Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 26 June 2014 at 2.00 pm

The Circle, 33 Rockingham Lane, Sheffield S1 4FW

The Press and Public are Welcome to Attend

Membership

Councillor Julie Dore	Leader of the Council
Dr Tim Moorhead	Chair of the Clinical Commissioning Group
Dr Amir Afzal	Governing Body Member, Clinical Commissioning Group
Ian Atkinson	Accountable Officer, Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children, Young People and Families
Professor Pam Enderby	Chair, Healthwatch Sheffield
Councillor Mazher Iqbal	Cabinet Member for Communities and Public Health
Margaret Kitching	Director of Quality & Nursing NHS England South Yorkshire and Bassetlaw
Councillor Mary Lea	Cabinet Member for Health Care and Independent Living
Jayne Ludlam	Executive Director, Children, Young People & Families
Laraine Manley	Executive Director, Communities
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
John Mothersole	Chief Executive, Sheffield City Council
Dr Ted Turner	Governing Body Member, Clinical Commissioning Group
Dr Jeremy Wight	Director of Public Health

Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

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

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

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. www.sheffield.gov.uk/healthwellbeingboard

PUBLIC ACCESS TO THE MEETING

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

Meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last.

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

FACILITIES

There are public toilets available, with wheelchair access and induction loop facilities are available.

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

26 JUNE 2014

Order of Business

1. Apologies for Absence

2. Declarations of Interest (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting.

3. Public Questions
To receive any questions from members of the public.

4. Integration of Health and Social Care and the Better Care Fund
To receive a presentation.

5. The Care Act 2014
To receive a presentation.

6. The Children and Families Act 2014
To receive a presentation.

7. Health Inequalities Plan (Pages 5 - 50)
Joint report of the Leader of Sheffield City Council, the Chair of NHS Sheffield Clinical Commissioning Group and the Director of Public Health.

8. Healthwatch Sheffield Annual Report
To receive a presentation from Healthwatch Sheffield.

9. Minutes of the Previous Meeting (Pages 51 - 64)
To approve the minutes of the meeting of the Board held on 27 March 2014.

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 25 September 2014 at 2.00 pm at a venue to be confirmed.

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Interim Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Councillor Julie Dore Leader of Sheffield City Council Dr Tim Moorhead Chair of NHS Sheffield Clinical Commissioning Group Dr Jeremy Wight, Director of Public Health
Date:	26 June 2014
Subject:	Health Inequalities Plan
Author of Report:	Jeremy Wight (0114 205 7462)

Summary:

Reducing health inequalities is a key priority for the Health and Wellbeing Board and is one of the identified outcomes in the Health and Wellbeing Strategy. Health inequalities are significant and persistent and are rooted in the unequal nature of society. The Fairness Commission considered health inequalities in detail and made a number of recommendations as to how they could be addressed. The Health and Wellbeing Strategy identified a number of actions aimed at reducing health inequalities in the City.

A draft Health Inequalities Action Plan, designed to implement the actions identified in the Health and Wellbeing Strategy, was discussed at a Strategy meeting of the Health and Wellbeing Board and at a well-attended engagement event in May.

As a result of those discussions, a number of changes have been made to the plan, including identifying the different impacts that different actions are likely to have and the timescales. In addition a further action, not in the original Health and Wellbeing Strategy, has been added, which is to increase health literacy and early engagement with health services in disadvantaged communities. This is added as action 3.10

Questions for the Health and Wellbeing Board:

- Is the Board content with the identification of leads and reporting mechanisms with regard to the actions identified in the Strategy and included in the plan?
- Is the Board content with the identified priority tasks?
- Is the Board content with the measures of impact?
- Does the Board agree to the addition of proposed action 3.10 to the Health and Wellbeing Strategy and to the plan?

Recommendations:

- That the Board should formally approve the plan, whilst accepting that further work is required on the detail.
- That the Board should request the identified lead individuals and relevant Groups / Boards to implement the plan.
- That the Board should request an annual report on progress.

Background papers:

- Appendix A – Tackling Health Inequalities Event Summary

Health Inequalities Plan:

Introduction

Inequalities in health in Sheffield have been well documented for over a century. They are significant and persistent, in spite of much good work that has been done to address them. Their nature and extent are documented in the Joint Strategic Needs Assessment and elsewhere. The roots of health inequalities lie in the unequal nature of society, and they will persist as long as society remains unequal. But this does not mean that we cannot do anything about them. The work of the Health Inequalities National Support Team, and the Marmot review, as well as recent King's Fund and British Academy reports provide extensive guidance for us to use locally.

Here in Sheffield, the Fairness Commission considered health inequalities in detail, and made a number of general recommendations as well as more specific ones relating to inequalities in the health system, mental health and wellbeing, and carers. The Joint Strategic Needs Assessment, as well as describing the health inequalities of the City, also made a number of recommendations.

The Health and Wellbeing Board has identified addressing health inequalities as one of its priorities (the other being the integration of health and social care). This is because not only are health inequalities unfair in themselves, but also because we will <u>all</u> benefit from a coherent and effective programme of work to address them. This is partly because any one of us may benefit directly from actions taken, even if they are undertaken specifically to address inequalities, and partly because reducing inequality is good for all of us.

Any of us can benefit from action to address health inequalities because although most diseases are more common in more disadvantaged communities, there are practically none that are exclusive to them. This means that systematic programmes to promote early diagnosis and effective treatment will have benefits across the whole City, even if a major part of the rationale is to address health inequalities. But perhaps less well recognised is the fact that the whole City will benefit if we improve the health of disadvantaged groups and so reduce health inequalities. This is because the whole City will benefit economically from a healthier workforce, (the Marmot report estimates health inequalities cost society £60Bn per year, nationally), because improving the health of disadvantaged groups should reduce the burden on the health and social care system overall, and because, as the work of *Wilkinson and Pickett* has shown, more equal societies are of benefit to everyone in those societies, not just the most disadvantaged.

The Board has approved a Health and Wellbeing Strategy, based on the JSNA, that identifies five outcomes which describe what it wishes to achieve for the people of Sheffield. One of these is that *health inequalities are reducing*, and nine actions are identified in support of that. However there are also actions in support of another outcome, *health and wellbeing is improving*, which will, when implemented, have also a significant impact on health inequalities. This is because any action that improves health for a section of the population that is in worse health than the rest, will in so doing reduce inequalities. Five (of the eight) specific actions identified in the Strategy in support of this outcome are included in this Action Plan, because they will have a particular impact on addressing health inequalities, if implemented effectively.

An earlier version of this plan was discussed at an engagement event, attended by over 80 members of the public and representatives from partner and stakeholder organisations, on 29th May 2014. Following that, a number of changes have been made to the plan, in particular a strengthening of emphasis on increasing health literacy, and appropriate demand for health services, in more disadvantaged communities.

