widen membership of the HWBB**, particularly into underrepresented sectors, to allow for a greater diversity of views, others thought that this might mean the Board would become too unwieldly and less effective as a partnership.

- Generally, there was an agreement that issues with membership are difficult to solve **without the Board having a clearly articulated purpose and scope**, to help understand who the right members around the table are to meet this remit.
- A key part of the membership question was also **how the HWBB takes its discussions out into the communities of Sheffield**. Several members agreed that the Board isn't very good at capturing the views of citizens and using these to influence the direction it takes. The Board therefore needs to think about how to better engage with the public, perhaps using mechanisms like Citizen Panels and drawing on best practice from elsewhere.
- Finally, Board members reflected on **the role of HWBB members as "system leaders",** with many agreeing that members should act not just as representatives of their organisation, but as champions of health and wellbeing across the city who take ownership of issues, disseminate information, and catalyse action elsewhere.

Relationship to other structures in Sheffield and beyond

Board members spoke about the HWBB's relationship to other structures in three main ways:

1. **The relationship to new Integrated Care structures** – On the whole, Board members thought that this would provide a good opportunity for city leaders to take a collective understanding of Sheffield's health needs into South Yorkshire discussions and influence how money and activity comes into the city. This said, there was general agreement that the HWBB needs to strengthen its own position first in order to be able to take full advantage of this relationship.
2. **The connection to other health and care forums in the city -** Board members tended to agree that the Joint Commissioning Committee and the Health and Care Partnership both do different things to the HWBB, albeit with some overlap. Many also felt strongly about the HWBB being an "all ages" board, and subsequently the need to link up better (or merge) with the Children's Health and Wellbeing Transformation Board. However, the different roles that the two boards play was also noted, with the HWBB focussing more on high level strategy and the CHWBTB on service transformation. So, while many can see the case for a formal all age Board, there's also issue about where the transformation work that the CHWBTB does would sit (the obvious place would be the HCP, but it's not clear how that sits with issues that cut across into education).
3. Finally, several members spoke about **the HWBB being able to influence other spaces** that relate to the wider determinants of health and wellbeing such as transport, housing and green space, given its focus on broader health inequalities. There was a desire to better map and connect up these different spaces, perhaps using the Sheffield City Partnership Board as the main convening point, to generate a stronger understanding of how things relate together.

Ensuring the Board is effective and impactful: recommendations for next steps

Scope & Purpose

The scope and purpose of the Board, as set out in the JHWBS and its terms of reference, seem to be broadly in the right place – but we need collective knowledge and ownership that everyone is confident in. There needs to be a focus on 'health and wellbeing in all policies', as well as an 'all-age' approach to the Board's work, whereby it champions both children's and adults' health and wellbeing. We also need more established mechanisms through which to monitor and demonstrate the impact the Board is making. With this in mind it is recommended that:

1. **The Board should develop a clear mission statement (with underpinning principles) that is collectively owned and understood by all Board members, and is regularly refreshed to ensure this remains the case**

    - This should be rooted in the overarching aim of the Joint Health & Wellbeing Strategy to eliminate health inequalities in Sheffield, and should also emphasise impact.
    - The principles that sit underneath this could be centred around:
        - Having a diversity of voices,
        - Promoting all age approach,
        - Sponsoring a holistic view of health and wellbeing,
        - Having open and honest conversations,
        - System leadership.
    - This mission will need to be articulated to all new members who join the Board, by making sure there is **a proper induction process/resources for new members**
    - Work to refresh this vision/mission and members' ownership of it could be undertaken through **a dedicated annual Board session.** These could be done in a workshop approach to allow for ongoing relationship building.

2. **The Board should actively assess the impact it is having through an annual report reflecting on what has changed as a result of Board discussions**

    - This report could be discussed as part of the annual development session proposed above, and should explicitly ask: for the discussions the Board have had this year (or relevant period), what has happened as a consequence?
    - This would focus on the Board's conversations rather on the strategy, to keep the focus on what has changed as a result of the Board's work, and to avoid an exercise of just matching existing planned activity to the Strategy
    - This would be supported by ensuring actions and next steps are deliberately captured at the end of discussions, ensuring these are something tangible to reference in the meetings minutes. This would give the Board more of a grip on how actions will be followed through and by which member(s) or attendee(s).

Functions

The discussions set out above suggest four functions for the Board to fulfil:

1. Its statutory duties in relation to the JSNA, PNA, Joint Health & Wellbeing Strategy and encouraging integrated working;
2. System leadership in providing strategic direction around health & wellbeing, providing space for leaders to get out their silos and bring things together, and for some areas of work drive progress;

3. Articulating Sheffield's health and wellbeing needs and the strategy to address them at a regional level, representing Sheffield into the new ICS structures;
4. For areas of work that impact on health & wellbeing but where the Board does not have ownership, providing challenge and support to those that do to ensure health and wellbeing is present in all work.

Based on this it is recommended that:

3. The Board agree that they have four functions to fulfil, covering:

a. Statutory duties as laid out in legislation;
b. System leadership around health & wellbeing, including driving progress on certain agendas;
c. Representing Sheffield and its approach to improving health & wellbeing for Sheffielders to ICS decision makers; and
d. Providing support and challenge to policy and decision makers in areas that impact on health & wellbeing

Methods

The Board's methods must reflect all that set out above: a focus on health inequalities; a commitment to have an impact on Sheffield; and the four functions set out. As acknowledged above, it is apparent that the Board cannot do everything set out in the JHWBS, as some of this is the responsibility of other places or organisations. But it does need to work better with other areas to help deliver better health outcomes for the city.

With that in mind, the following is an attempt to describe the types of work the Board may want to engage in:

1. Business meetings, focused on delivering statutory duties and providing accountability
2. Focused workshops with broad attendance on the issues the Board can and wants to grip and drive progress
3. Joint sessions with other groups/boards to understand and influence agendas that are owned elsewhere
4. Reflection, development and understanding impact
5. Shorter introductory discussions to understand a policy area and identify potential for further work

As noted above, it may be appropriate for the Board to consider how the nominal 33 hours of time available across a given year is allocated against each of these activities.

Examples from other HWBBs (see e.g., this document from Hull) suggest that a themed workplan with space for the various functions that the Board wants to fulfil can help to structure the Board's work in a more effective way.

In addition, to have impact on health & wellbeing in Sheffield it is essential for the Board to engage in conversations that are genuinely open, honest, and challenging, and focused on identifying:

- what is good and can be built on;
- where challenges are that need addressing;
- what the evidence says about how to do this; and
- what we can learn from elsewhere.

This should be reinforced and Board members should commit to supporting this approach. This could be supplemented by:

1. Exploring ways to become more person-centred (looking at things through the lens of an individual experiencing health inequalities);
2. "Making things real" to people by holding more open, engagement sessions; or
3. Ensuring lived experience is an essential feature of Board discussions.

Impact could also be driven by engaging more actively in planning on an annual basis, making commitments for the year ahead and linking these to the annual report and refresh of the Board's mission discussed under Scope and purpose.

The resources available to the Board, both in terms of scheduled meeting time and people to do the necessary preparation, are critical in this. Organisations will need to be willing to support relevant staff to engage in preparing items for the Board if discussions are to be fruitful.

In addition, the Board's function of representing Sheffield into the ICS means that it is essential the Board is well engaged with and understands the Sheffield public. The Board agreed in October 2021 to support a new role to coordinate engagement across health & wellbeing in Sheffield, and to continue funding Healthwatch to conduct engagement in relation to the Health & Wellbeing Strategy. Beyond this there was a strong feeling in the interviews that how the HWBB relates to members of the public is something that needs to be fundamental to what the Board does. To aid with this it was suggested that the Board could:

- Ensure in person meetings are conducted in different settings, including in communities;
- Establish engagement/open door sessions with the public

With each of these, however, the Board will need to think about whether anything needs to change to make discussions more accessible to the public.