This is not another strategy, but an *Action Plan*. It picks up the actions identified in the Health and Wellbeing Strategy, expands on them where necessary, identifies who should be responsible for their implementation, over what timescale and where in the governance structures of the Council and CCG these actions should be reported to. Ultimately, the Health and Wellbeing Board has final responsibility, and it is recommended that an annual report should be taken to the Board on progress overall, and discussed.

The Health and Wellbeing Board has also agreed an *Outcomes Framework* to be used to monitor implementation of the Strategy. That can also be used to monitor progress in addressing health inequalities, but some additional measures are needed to monitor the implementation of this plan.

Impact and timescales

Health inequalities are multifaceted, and can be described and measured in countless different ways. There are many different ways to divide up society into different groups whose health can be compared. We tend to use divisions based on where people live, partly because many of the root causes of health and hence health inequality are strongly linked to that, but also because almost all health data comes with a postcode attached, which makes analysis more straightforward. But there are other ways to divide society, such as by ethnicity, or by identifying specific 'communities of identity'.

Equally, there are many different aspects of health that can be measured. We place a lot of emphasis on life expectancy, partly because it has resonance with the population in general, but also because it can be calculated reasonably straightforwardly from death certification data. But it is only one measure, and some would argue a rather limited one, of the health of a population. Inequalities in mental health, for example, are little reflected in differences in life expectancy between geographically defined communities.

As a result, it is difficult to say categorically which actions will have the biggest impact on health inequalities: it all depends on what aspect of health inequalities one is considering, and for which groups in the population.

Having said that, it is clear that those actions that will have a big impact are those that relate to a cause of ill health that is amenable to intervention, where that cause is common (i.e. relatively large numbers are affected), where it is unevenly distributed across society, and where the adverse health consequences are severe. Smoking is one such cause, for example, so that the abolition of smoking within society would have an enormous impact on health inequalities. The plan does categorise actions according to whether the impact will be low (relatively small gain in health and reduction in inequalities, affecting few people), medium or high (large health gain, deaths avoided, large reduction in inequalities, affecting many people).

The root causes of health inequalities lie in the structure of our society, and many of the actions identified in this plan will take years to have an impact on any measure of health inequality. But that does not mean everything is very long term. A balanced approach to addressing health inequalities has to incorporate actions that can have a short (1 – 3 years) and medium (4 -10 years) term impact, as well as over the longer term (ten years and more). If we take differences in life expectancy as a measure of health inequality, and note that three quarters of the differences in life expectancy across the City is caused by premature death due to cardiovascular disease, cancer and respiratory disease, all of which are chronic diseases developing over years or decades, then it is clear that to have an impact in the short term we need to be offering better treatment and care for people who already have, or are at high risk of developing, those conditions. This means improving access to treatment and care, risk stratification to identify those at highest risk, and systematic case finding and optimal treatment. On the other hand these actions would be of limited value without others that will have an impact over the medium (e.g. helping people to address unhealthy lifestyles), and longer (addressing the 'root causes') terms.

This *Plan* includes actions that will have an impact in the short, medium and long term.

Use of resources

Resources in the public sector are extremely tight, and there are no new resources available for the implementation of this plan. However many of the actions are either already incorporated into existing budgets and commissioning plans, or may be cost saving. Where there is a need for additional investment for specific actions, business cases will have to be made to the appropriate budget holders, and the relevant bodies will have to consider the extent of their commitment to reducing health inequalities and the opportunity cost of shifting resources.

When resources are tight, it is more important than ever to take into consideration the cost effectiveness of different interventions, since it would be wrong to pursue actions that have a modest impact, or an impact on only a small number of people, if this is done at the cost of not doing things that have a greater impact on larger numbers. Unfortunately the information needed to make detailed methodical judgments about this (cost, extent of measurable health improvement, numbers who will benefit) is not always available, but that should not prevent us from considering the issue.

One critical issue is the question as to whether the mainstream Council and Health Services expenditure is appropriately distributed across the City to reflect the differing levels of need of different communities. In health services, the *Inverse Care Law* describes the way that resources tend to be skewed, not towards the communities that have the worst health and need them most, but towards those that have the best health and need them least. This is a natural consequence of a demand led system, and persists despite many years' efforts to redistribute resource. Council provided (or commissioned) services are not demand led in quite the same way. The first action in this plan – Action 3.1 – incorporates the intention to understand better how the use of our resources matches need, in order to be able better to devise strategies to do this better.

Governance and review

Any action plan is only as good as its implementation. There is no one body, apart from the Health and Wellbeing Board itself, that has responsibility for all of the actions in this plan. What the plan does do is to identify the individual who has responsibility for leading the delivery of each action, and the Board or Committee that must oversee it. Within the Council this will be in most cases the *Better Health and Wellbeing Strategic Outcomes Board*, and in the CCG, the *Clinical Executive Team.* It is suggested that an annual report is prepared on progress overall, for the *Health and Wellbeing Board* itself. Although all the actions are to be led by statutory bodies within the health and social care sector (the Council, CCG or NHS England Local Area Team), they will undoubtedly be looking for support as appropriate from other agencies in the public, voluntary and private sectors. In that respect, this is a health inequalities plan for the whole City.

This plan is intended to be implemented during the financial years 2014/15 through to 2016/17, by which time it will be due for refresh, if not review.

Health Inequalities Action Plan

H&WB Strategy *Action* 3.1 Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Louise Brewins	Define populations / 'communities of identity' and the health measures of interest.	Agreed list of communities of interest. Agreed set of health measures of interest for each community.	May 2014 June 2014	H&WB Strategic Coordinating Group	Unclear at this stage, though some communities comprise a substantial proportion of the population. Timescale for impact likely to be medium to long term	No comprehensive PHOF measures although number are specific to certain communities e.g. disabilities, age, gender & maternity.		Key measure of impact will be the extent to which the intelligence provided is used by others to improve outcomes for these communities.
	Identify means to collect, analyse and use additional data, including financial data, as appropriate.	Proposals drawn up including means to achieving them	June 2014	As above	As above	As above		As above
	Produce a set of community health and wellbeing profiles.	Profiles produced	Sept 2014	As above	As above	As above		As above

H&WB Strategy *Action* 3.2 Agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community-based organisations.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (eg PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Chris Nield Sharon Squires Martin Hughes Chris Nield	Agree approach and develop a city wide framework, through SEB resilience task & finish group. Develop resilience & social capital through work commissioned by Local Area Partnerships (LAPs) Develop social capital in the Community Well-being Programme (CWP) [1] Working in the most deprived areas of the city. Develop a commissioning strategy to achieve this. Sustain & develop the Health Trainers & Health Champions programmes to build social capital. Commissioning this work through community providers	Approach agreed and disseminated Locality plans include actions to develop resilience Contracts in place which develop social capital and resilience in the CWP and Health Trainers and Champions contract.	June 2014 April 2015 October 2014 April 2015	Sheffield Executive Board	Effective strengthening of communities and enhancement of social capital likely to have significant beneficial impact on health, including mental health. Timescale medium to long term.	**PHOF Indicators** Social Connectedness Self – reported well Being: People with a low Satisfaction score Self-reported well-being: People with a low Happiness score		*This work needs to link with Locality work and the development of integrated Health and Social care including the joint procurement of community interventions*
	Provide training to increase knowledge & skills about community development &	Provision of training courses				Self-reported well-being: People with a		