Based on this it is recommended that:

4. **The Board set out an understanding of the types of discussion they expect to engage in, and task the Steering Group with explicitly considering this in drawing up the Board's Forward Plan.**

5. **The Board reflects on how best to use the time available across a given year, and in particular the appropriate balance between public formal committee meetings and more informal workshop development sessions.**

6. **The Board should dedicate one meeting per year to refreshing ownership of its mission, understanding the impact of its work over the previous year (and beyond), and agreeing the areas it will focus on over the coming year. This should link to the publication of the annual report proposed in Recommendation Two.**

7. **Board members commit to support those developing work on behalf of the Board to bring open, challenging discussions that aim to pinpoint:**

    a. **what the real world experience is for people in the area in question;**
    b. **what is good and can be built on;**
    c. **where challenges are that need addressing;**
    d. **what the evidence says about how to do this; and**
    e. **what we can learn from elsewhere.**

8. **The Board re-commits to delivering on the recommendations of the Engagement Working Group, including ensuring that engagement work conducted by all partners including Healthwatch and VCS organisations is fed into Board discussions, and to exploring how else the Board could connect with the communities and people of Sheffield.**

Membership

There were several key issues that need to be addressed in terms of the Board's membership. With each of these, it is important to bear in mind that the Board is at 22 members currently and it may not be advisable to exceed this in the new arrangements. One option discussed frequently in the interviews and in December's HWBB meeting was to strip core membership of the Board down to statutory members and then invite non-statutory members into discussions when relevant to them. This would allow for a greater diversity, whilst still maintaining the stability required for an effective partnership. It would also facilitate an approach that explicitly drew a distinction between the statutory and non-statutory activities of the Board.

Beyond this, there were three key issues identified in relation to the Board's membership through the December meeting and interviews:

1. An "all age" board needs an "all age" membership

    - We need to think about what we need to do to adjust membership of the HWBB to make it properly all age.
    - This will mean inviting others in from constituencies that are not fully represented at the moment, such as:
        - Education & Skills
        - Early years
        - Children's NHS and social care
    - The relationship between the HWBB and Children's Health & Wellbeing Transformation Board is relevant to this question. However it must be noted that there is a difference in role between the CHWBTB and the HWBB: the CHWBTB is more focused on service transformation work, and this work would still need a home.

2. NHS and Council governance changes

    - The existing co-Chairing arrangements, and link to the CCG Governing Body as well as Council governance structures, has been a valued symbol of the Board as a partnership. However, it is not clear how this should continue when the CCG ceases to exist. It is expected that CCG officers will transfer to the ICS in a lift-and-shift model; however it is not clear who the appropriate replacements for CCG Governing Body members, and in particular the Chair of the Governing Body in their role as co-Chair of the Board, would be.
    - In terms of SCC Elected Member representation, it is suggested that the Chair of the Adult Health and Social Committee in the new SCC governance structure, and the Chair of the Education, Children & Families committee, should be members of the Board, maintaining SCC Elected Member presence on the Board.
    - However there may be a need to reflect further on chairing arrangements, considering both the symbol of partnership, and the commitment to an all-age approach.

3. What sort of voice do we need?

- A number of members have suggested that to better reflect its role as a city partnership, as well as a committee of the Council, membership of the Board should be rebalanced away from SCC members and officers and current NHS CCG voices.
- Beyond this, questions have also been raised about some existing membership arrangements; for example:
    - Has the approach taken to NHS Provider representation (focusing on clinical and non-exec voices) been the right one? Should membership be focused on individuals who are able to speak on behalf of and effect change in their organisation (i.e. executive voices)?
    - Has the current approach to Board deputies, of locating within professional constituencies rather than organisations, worked?
    - Has the university membership provided the expected benefits, in terms of connecting the Board to current research? If not, should this be reconsidered, either in terms of identifying a different member, or using this as an opportunity to diversify representation elsewhere?
    - It is not clear that the elected member with responsibility for communities and Executive Director for Place have resulted in a strong input around housing issues as intended, the returning to the approach proposed in 2017 of offering a place to a social landlord would serve to reduce SCC membership, maintain housing voice at the Board, and diversify the voices round the table.
    - The Board needs to consider how to ensure the voices involved in Board discussions are representative of the city as a whole. There may be opportunities to work with Local Area Committees in pursuit of this.

With that in mind, it is recommended that:

9. **The Board should consider whether there would be benefits it establishing a minimal, core membership based on statutory requirements to address statutory duties, with a broader and more flexible invite list for the other functions described in this paper.**

10. **The Board should adjust membership to include more places for organisations or constituencies with a focus on children and young people, including but not limited to:**

    a. **Education & Skills**
    b. **Early years**
    c. **Children's NHS and social care**

11. **The Board should engage with ICS leadership to discuss the most appropriate adjustments to membership to account for the shift in structures, governance and responsibilities in the NHS locally.**

12. **The Board should agree to reserve a place for each of the Chairs of the Sheffield City Council Adult Health & Social Care, and Education, Children & Families Committees.**

13. **The Board should agree to revisit chairing arrangements once arrangements with the ICS have been clarified.**

14. **The Board should change current membership arrangements as follows:**

    a. **The two places reserved for a clinical and non-executive voice from NHS Providers should be re-allocated to Chief Executives of NHS Providers**

b. **The places for the Executive Member for Communities and Executive Director of Place should be removed, and the place for a social landlord should be reinstated.**
c. **Arrangements for deputies should be clarified, with members expected to identify an appropriate individual from their organisation to attend on their behalf when they are unable to.**

15. **The Board should consider any other changes to the membership that might be beneficial.**

16. **In making the above changes, the Board should actively seek to broaden representation in its membership.**

Relationships with other bodies

There are two key aspects for consideration here:

- **SCPB and other strategic partnerships**: As acknowledged, SCPB is currently doing some work with partners to develop a City Vision and a set of city missions to help guide the work of the city and map out what fits where. The suggestion would be for the HWBB make best use of this work, starting with the discussion at February's HWBB which will give the Board an opportunity to influence what goes into the City Vision from a health and wellbeing perspective. Following this, it'll probably be appropriate to have regular 'check ins' with the City Strategy as it develops and starts to come into fruition.

  This links to explicit joint conversations/work with other bodies the Board wants to have, to be able to influence activity happening elsewhere that could impact health and wellbeing. As well as making sure for there is space for this in the workplan (as mentioned in the '*Methods'* section above), the Board needs to make better use of overlapping membership where people attend two or more different boards and could act as conduits between them. This could perhaps be formalised through a 'feedback from other partnerships' or 'emerging work from elsewhere' item on the agenda, linked to AOB.

- **ICS**: As the new IC arrangements are developed and beyond this, the Board is likely to want some dedicated time on the workplan to generate a collective understanding of what Sheffield's HWBB wants to feed up to the ICS. We do, however, need to be careful that this doesn't become too NHS & care focussed or too operational, but instead focusses on really understanding what Sheffield health and wellbeing needs are and where we want to put in challenge to the wider system.

Based on the above, it is recommended that:

17. **The Board actively engage in the development of the City Strategy, seeking to ensure that health & wellbeing is properly embedded in it, and that the Health & Wellbeing Strategy connects well and serves to support delivery.**

18. **The Board engage with other partnerships to explore how to influence agendas being developed elsewhere, to ensure identification of potential win-win opportunities leading to maximum impact on health & wellbeing in Sheffield, and to reduce duplication.**

19. **The Board maintain an ongoing dialogue with the ICS to build an effective relationship for future delivery.**

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 28th October 2021

PRESENT: Terry Hudsen (GP Governing Body Chair, Sheffield CCG) (Chair)
Councillor George Lindars-Hammond (SCC) (Co-Chair)
John Macilwraith (SCC)
Simon Verrall (South Yorkshire Police)
Chris Newman (University of Sheffield)
Helen Steers (VAS)
Judy Robinson (Sheffield Health Watch)
Sandie Buchanan (Director of Commissioning Development)
Cllr Alison Teale (SCC)
Chris Gibbons, Public Health Principal, SCC (deputising for Greg Fell)
Dan Spicer (SCC)
John Macilwraith (SCC)
Fiona Martinez (SCC)

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Alexis Chappell (SCC), Dr David Hughes (Sheffield Teaching Hospitals NHS Foundation Trust), Greg Fell (Director of Public Health), David Warwicker (Clinical Commissioning Group), Zac McMurray (Sheffield CCG), Councillor Jayne Dunn (Sheffield City Council), Mark Tuckett (AVP), Jane Ginniver (AVP), Kate Josephs (Sheffield City Council), James Henderson (Sheffield City Council), Mick Crofts (Sheffield City Council) and Dr Mike Hunter (South Yorkshire NHS).