[1] Previous known as the Healthy Communities Programme

H&WB Strategy *Action* 3.2 Agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community-based organisations.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (eg PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	health. Provide for local communities & front line staff					high Anxiety score		
	Develop social capital & resilience as part of the Better Care integrated Health & Social Care plan	Community development interventions are included in the Better care plan for developing integrated health & social care services.		Health and Well Being Board				
	Agree metrics							
	Agree and implement programme of action							

H&WB Strategy *Action* 3.3 Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined-up city localities.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Dave Caulfield, Director of Regeneration & Development Services, Place Portfolio, PCC	Development of the Housing Delivery Investment Plan to step up housing delivery in the city to meet social & economic need	Completed plan agreed by Place Leadership Team and Executive Management Team	July 2014	A Great Place to Live Strategic Outcome Board Executive Management Team	Medium Timescale -; medium to long term	% of households who feel their home is adequate for their house-hold's needs Overall domestic emissions of CO_2 in the local authority area Number of long-term empty homes (over six months) in all tenures % of all tenants leaving a council tenancy within two years No of private rented homes where action is taken to reduce Category 1 hazards/ statutory nuisance	Raising awareness of the importance of good quality housing in promoting health and wellbeing. Lobbying to improve standards, particularly in private rented accommodation	2013 Strategic Housing Market Assessment has provided a baseline for the first impact measure but assessment only carried out every five years.

H&WB Strategy *Action* 3.3 Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined-up city localities.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	Refresh of the Air Quality Action Plan (AQAP)	Air quality action plan agreed by key partners	*xxx 2014*	A Great Place to Live Strategic Outcome Board	Medium to high Timescale – medium to long term	*Relevant PHOF measure* Fraction of mortality attributable to particulate air pollution	Ensuring that improving air quality in the City remains a high profile strategic objective	Refresh should reflect findings of recently completed Low Emission Zone study Refresh and delivery of specific projects will involve services across the Council and partners including the bus operators, taxi drivers, the Highways Agency and key strategic partners such as Amey, Kier and Veolia. Multi-agency AQAP Steering Group overseeing the refresh.

H&WB Strategy *Action* 3.4 Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**

H&WB Strategy *Action* 3.4 Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Susan Hird	Analyse access difficulties	Report completed, identifying groups, reasons, and consequences	September 2014	Better Health and Wellbeing Strategic Outcome Board / CCG Clinical Executive Team	Medium impact Medium timescale	Many PHOF indicators linked to this. The key ones are probably: 2.17 Recorded diabetes 2.19 & 2.20 Cancer dia-nosed at stage 1/2 & screening uptake & coverage 2.21 Access to non-cancer screening progs 2.22 Health Checks 3.3 Imms & vacs uptake & coverage . 4.3 Preventable mortality 4.4 to 4.7 Under 75 mortality (various) 4.8 – 4.10 Mortality from other specific causes	Depends on what we find/reasons for not being able to access services. Could include lobbying externally to city, addressing wicked issues in the city, bringing disparate parties together etc	Links to action 3.1 on data –achieving action 3.4 may be partly contingent on achievement of data task. This could delay timescales for this action as a whole.

H&WB Strategy *Action* 3.4 Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
						4.12 Prevent-able sight loss. PHOF sexual health indicators x 3. CYP PHOF indicators (Various)		
	Identify ways to improve access, prioritising areas with significant health consequences.	Report completed, identifying priority areas for action and mechanisms for achieving change.	December 2014					
	Simplify how people access care.	Actions from report above implemented and adopted into organisations (commissioners and providers) as business as usual.	April 2015					

H&WB Strategy *Action* 3.5 Ensure every child has the best possible start in life, including: focused action, reducing infant mortality, improving parent/child attunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Sue Greig CYPF, SCC	Implementation of infant mortality strategy Tobacco Control Board to consider impact of household tobacco use in pregnancy and upon infants	Stakeholder event planned to refresh priorities and agree new objectives for each work strand; particular focus upon maternal obesity and smoking in pregnancy Additional actions to reduce infant mortality risk associated with parental tobacco use and exposure to secondhand smoke	July 14 September 14	Children's Health & Wellbeing Partnership Board (CHWPB) Sheffield Safeguarding Children Board (SSCB)	High impact, short to long term	PH infant mortality indicator (4.1) Sudden infant death rate BME infant mortality rate PLUS indicators re risk factors for infant mortality: Breastfeeding Smoking in pregnancy Early access to antenatal care Maternal obesity Teenage conceptions Reducing risk of recessive genetic disorders Child poverty		To discuss with Kate Jones
Sue Greig CYPF, SCC	Mobilisation of fully integrated sexual health service which has a specific focus on young people. Citywide consultation with	New service mobilised. Central clinic meets You're Welcome Young	Q2 14/15	Better Health and Wellbeing Strategic Outcome	High impact short to long term	PHOF Under 18 conception rate Chlamydia		

H&WB Strategy *Action* 3.5 Ensure every child has the best possible start in life, including: focused action, reducing infant mortality, improving parent/child attunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	young people to seek their views on sexual health and sexual health services Re-design of GP led contraception services targeted in areas with the highest teenage pregnancy rates New sexual health community outreach plan developed	People Friendly standards. Consultation with young people re sexual health services completed and recommendations implemented New GP model in place Plan developed and implemented	Q2 14/15 Q3 14/15	Board Sheffield Sexual Health Service Integration Board		diagnoses rate (15-24 yr olds)		
Sheila Paul/Sue Greig Place/CYPF, SCC	Establishment/procurement of new 0-5yrs childhood obesity service to deliver HENRY and re-specification of children and young people's community based weight management service Continued delivery of NCMP with a specific focus on supporting schools in areas of high prevalence with healthy eating and physical activity sessions/information.	New childhood obesity service and model of delivery across city. Number of referrals to service and reduction in prevalence High NCMP coverage (above 95%). Identification and	Q1 14/15 Q2 14/15	Sheffield Food & Physical Activity Board	High impact short to long term Medium impact short to long term	PHOF 23.6 Excess weight in 4/5 and 10/11 year olds		

H&WB Strategy *Action* 3.5 Ensure every child has the best possible start in life, including: focused action, reducing infant mortality, improving parent/child attunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	Implementation of the CYPF Children, Young People and Food Implementation Plan to deliver C &YP elements of the Sheffield Food Strategy Continued focus on providing schools with individual school level DMFT data supported with the Top Teeth DVD and health promotion in schools.	delivery of interventions in target schools. Plan developed and implemented across Early Years, Schools and other settings	Q2 14/15					
Sue Greig CYPF, SCC/NHS England	Targeted focus to increase vaccination and immunisation rates amongst vulnerable groups of children and young people (LAC, Roma).	Increase in V&I coverage across vulnerable groups. Raised awareness through targeted professional training.	Q1/Q2 14/15	CHWPB	Medium impact Short to long term			
Sue Greig CYPF, SCC	Early years focus on Emotional Wellbeing & Mental Health, through enhancing and supporting early attunement and attachment. Delivered as part of the Best Start model in Sheffield. See Best Start	Enhanced delivery of the universal Healthy Child Programme across the city; with a focus on attunement/ attachment in	Q2 14/15	Sheffield Best Start Are Partnership Board & Executive Steering Group	High impact short to long term	PHOF: Smoking in pregnancy Breast feeding School readiness Parental confidence		

H&WB Strategy *Action* 3.5 Ensure every child has the best possible start in life, including: focused action, reducing infant mortality, improving parent/child attunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Dawn Walton, CYPF, SCC Margaret Ainger (CCG)	Sheffield Lottery Submission Develop agreed city wide Early Years Strategy as part of FSCH Early Years workstream	early years. Redesign of Early Years System with a focus on prevention and early intervention.	Q2 14/15	CHWPB	High impact short to long term	Parental stress Child development As above PLUS: Take up & quality of Free Early Learning Children's Centre reach Parental learning & skills		
Sue Greig CYPF, SCC/Steve Jones (SCHFT)	Develop Future Shape Children's Health emotional wellbeing and mental health workstream Complete comprehensive emotional wellbeing and mental health needs assessment for children and young people Complete whole service review Agree joint action to address identified system gaps	Workstream scope endorsed by CHWPB HNA completed and disseminated Workstream actions and milestones agreed by CHWPB	Q1 14/15 Q1 14/15 Q2 14/15 Q3 14/15	Children's Health and Wellbeing Partnership Board Children's Joint Commissioning Group	High impact short to long term	Pupil persistent absence NEETs First time entrants to youth justice Emotional wellbeing of LAC Self reported emotional wellbeing (ECM survey) Hospital attendances for Self harm		

H&WB Strategy *Action* 3.5 Ensure every child has the best possible start in life, including: focused action, reducing infant mortality, improving parent/child attunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
						DNA rates for specialist MH services		
Sue Greig, CYPF, SCC	Context for all of the above is the implementation of recommendations from the Future Shape Health programme review (completed end 13/14) to establish 4 priority workstreams: • Early years • Emotional wellbeing and mental health • Children with Complex needs (Lead Kate Laurance CCG) • Parent/carer and children and young people engagement and participation (Lead: Bethan Plant CYPF /Lesley Pollard Chilypep)	Revised programme and work stream plans in place Sheffield Future S hape Children's Health Programme implementation – engaging all partners and delivering service redesign and reducing inequalities in children, young people and families health and wellbeing	Q1 14/15 From Q2 14/15		High impact short to long term	As above		
Sue Greig CYPF, SCC	Implementation of infant mortality strategy	Stakeholder event planned to refresh priorities and agree new	July 14	Children's Health & Wellbeing Partnership	High impact, short to long term	PH infant mortality indicator (4.1) Sudden infant		To discuss with Kate Jones

H&WB Strategy *Action* 3.5 Ensure every child has the best possible start in life, including: focused action, reducing infant mortality, improving parent/child attunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	Tobacco Control Board to consider impact of household tobacco use in pregnancy and upon infants	objectives for each work strand; particular focus upon maternal obesity and smoking in pregnancy Additional actions to reduce infant mortality risk associated with parental tobacco use and exposure to secondhand smoke	September 14	Board (CHWPB) Sheffield Safeguarding Children Board (SSCB)		death rate BME infant mortality rate PLUS indicators re risk factors for infant mortality: Breastfeeding Smoking in pregnancy Early access to antenatal care Maternal obesity Teenage conceptions Reducing risk of recessive genetic disorders Child poverty		

H&WB Strategy *Action* 3.6 Recognising that the city has growing numbers of new arrivals, including Roma, develop appropriate strategies to ensure families are appropriately accessing health, social care and education services.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Janet Sharpe	Develop a new arrivals health and education policy	*Policy completed and agreed*	Stage 1: Q4, 2014/15 Stage 2: 5 Year Plan	H&WPB, GPL Board, HRA Board	Modest impact, medium to long term	TBC	Support the New Arrivals Strategic Action Plan, Allocation of Public Health and Grant Aid funding to support development work/ community projects to support Roma community.	This is part of a comprehensive Strategic Action Plan for Roma Community in Sheffield. This includes developing health plan for community, addressing poor quality private sector housing, reducing over-crowding, promotion of easy access to GP services rather than use of A&E services, addressing impact of poor diet, early identification of vulnerability/ heath conditions. Immunisation programmes for TB and hep B and genetic disorders prevalent with this community.

H&WB Strategy *Action* 3.7 Commission disease-specific interventions, including a programme to improve the physical health of the severely mentally ill or those with a learning disability.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Tim Furness / Ted Turner	Use the JSNA, the outcome of action 3.4 and other PH advice to inform CCG commissioning intentions for 2015/16 and future years. Retain tackling health inequalities as a priority for any investments that can be made. Identify area(s) of greatest need and greatest potential impact, and identify priorities (which will include the physical health of people with mental illness or learning disability) Agree actions with providers, including GPs, to improve staff awareness of specific needs of patients with MH or LD, and support them contractually Consider potential case for establishing specialist post or service to meet physical needs of people with MH or LD	CCG commissioning intentions highlight identified priority areas and planned interventions JSNA – and CCG reference to it, demonstrates understanding of need and priorities Inclusion of actions in provider plans and in contracts Business case considered by	Sept 2014 Feb 2015 March 2015 Dec 2014-06-06	CCG Clinical Executive Team	Medium impact over medium timescale.	2.17 Recorded diabetes 2.19 Cancer diagnosed at stage 1 and 2 (placeholder) 2.20 Cancer screening uptake and coverage 2.21 Access to non cancer screening programmes (6 indicators, not yet available) 2.22 Health Checks uptake and coverage 3.3 Imms and vaccs uptake and coverage 4.3 Mortality from preventable causes disease	Although primarily a health services issue, many marginalised groups who will benefit (e.g. new arrivals) will also have social needs which militate against access to health services. H&WBB can bring together parties and help solve 'wicked issues'.	Overlap with action 2.8 Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield

		CCG						
H&WB Strategy *Action* 3.7 Commission disease-specific interventions, including a programme to improve the physical health of the severely mentally ill or those with a learning disability								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
						4.4 to 4.7 Under 75 mortality from CVD, cancer, liver disease, respiratory		
	Ensure carers of people with MH and LD are included in city's actions to support carers	Inclusion in city's carers plan.	n/k			4.8 Mortality from communicable disease 4.9 Excess under 75s deaths in people with SMI 4.10 Suicide 4.12 Preventable sight loss		
	Prioritised interventions included in CCG 2015/16 commissioning intentions, and other organisations' plans where appropriate	Interventions included in CCG commissioning intentions for 2015/16	December 2014					
	Commissioning of prioritised services	Services starting in 2015	April 2015					