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest made.

3. PUBLIC QUESTIONS

3.1 No public questions were received.

4. COVID-19 UPDATE

4.1 Chris Gibbons was in attendance to provide an update on COVID-19. Chris talked attendees through a number of slides outlining the current COVID-19 position in Sheffield. He stated that Sheffield's infection rate was lower than a number of cities within South Yorkshire. Chris stated that there had been some increases in younger people, between the ages of 19 and 24, and for those living in Care Homes. Chris said that the removal of restrictions on gathering and working from home had influenced the increase.

4.2 Chris stated that hospital admissions were rising. He stated that flu cases and other respiratory illnesses were also factors in the rise in hospital admissions.

Chris said that hospital numbers would continue to increase and stated that a further COVID-19 peak was due to occur.

4.3 Chris shared some information on vaccination and immunity in Sheffield. He stated that vaccination rates were decreasing but added that this was to be expected. He said that it was essential that people had their vaccinations and booster jabs, where required.

4.4 Helen Steers asked what the correlation was between those who have been vaccinated and hospitalisation. Chris stated that hospitalisations were most likely for those who had not been vaccinated or those who were immunocompromised. Helen suggested that this information be more widely publicised.

4.5 Terry Hudsen asked the board to consider how they might use this information to inform the public and partner organisations.

4.6 Councillor George Lindars-Hammond referred to the role of inequality on the vaccination programme. Councillor Lindars-Hammond asked whether there had been a clear difference in terms of infections and hospitalisations in areas of Sheffield where health inequalities were at their greatest, in comparison to more prosperous areas of Sheffield. Chris responded and stated that there was a sense that understanding the prevalence of COVID depended on testing which was occurring at varying rates across the city. In terms of the hospital admissions, Chris stated that there was not a breakdown based on socioeconomic background available; however, he said

4.7 Judy Robinson asked how the COVID-19 review plan was being used during this phase of the pandemic.

5. ICS AND HEALTH AND WELLBEING – UPDATE AND ROLE OF THE BOARD

5.1 Chris and Sandy were in attendance to update the board on the relationship between Integrated Care Systems and the Health and Wellbeing Board. Chris stated he was aware that there had been a significant number of apologies and he said that he wanted to have input from all members of the board. He added that the supplied report was to provide Board Members with an understanding of the new Integrated Care Board and Partnership.

5.2 Chris stated that there was some ongoing work on the Health and Wellbeing Board Terms of Reference, including some one-to-one meetings with Health and Wellbeing Board members.

5.3 Chris shared some information on themes provided by the Director of Public Health, Greg Fell. These themes included resourcing, the board's intentions on joint commissioning, existing assets available and community capacity.

5.4 Sandy said that the Joint Commissioning Committee could assist in improving the relationship between Integrated Care Systems and the Health and Wellbeing Board.

5.5 Chris stated that the key question was 'How (practically) is our Sheffield Health and Wellbeing Board going to influence the work of the new Integrated Care Board and Partnership?'

5.6 Terry stated that there are three acronyms being used: the 'Integrated Care Systems' (ICS) which would be made up of two components, a Statutory Commissioning Board and the Integrated Health and Care Partnership (ICP). Terry stated that the partnership should inform other Health and Wellbeing Boards in the surrounding areas, for example Rotherham's Health and Wellbeing Board.

5.7 Helen stated she felt there would need to be a number of connections between boards and organisations. Terry stated that this issue would form part of the constitution for the consultation.

5.8 John Macilwraith stated that he felt this was an opportunity which the board should seize. He stated that the Council HAD a Health and Wellbeing Strategy which highlights the role of health inequality. John asked how different departments within the Council could address these issues.

5.9 George Lindars-Hammond said that he was interested in looking at the Integrated Care Partnership as he felt it was the least developed element. He stated he was optimistic, but that he had some queries around how the partnership would work with the Health and Wellbeing Board and Sheffield's other organisations. George asked how funding could be used to address some significant health inequalities. George said he felt this would be a significant challenge for the board without duplicating work and whilst keeping one another informed of work carried out.