H&WB Strategy *Action* 3.8 Support quality and dignity champions to ensure services meet needs and provide support.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Healthwatch Sheffield	Identify number/types of Dignity Champions across the City	Mapping exercise completed	2015	Healthwatch	Low impact, short to medium term		Through lending explicit support	
	Recruiting more Champions from all communities across the city to become Dignity Champions – extra targeting at communities experiencing Health Inequalities	Recruitment and training pack for Dignity Champions is prepared						
	Review and evaluate effectiveness of support currently provided to Dignity Champions	Survey conducted and qualitative interviews						
	Consider new and emerging capacity and capability requirements (e.g. end of life care priority)							
	Prepare an action plan	Action plan prepared						

H&WB Strategy *Action* 3.9 Work to remove health barriers to employment through the Health, Disability and Employment Plan.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Chris Shaw	Deliver pilot project for ESA claimants with JCP	12 months delivered, outcomes evidenced	2015	Employment and health task force or new arena	Low impact, medium to long term.	PHOF measures 108(i,ii,iii) plus Improved referral route from primary care to JCP and increased availability of access to effective Local intervention Reduction in ESA claimants, increase in employment outcomes + work readiness for ESA claimants	Ensure health and care agencies recognise good employment as a route to improved health, and minimise the health and social care barriers to making this a reality—	Caring profession may traditionally see employment as a situation to avoid during recovery or as not a viable long term outcome. Evidence increasingly recognises good employment to be a key factor in recovery or as part of a healthy future living with disabilities or long term conditions.
	Review of supported employment investment	Review Completed	August 2014	Employment and health task force or new arena	Med Impact medium term	PHOF measures 108(i,ii,iii)	Support the review and input into its comments when appropriate	
	Launch Good Employer Charter	Launched	October 2014	Employment and health task force or new arena.	Medium impact short- medium term	PHOF measures 109(I &ii)	Encourage organisations they commission to participate in the employment	Could potentially use HWB 'kudos' to recognise good employment practice – e,g. sponsor an award at the Chamber of Commerce awards ?

H&WB Strategy *Action* 3.9 Work to remove health barriers to employment through the Health, Disability and Employment Plan.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
							charter to ensure maximum spread' good work' ion the City, and promote it with the Chamber of trade etc. ,	
Chris Shaw	Increase the dialogue between Health, employment organisations , employers and disability organisations across the City	Membership and ownership agreed, agenda agreed and 'mode of communication' established	April 2015	Employment and health task force or new arena	Reduced health/ disability based unemployment	PHOF 1.08 (I,ii+iii)		
	Using the social model of disability to increase the employment opportunities for vulnerable people across the City	Targets achieved for related PHOF measures	April 2016	Employment and health task force or new arena	Reduced health/ disability based unemployment	PHOF 1.08 (I,ii+iii)	Encourage employment opportunities through contracts, own the social model of disability	

H&WB Strategy *Action* 3.10 To promote health literacy and earlier engagement with health services in disadvantaged communities								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Chris Nield	Develop a strategy for health literacy and early engagement	Strategy developed	October 2014	Better Health and Wellbeing Strategic Outcome Board	Medium impact, medium to long timescale		By lending explicit support to this work	
	Work with health champions, local VCF organisations, local general practitioners etc to implement health literacy strategy	Partners fully engaged in implementation of strategy. Continuing programme for promoting health literacy in place	March 2015	Better Health and Wellbeing Strategic Outcome Board	Medium impact, medium to long timescale	To be completed	By supporting the programme	

H&WB Strategy *Action* 2.1 Promote a city-wide approach to emotional wellbeing and mental health, focusing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Joe Fowler		.		Mental Health Partnership Board	Medium impact., short term, continuing to longer term.	Social Connectedness Self – reported well Being: 4.10 Suicide rates	Drive ownership of partners of citywide approach	
	Revised City-wide wellbeing campaign (based on 5 ways to wellbeing)	Campaign launched	February 2015					5 ways helps people understand what they can do to promote their own wellbeing
	Develop front line staff awareness/skills around MH and wellbeing	Develop and roll out awareness/ training sessions, & other resources as appropriate to the workforce	Initial resources developed September 2014, rollout continuing					Build on current training programme (MH and PH) and other routes to develop frontline staff.
	Influence service specifications to incentivise and drive improvements to wellbeing	Specifications influenced	Ongoing					Aiming to mainstream thinking about wellbeing
	Deliver anti-stigma campaign	Anti-stigma campaign activity delivered	Ongoing					Time to change campaign supported in a variety of ways
	Review MH strategy and agree actions going forward	New strategy agreed	Consultation in September 2014					To include improvements in services for people who are unwell, along with prevention activities for those at risk.

H&WB Strategy *Action* 2.4 Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Ollie Hart	The H&WBB to recognise and pursue an ambition to hold the city accountable to a 1% year on year step change in proportion of population judged to be physically active.	Explicitly adopted and minuted by H&WBB	Sept 2014	H&WBB	Achievement of individual sections of the plan in isolation, are likely to have low impact, however each aspect will have a synergistic effect – achievement of overall increase in Physical activity levels will be high impact – especially reducing impact on NHS demand and budget.	Use of current survey data to assess PA levels, but to include more novel ways of objectively assessing levels of activity (movement sensors). Measures of those a) doing at least 30mins of moderate physical activity (PA)/ week b) doing at least 150mins of moderate 0r 75 mins of vigorous PA/ week	The HWB is asked to champion universal acceptance and consideration of principles and objectives of the plan, and ensure all major bodies in the city support it's implementation .	Supporting the implementation of the whole movemore plan will be the best way to achieve the culture change required for this population change.
Ollie Hart	Empower a multidisciplinary innovation group in the city to effect change in policy around creating environments and opportunity for PA in all	20 + documents covering governance, legislation, or tender briefs,	May 2015	H&WBB	As above	As above	By explicitly championing approach.	Suggest that the current food and physical activity board, chaired by Graham Moore, are given this role. HWB support appropriate

H&WB Strategy *Action* 2.4 Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	contexts but with the principal of proportional universalism (Marmot) driving that change to reduce HI.	affecting environmental change (eg town planning, large scale construction) where consideration of movemore plan is specified.						influence and impact of this board on workings of SCC/ NHS and other commissioning bodies in the city
Ollie Hart	Establish movemore digital hub as key 'go to' resource for physical activity (including activity finder, promotional and marketing materials, wide range of advice/ local information)	Activity finder is populated by more than 100 different providers, with over 3000 activities. Site receives high level of weekly visits (1,000/ week+)	May 2015	Food and Physical Activity Board	As above	As above	HWB is asked to champion promotion / marketing of the hub.	Movemore brand already established. www.movemore-sheffield.com already live with over 1000 activities.
Ollie Hart	Create an active Movemore network of engaged people and communities. Following an Asset based community development approach	Identify 14 community builders (2/ assembly) who are able to connect communities to multiple opportunities	May 2015	Food and Physical activity board	As above	As above	The assistance of HWB is sort in ensuring synergy with other areas of commissioning (eg Resilience group, Food executive,	Movemore board has started this work with funding from 2012/13 public health budget. Extra funding sought from health and Social volunteers fund- outcome awaited.

H&WB Strategy *Action* 2.4 Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
		including movemore initiatives. Over 100 community partner organisations/ groups endorsed by Movemore (demonstrate adherence to 12 principles of movemore plan)					Housing teams)	
Ollie Hart	Mass participation event to stimulate profile and engagement with movemore. Utilising movement sensors to create mass participation challenges	Successful pilot of technology and supporting infrastructure for 500 people. Plans to expand to much larger event involving 50,000+ people in 2015	Pilot – 1 year. Full event – 2 years	Food and Physical activity board. Prof Steve Haake (research lead NCSEM, Faculty of Health and Wellbeing SHU)	As above	Such a challenge will allow more accurate objective measures of participation and of activity levels		Bid was submitted as Sheffield's city bid for Mayor's challenge – unsuccessful. Some initial scoping work undertaken with SCC and SHU. Options to consider local sponsorship

H&WB Strategy *Action* 2.5 Commission and implement an integrated approach to reducing levels of tobacco use through integrating work on: 1) helping people to stop smoking; 2) Smokefree environments; 3) Smokefree C&YP 4) community based action on illegal tobacco 5) Social Marketing and communications to reduce smoking prevalence and denormalise tobacco use; 6) reduce smoking prevalence amongst pregnant women.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Lynsey Bowker	Commission a comprehensive programme of tobacco control to reduce citywide smoking prevalence. The programme will be based on evidence from World Health Organisation, comprehensive consultation and local need.	Programme fully commissioned	80% completion by August 2014 100% Completion by April 2015	Tobacco Control Programme Board	High impact. Reducing smoking prevalence will significantly improve health and impact on inequalities in the short, medium and long term.	All contracts will contribute towards the following PHoF indicators: i) 2.14: Smoking prevalence adults over 18 ii) 2.9: Smoking prevalence 15 year olds iii)2.3: Smoking status at time of delivery Local ECM survey: CYP tobacco use	H&WBB members should ensure that as a city we uphold principles outlined in the Local Gov. Declaration on Tobacco Control, signed by SCC Jan '14. Key action includes: act at a local level to reduce smoking prevalence, raise the profile of the harm caused by smoking in communities and develop plans with our partners to address the causes and impacts of tobacco use.	Model developed in line with WHO evidence, full consultation and South Yorkshire led programme budgeting style exercise. Programme and funding signed off within SCC
		All services commissioned for three year period 2014 -17 (with option to extend for an additional year).	Contracts awarded 1st Feb '14					Six services (lots) commissioned in total. Lots 1-4 procured and fully mobilised by 1 April '14. Contract for Lot 5

H&WB Strategy *Action* 2.5 Commission and implement an integrated approach to reducing levels of tobacco use through integrating work on: 1) helping people to stop smoking; 2) Smokefree environments; 3) Smokefree C&YP 4) community based action on illegal tobacco 5) Social Marketing and communications to reduce smoking prevalence and denormalise tobacco use; 6) reduce smoking prevalence amongst pregnant women.								
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								(marketing and comms) awarded April '14 and service in place by Jun '14. Lot 6 smoking in pregnancy delayed. Need to ensure approach is aligned to strategy within SCC CYP.
		Services fully mobilised	By 1 April '14					
		Ongoing programme delivery with quarterly monitoring and routine evaluation	April '14 – March 2017 (Contracts all include option to extend for an additional year)					Tobacco Control 'Hub' established. All providers will be part of the 'hub' to ensure coordinated action across the city. Quarterly performance meetings with all providers. Ongoing programme evaluation.

H&WB Strategy *Action* 2.6 Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Jo Daykin-Goodall	Implement the DACT Commissioning & Procurement Plan for community substance misuse treatment approved by Sheffield City Council Cabinet (January 2014).	Award of three contracts – Opiates, Non-Opiates, Alcohol.	Opiates and Non-Opiate contracts to commence 1st October 2014, Alcohol to commence 1st April 2015.	Director of Commissioning Safer & Sustainable Comm-unities Partnership	Low to medium Timescale short to medium term	Performance against PHOF 2.15i and ii DOMES (PHE) and LAPE performance		-
Victoria Horsefield CYPF, SCC	Ongoing Implemention of the city wide Hidden Harm Strategy			Sheffield Safe guarding Children Board		As above No of children in need/child protection/in care, where parental substance misuse a safeguarding risk		
Sue Greig, CYPF, SCC	Continued implementation of the Novel Psychoactive Substances (NPS) plan underpinned by accessible targeted & specialist sub-stance misuse services which focus on reducing harm of substances misuse, including alcohol, & a reduction in associated risk taking		Ongoing	Substance Misuse Joint Commissioning Group		No of young people leaving specialist treatment in a planned way No of Looked After Children accessing early support		

H&WB Strategy *Action* 2.6 Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	behaviours & poor outcomes. Refreshed substance misuse curriculum tool available in all primary and secondary schools		Q2 14/15			ECM survey substance misuse and alcohol misuse		

H&WB Strategy *Action* 2.8 Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Susan Hird	Cancer and cardiovascular disease continue to be specific priority in JSNA and JHWS. These should include information about the underlying causes of these diseases and what we know about where they are most prevalent in the City.	Cancer and cardiovascular disease in JSNA and JHWS	Ongoing	CCG Clinical Executive Team	Medium to high impact, short to medium term.	2.17 Recorded diabetes 2.19 Cancer diagnosed at stage 1 and 2 (placeholder) 2.20 Cancer screening uptake and coverage 2.22 Health Checks uptake and coverage 4.3 Mortality from preventable causes 4.4 to 4.7 Under 75 mortality from CVD, cancer, liver disease, respiratory disease 4.9 Excess under 75s deaths in people with SMI 4.12 Preventable sight loss		Overlap with action 3.7 Commission disease-specific interventions, including a programme to improve the physical health of the severely mentally ill or those with a learning disability.

H&WB Strategy *Action* 2.8 Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	Identify 2-3 key actions/interventions that can be taken city-wide to reduce premature deaths from cancer and cardiovascular disease, taking into account work that is already happening. Prevention should be a priority.	Report completed, identifying agreed priority actions/interventions	September 2014					
	Implementation of interventions	Intervention incorporated into organisational objectives and plans	April 2015					

Appendix: Local recommendations aimed at addressing health inequalities

Fairness Commission:

General

1. All organisations in Sheffield should explicitly commit to tackling the wider determinants of health and using their services (commissioning or direct delivery) to reduce health inequalities wherever possible.
2. The NHS and Sheffield City Council should use their available budgets to **prevent health and wellbeing problems from occurring** in the first place.
3. Sheffield City Council and the Sheffield Clinical Commissioning Group should spend a progressively increasing amount, both in absolute terms and as a proportion of their budgets, on **initiatives addressing the wider determinants of health**, aimed in particular at people in poverty and with the worst health, or those in danger of having the worst health. This expenditure should be identified and accounted for in an annual report.
4. **Health and Wellbeing Board (HWB) members must fully utilise their individual and collective position, influence and resources** to achieve better health outcomes for Sheffielders in most need. The HWB comprises some of the city's most senior politicians, officials and medical professionals and the Board must act to address the wider determinants, champion and challenge Government and partners in the city (e.g. employers) to contribute to a holistic approach to wellbeing in Sheffield and stand up for the city's health needs.
5. Public sector organisations should implement a **health inequalities assessment** for all major strategies and developments. This should also form part of a voluntary 'Fair Employer' code and the City Council and NHS 'Compact' with the voluntary sector
6. The city should **promote women's health in general, pre-pregnancy, in pregnancy and after giving birth**. This would include, for example, promoting early registration with a midwife when pregnant, and promoting breast feeding and post-natal support.