5.10 Terry stated that he felt it was important to recognise that the legislation did not change the statutory nature of the Health and Wellbeing Boards. He noted it was important to ensure that the Health and Wellbeing Boards and the partnerships complement one another and added that the Strategic Needs Assessment would assist with this. Terry stated that when the Board thought about different determinants of poor health and poor wellbeing, there could be similarities across South Yorkshire alongside differences. He asked that the board consider which strategies would work for the system as whole, and which strategies should alter dependent on the City.

5.12 Julie asked what the hierarchy of boards would be, and asked whether there would be clarification on the seniority of these boards. Julie stated that Healthwatch believed that the further away decision making was from the people it affected, the less influence those people would have on these decisions. Julie asked that engagement be considered and embedded in the structure of these organisations. Chris stated that there would be further discussions on this.

5.13 Sandy said that given the transition of the CCGs going into the ICB next year it would be a focus to increase engagement.

5.14 **AGREED:** Councillor George Lindars-Hammond suggested that the board agree to convene a meeting between Health and Wellbeing Board Chairs within South

Yorkshire before returning to the board with some information on similarities and/or differences between the work of the boards. Chris and Sandy agreed this would be an appropriate move forward. It was stated that the designated Chair for the Integrated Care Board would be joining the meeting in January.

5.15 Chris stated that much of the work carried out during the pandemic had improved regional collaboration work.

6. BETTER CARE FUND

6.1 Jennie Milner was in attendance to present a report put together by Sheffield City Council in conjunction with Clinical Commissioning Groups (CCGs).

6.2 Jennie gave an overview of the reports aims.

6.3 Jennie outlined the Ambulatory Care Sensitive Conditions which were being considered. She said that the expectation was that 1,200 of these cases would have been presented last year; however, she said there were fewer admissions last year due to COVID-19 and people staying at home rather than going into hospital with these conditions.

6.4 Andrew stated that last year it was decided that 14 days and 21 days were the metrics to follow when examining longer-term hospital patients. Andrew outlined the number of patients in hospital from March 2021 to October 2021 and stated his belief that unless individuals were very unwell, they should not be in hospital.

6.7 Andrew outlined some of the reasons it was felt that patients could be in hospital for a longer length of time, including patients waiting for intervention, patients who did not have an agreed care plan and patients who were not well enough to go home. Andrew stated that partners met daily and escalated things twice a week, with the intention of reducing the number of inpatients. Andrew stated they were intending to put together a more targeted support team.

6.8 Andrew stated that the System Partnership approach to COVID-19 had been helpful in supporting the health of Sheffield citizens. He shared information with attendees around how System Partners could assist with reducing the number of inpatients.

6.9 Jennie asked Board Members whether they understood the planning guidance requirements and new metrics included within the Better Care Fund, and she asked that the Joint Commissioning Committee continue to monitor progress on behalf of Health and Wellbeing Board. She also asked whether the Board was happy to delegate approval of the narrative plan and submission to the Co-Chairs.

6.10 Terry reminded attendees that the Council was nine months past the beginning of the financial year.

6.11 Terry asked Jennie and Andrew whether they felt that the historical nature of the

metrics provided would pose any challenges with the BCF.

6.12 Jennie stated that she felt the biggest challenge would be the length of stay one. She added that they had been asked to use the figures from the previous year and said if that had been done the figures would be significantly different. She said she had consulted with the region and asked whether the current position could be used as a starting point.

6.13 Andrew stated that they were previously asked to reach pre-COVID-19 levels, which he had felt was a challenging target.

6.14 George Lindars-Hammond stated that he felt the Board should thank everyone involved in carrying out the work being carried out in this area. He said that he felt there had not been enough support available at a national level to enable a long-term vision which helped to avoid crises.

6.15 Chris noted that there appeared to be many references to singular conditions. He said that a number of people in this situation would have multiple conditions and asked how this information was being gathered and used to inform the plan. Andrew stated that the work carried out aimed to consider how care could be optimised for those with chronic conditions.