Inequalities in the health system

7. The HWB should **use the Joint Strategic Needs Assessment to better understand the equity of the health spend** in Sheffield
8. The HWB partners from the Clinical Commissioning Group and Sheffield City Council must **ensure that health spending in the city is more fairly utilised** based on the relative needs of communities. This includes making services more accessible and appropriate to groups who currently underuse services.
9. That there is a significant **increase in primary and community care** in Sheffield, particularly in the most deprived areas of the city delivered locally in accessible venues
10. That the quality of health, care and public health services is of a **consistent, high quality** across all areas of the city
11. Communities are supported with the necessary skills and information to recognise health concerns and have the confidence to seek advice and support from health services. This should include **removing barriers to services** which are disproportionally experienced by some communities.

Mental health and wellbeing

12. **Supporting people to receive early diagnosis** to reduce the health inequalities experienced by those individuals and prevent other problems spiralling from the mental health issue, for example debt.
13. **The diagnosis and treatment of mental wellbeing problems in children** needs to improve.
14. That commissioners need to **increase the prominence given to mental health and wellbeing in commissioning plan**s, to fulfil the aspirations around this area in the Health and Wellbeing Strategy. This should include moving existing resources from other areas of the health

system to strengthen mental health and wellbeing services, particularly if this is likely to improve the prevention of mental ill health.

15. That the **commissioning of services for the physical health care of people with mental health problems needs to be radically rethought**. This means the strengthening of the local evidence base in this area, and the re-prioritisation of resources from other areas of the health service.

Carers

16. **All employers are encouraged to support carers to be in work**, for example through paid leave for carers and flexible working arrangements for all employees which would have particular benefits for carers.
17. **All schools in Sheffield recognise, identify and support young carers** as a vulnerable group of young people who have a right to an education, aspiration and achievement and to ensure a successful career and adult.
18. Making sure that the right level of **respite care** is available in the city.
19. The city needs to **identify 'hidden carers'**, those people who take on caring responsibilities but have not been identified as a carer and therefore potentially missing out on support available to them. This should focus on young people and certain BME groups who are group of people likely to have a greater proportion of hidden carers.
20. The **'With Carer Pass' should be extended to all carers caring for a disabled person**.
21. The **special needs of older lifelong carers** are recognised by commissioners and service providers.

Joint Strategic Needs Assessment

1. Limit the negative impact of welfare reform: welfare reform will have a huge impact on the City and a negative impact on health and wellbeing, both for those affected by the reforms and those affected more broadly by health inequalities. We must minimise the negative impact where possible and in particular, the potential 'double negative impact' for families with children aged under five, families with more than two children and lone parent families.

2. Focus on housing: Conditions in the private rented sector and fuel poverty are both real concerns in Sheffield and interventions should prioritise these two issues and those most at risk.

3. Improve employment opportunities: Fewer people work in Sheffield than the national average and we need to improve volunteering, training and employment opportunities, particularly for young people.

4. Better understand mental wellbeing: Sheffield experiences poorer levels of mental wellbeing than the national average. We need a more comprehensive understanding of the specific factors that contribute to wellbeing if we are to improve locally.

5. Focus on leading causes of mortality and morbidity: Long terms conditions (such as coronary heart disease and cancer) are among the leading causes of premature death in Sheffield and dementia a significant factor in increasing morbidity**.** This will have significant implications for health and social care services including acute hospital services, residential care and end of life care. These must be a priority for health and social care commissioners for the foreseeable future.

6. **Smoking** remains the largest, reversible cause of ill health and early death in Sheffield. Evidence places increasing importance on implementation of a comprehensive tobacco control programme as the key means by which to reduce prevalence of smoking in the future.

7. Identify geographical health spend: We need to establish how health expenditure is distributed geographically within the City and map this against geographical health outcomes. Spend should reflect our aspiration to reduce health inequalities.

8. Develop a better understanding of health inequality by 'group': Whilst we have good data on inequality by geography, we do not have it by group. Groups such as BME communities, children with learning difficulties, homeless people, victims of domestic and sexual abuse and carers are all reported nationally to have below average health, but local data are lacking.

9. Map assets: If we are to reduce health inequalities in the City, it is not enough to know about need alone – we also need to understand what assets we have so that we can build on them.
10. Reduce dependence on high end health and social care services: The growth and changes in our population and balance of our investment profile means that the current service model is unsustainable. We must therefore find new ways of responding to need which places a premium on prevention, early intervention, integrated working and care in the community. Although there is a move to do this, there is still a long way to go.
11. Acknowledge the impact of spending cuts: cuts that are impacting on the NHS, local government and the voluntary sector cannot be overlooked and are beginning to have a negative impact on service provision. It is important to question how realistic the outcomes of the Joint Health and Wellbeing Strategy are in light of these funding changes.
12. Measure service access and experience: more emphasis must be placed on collecting and analysing service access and experience data. Without this, it is impossible to measure the extent to which "people get the help and support they need and is right for them".

Health and Wellbeing Strategy

Outcome 3: Health inequalities are reducing

1. Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.
2. Agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community-based organisations.
3. Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined-up city localities.
4. Identify which groups are least able to access services and establish reasons for difficulties and the health consequences of this. Work to improve access, prioritise those areas where the difficulties in access have significant health consequences, and simplify how people access care.
5. Ensure every child has the best possible start in life, including: focused action with the most deprived areas and groups, reducing infant mortality, developing strategies that improve parent/child attunement in early years, increasing the uptake of childhood immunisations, reducing the number of under 5s A&E attendances, reducing smoking rates in expectant mothers, improving children's dental health, increasing the rate of breastfeeding, reducing teenage conceptions, reducing obesity in children and young people.
6. Recognising that the city has growing numbers of new arrivals, including Roma, develop appropriate strategies to ensure families are appropriately accessing health, social care and education services.
7. Commission disease-specific interventions to tackle poor health in population groups that have worse health, including a programme to improve the physical health of the severely mentally ill or those with a learning disability.
8. Support quality and dignity champions to ensure services meet needs and provide support.
9. Work to remove health barriers to employment through the Health, Disability and Employment Plan.

Outcome 2: Health and wellbeing is improving

1. Promote a city-wide approach to emotional wellbeing and mental health, focusing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.
2. Commission a needs-led response to support children and young people's emotional development to enable them to develop personal resilience and manage transition from childhood to adulthood.

3. Support the implementation of the new city Parenting Strategy which focuses on positive parenting and developing resilient families and communities so that all children have a stable and enriching environment in which they will thrive.
4. Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.
5. Commission and implement an integrated approach to reducing levels of tobacco use through integrating work on: smoke-free environments; helping people to stop smoking; using mass media by reducing the promotion of tobacco; regulating tobacco products; reducing the affordability of tobacco; and substance misuse services.
6. Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.
7. Commission a joint plan and integrated pathway across the city including schools and the commercial sector to act preventatively and with lower-tier interventions to tackle obesity, providing accessible information.
8. Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.

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Sheffield Health and Wellbeing Board

Engagement Event 29 May 2014

Tackling Health Inequalities

Event Summary

What was the event?

Sheffield's Health and Wellbeing Board is a group of senior councillors, GPs, managers and representatives of Sheffield people who work together to connect health, social care and wellbeing in Sheffield. It has several engagement events a year.

This event's main focus was on looking at what Sheffield's Health and Wellbeing Board could do to tackle health inequalities, a topic that has been a priority for the Board since it was created.

Who came to the event?

A wide variety of people attended – members of the public, service users, providers including NHS hospitals and voluntary, community and faith sector organisations, frontline workers, and statutory organisations – as well as Health and Wellbeing Board members.

What did people say about the event?

People enjoyed the event, with all but one giving it 4/5 or 5/5. They enjoyed meeting others and talking about different themes.

Summary of conversations and views

We have summarised some of the main themes coming out of the event below:

- We need to be sure to promote and communicate good health and wellbeing, and promote the services which'll help and support people to be healthy and well.
- See people as a whole, covering mental *and* physical health; don't just offer medical solutions.
- Work should be done to increase spend in preventative activity.
- Develop the role of the GP (and other frontline workers), ensuring their awareness of key services that support those who are particularly affected by a health inequality.
- People and communities have a range of resources and assets at their disposal – they should be used as partners.
- We need to ensure we involve people, their families and providers in decision-making and use their feedback.
- Access to services is a crucial issue – and there *are* things we can do to improve this.
- Organisations should work together to achieve better outcomes for people. Some professional cultures may need to be challenged.
- Quality and dignity are really important things.
- Pilot projects are good but we need to make sure that projects that work become widespread.
- The Health and Wellbeing Board can add value – and attendees and organisations can add value as well.

What's next?

The Health Inequalities Action Plan will be discussed at the Health and Wellbeing Board on 26th June 2014. The feedback from this event will be fed into the final version of the plan.

Sheffield Clinical Commissioning Group
NHS England
healthwatch Sheffield
Sheffield City Council

www.sheffield.gov.uk/healthwellbeingboard

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HEALTH AND WELLBEING BOARD

Written response to a public question asked at the meeting of the Board held on 27 March 2014

1. Extract from the minutes of the meeting held on 27 March 2014

"Public Question Concerning Public Health Grant

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

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

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

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

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

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

2. Response from the Chief Executive, Sheffield City Council, to Mr Hartley dated 9 April 2014

"I am writing further to the questions that you asked at the last Health and Wellbeing Board on 27th March 2014. Those questions related to the size of the Public Health Grant, and also the previous and planned activities of the Health and Wellbeing Board. You also raised a question concerning the funding of Healthwatch Sheffield.

In terms of the Public Health Grant, prior to the 2013/14 financial year, the service was embedded within NHS Sheffield Primary Care Trust (PCT). It transferred to the City Council on 1st April 2013. In the 2013/14 year the Public Health Grant was £29,665,300. In 2014/15, the grant will be £30,747,900.

In terms of the four activities organised by the Board in 2014, I take this to mean the four engagement events organised by the Board. These took place on the following dates:

- Thursday 25th April 2013. The cost of the event was £701.

- Thursday 25th July 2013. The cost of the event was £328.

- Thursday 31st October 2013. The cost of the event was £80.

- Thursday 30th January 2014. The cost of the event was £71.

In terms of the four activities planned for 2014/15 these are as follows:

- Thursday 29th May 2014 with the theme of tackling health inequalities.

- Thursday 31st July 2014 with a theme to be chosen by Healthwatch Sheffield.

- Thursday 1st October 2014 with a theme yet to be confirmed.

- Thursday 29th January 2015 with a theme yet to be confirmed.

In terms of Healthwatch Sheffield, all local authorities have a duty to ensure that there is a Healthwatch established in their area. Funding is received by the local authority from the Department of Health to enable them to do this although local authorities have the freedom to decide exactly how they will ensure there is a Healthwatch within a framework laid down by the Department for Health. In Sheffield a consultation process with citizens during 2012/13 established that the preference was for Sheffield City Council to tender for a contractor to establish and run Healthwatch in Sheffield. This process took place early 2013 and since April 2013 Voluntary Action Sheffield has been under contract to Healthwatch in the city. This contract is monitored for quality as with any other Council contract and will run to 2015."

SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 27 March 2014

PRESENT:

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

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

Ian Atkinson, Accountable Officer, Clinical Commissioning Group

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

Professor Pam Enderby, Chair, Healthwatch Sheffield

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

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

Dr Zak McMurray, Clinical Director, Clinical Commissioning Group

John Mothersole, Chief Executive, Sheffield City Council

Laura Sherburn, NHS England

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

Dr Jeremy Wight, Director of Public Health

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

In Attendance

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

Joe Fowler, Director of Commissioning, Sheffield City Council

Sue Greig, Consultant in Public Health, Sheffield City Council

Chris Shaw, Head of Health Improvement, Sheffield City Council

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1. APOLOGIES FOR ABSENCE

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

2. DECLARATIONS OF INTEREST

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

3. PUBLIC QUESTIONS

3.1 Public Question Concerning Personal Health Budgets

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

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

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

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

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

3.2 Public Question Concerning Public Health Grant

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.3 RESOLVED that:

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

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

5. JOINT STRATEGIC NEEDS ASSESSMENT ANNUAL REPORT 2013-14

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.3 RESOLVED that the Board:

(1) Notes the significant progress achieved to date;

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

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

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

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

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

5.4 **Reasons for the recommendations**

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

6. JOINT HEALTH AND WELLBEING STRATEGY WORK PROGRAMMES

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

6.2 A Good Start in life

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

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

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

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

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

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

6.3 Building Mental Wellbeing and Emotional Resilience

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

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

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

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

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

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

6.4 Food and Physical Activity

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

2020.

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

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

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

A detailed implementation plan and evaluation framework was in development.

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

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

6.5 Health, Disability and Employment

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

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

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

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

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

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

6.6 Supporting People Closer to Home

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.8 RESOLVED that the Board:

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

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

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

7. MINUTES OF THE PREVIOUS MEETING

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

8. DATE AND TIME OF NEXT MEETING

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