6.16 Jennie stated that the Key Performance Indicators considered were the main focuses.

6.17 **AGREED:** In response to the two questions asked, Board Members agreed they understood the guidance requirements. They stated that Health and Wellbeing Board would delegate the signoff of the plan to Co-Chairs Terry Hudsen and Councillor George Lindars-Hammond.

7. HEALTH AND WELLBEING BOARD AND ENGAGEMENT

7.1 Rosie May was in attendance and outlined the work of the Engagement Group to date. She stated that the group needed to put together a strategy and engagement plan for the coming 3 years. Rosie stated that there were not at that time enough resources to carry out the required work. She added that there was a good report provided by SHAH but she said that it indicated information was not shared between partners.

7.2 Rosie stated that they had commissioned Healthwatch to assist; however, she stated there had only been a limited budget for this. She recommended that this figure by doubled from £10,000 per annum to £20,000 per annum.

7.3 Rosie asked that the Engagement Working Group continue to work as a steering group going forward.

7.4 Helen clarified that Healthwatch works with individuals rather than the VCS.

7.5 George thanked those who were involved in this work and report. He stated that he felt it was important that what the Engagement Working Group had requested was met.

He said that the Board did not then have allocated funds, and asked that the full partnership of the Board could work together to try to get this funding. He stated that he felt it was important that there be a clear idea of how to work with existing partners and bring in additional staff.

7.6 Judy stated she agreed with George, and added that she felt it was important to connect Together the work already being carried out.

7.7 Terry stated that he felt there it was important that there be a co-ordinated response. He suggested that the phrase be 'the Engagement Working Group begins to define…' be used.

7.8 Terry noted that financial decisions could not be made here, but added that the Board would support these suggestions.

7.9 George suggested that wording along the lines of 'the Board agrees an ambition' be added.

7.10 Rosie stated that improving the sharing of information would be less costly longer term.

7.11 **AGREED:** The Engagement Working Group's requests were agreed upon.

8. HEALTHWATCH UPDATE

8.1 Judy provided an update on Healthwatch's recent themes. She stated that feedback had not all been negative, but said that she was sharing negative feedback to highlight what they felt needed be improved. She said that access continued to be an issue for those with disabilities. Judy stated that mental health resources were limited, and only provided for a short period time. She said that a number of people had said they found it challenging to log a complaint. Judy stated she had met with the Dental Commissioner as this was a national issue whereby many individuals were not able to access NHS dental healthcare but were unable to pay for private appointments. Judy said that small changes could make a significant difference to people with access issues. She added that Healthwatch felt these changes should address inequality wherever possible.

8.2 Councillor George Lindars-Hammond asked how Healthwatch felt they might need to change in order to improve the quality of their work as the system changed, and how the system might support that change. Judy stated that Healthwatch were trying to work with their colleagues Nationally. Judy added that she felt that the more the board engaged with local people on these issues the more successful Healthwatch's work would be.

8.3 John Macilwraith asked how the board could support the voice of the service user. Judy stated that Healthwatch found it difficult to link the voices of service users to decisions being made. She said that reports could be completed, alongside recorded lived experiences; however, linking these voices and stories to decisions were challenges.

8.4 Terry Hudsen asked how the board might also incorporate the voices of those who do not get access to services which they might require. Helen stated that COVID-19 had increased waiting lists for mental health services. She stated that she felt the board should use the intelligence provided by Judy to consider how those requiring the services can be supported.

8.5 Simon stated that many people seen by South Yorkshire Police do not know how to access these resources. He stated that as many elements of face-to-face support, for example, a GP appointment, had now been reduced. He suggested that these support markers and resources needed to be better shared with those who require the support the most.

8.6 Terry Hudsen informed attendees that Healthwatch had shared some Speak Up reports which did focus on the experiences of people with learning disabilities, autism and mental health. He recommended that attendees review these.

9. MINUTES OF THE PREVIOUS MEETING

9.1 **AGREED** that the minutes of the meeting held on the 25th of March 2021 to be approved as a correct record.

10. DATE AND TIME OF NEXT MEETING

10.1 The next meeting of Sheffield Health and Wellbeing Board would be held on Thursday 9th December 2021 at 2.00pm.

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