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Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 11 December 2014 at 2.00 pm

Town Hall, Pinstone Street, Sheffield, S1 2HH

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
Richard Armstrong	Interim Director of Commissioning, NHS England
Ian Atkinson	Accountable Officer, Clinical Commissioning Group
Dr Nikki Bates	Governing Body Member, Clinical Commissioning Group
Maggie Campbell	Healthwatch Sheffield
Councillor Jackie Drayton	Cabinet Member for Children, Young People and Families
Councillor Mazher Iqbal	Cabinet Member for Communities and Public Health
Councillor Mary Lea	Cabinet Member for Health Care and Independent Living
Jayne Ludlam	Executive Director, Children, Young People & Families

Sheffield City Council

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 would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

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

FACILITIES

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

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

11 DECEMBER 2014

Order of Business

1.	**Apologies for Absence**	
2.	**Declarations of Interest** Members to declare any interests they have in the business to be considered at the meeting.	(Pages 1 - 4)
3.	**Public Questions** To receive any questions from members of the public.	
4.	**Update on the Joint Health and Wellbeing Strategy: Outcome 2 - Health and Wellbeing is improving** Report of the Co-Chairs of the Health and Wellbeing Board.	(Pages 5 - 24)
5.	**Update on the Integrated Commissioning Programme (Better Care Fund)** Report of the Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group and the Director of Commissioning, Sheffield City Council.	(Pages 25 - 28)
6.	**Sheffield Strategy for Mental Health** Report of the Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group.	(Pages 29 - 64)
7.	**Pharmaceutical Needs Assessment for Sheffield 2015-18** Report of the Director of Public Health.	(Pages 65 - 118)
8.	**Briefing on Preparedness for Winter and the Ebola Virus** Report of the Co-Chairs of the Health and Wellbeing Board.	(Pages 119 - 124)
9.	**Minutes of the Previous Meeting** To approve the minutes of the meeting of the Board held on 25 September 2014.	(Pages 125 - 134)

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 26 March 2015 at 2.00 pm

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

Date: 11 December 2014

Subject: Update on the Joint Health and Wellbeing Strategy: Outcome 2 – Health and wellbeing is improving

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Author of Report: Louisa Willoughby, 0114 205 7143 *and other authors as stated*

Summary:

The Joint Health and Wellbeing Strategy is the Health and Wellbeing Board's strategy for Sheffield and as such is Sheffield's overarching city strategy in all matters relating to health and wellbeing. Outcome 2 of the Strategy focuses on specific aspects of children's and adults' health and social care and the wider determinants of health to improve health and wellbeing in Sheffield. The outcome has eight key actions and is supported by nine indicators. This report sets out:

- What has happened under each action over the past year and any issues and opportunities for the action in the year to come.
- Areas where the Health and Wellbeing Board can make a difference.

Recommendations: Health and Wellbeing Board members are invited to:

- Actively support the recommendations made under each action in the report.
- Discuss in depth and pay particular attention to the following areas:
  - How the Council and city-wide partners can be encouraged to support the Move More programme and promote physical activity, particularly in the built environment.
  - What a refreshed approach to regulating e-cigarettes and tobacco control could look like.
  - How the Council's licensing powers can be utilised to support healthy alcohol consumption in the city.
  - How emotional wellbeing and resilience can be more promoted across the city.
- Support the ongoing programme of needs assessment.
- Request another update on this outcome in December 2015.

Background Paper: Sheffield Joint Health and Wellbeing Strategy 2013-18

Sheffield Health and Wellbeing Board
Update on the Joint Health and Wellbeing Strategy

Outcome 2 – Health and wellbeing is improving

December 2014

1. What is this outcome about?

This outcome focusses on specific aspects of children's and adults' health and social care and the wider determinants of health to improve health and wellbeing in Sheffield. Health in Sheffield has improved significantly in the past few decades. People in all parts of the City are living longer and deaths from major illnesses, especially heart disease and cancer, have reduced. However, there are a number of areas of concern, such as infant mortality rates, unhealthy lifestyles and poor mental health and wellbeing that will require concerted action over the coming years if this trend in improving health and wellbeing is to be maintained.

The outcome is split into two main themes:

- Emotional wellbeing.
- Living longer.

It is supported by nine outcome indicators which are set out in more detail in Appendix A. The outcome also has connections with the city's Health Inequalities Action Plan.

2. How are we performing? – Indicators for outcome 1

Section completed by Louise Brewins, Head of Public Health Intelligence, Sheffield City Council

Although the indicators of overall health (as measured by life expectancy and preventable mortality) continue to improve in Sheffield we still lag behind the average for England and, in some cases, a number of the core cities. For three indicators however (smoking, childhood obesity and breastfeeding) figures are relatively static whilst for alcohol-related admissions and depression, they are worsening.

Given the difference in time periods for which data are available and the time lag involved in the impact of lifestyle and behaviour on disease frequency and hence mortality and overall life expectancy, we are unlikely to see the full effect of any positive or negative changes in lifestyle and behaviour for several years to come. Our focus should remain fixed therefore on prevention and early intervention particularly in relation to health behaviours and risk factors for disease.

Further information about these indicators can be found in Appendix A.

3. What do we need to know? – Developing the evidence base for outcome 2

Section completed by Louise Brewins, Head of Public Health Intelligence, Sheffield City Council

The Joint Strategic Needs Assessment highlighted a number of areas where further, more detailed needs assessment and analysis would be undertaken or where further work was required:

- In-depth analytical work is being undertaken to identify and understand variation in relation to the main causes of ill health and early death. This includes cancer, cardiovascular disease and liver disease. A key focus for this work is 'preventable years of life lost' which seeks to ensure prevention and early intervention programmes achieve maximum impact on reducing premature

death and increasing healthy life expectancy. In addition, the highly detailed analysis for the Council's infant mortality strategy (relating to risks, causes, trends and patterns) has recently been updated (June 2014).

- The following four health needs assessments (HNAs) have been completed: older people in care homes; sensory impairments; emotional and mental wellbeing of children and young people; and children and young people with complex needs. All four HNAs have been published on the Council's website. These HNAs are now being used to underpin commissioning within relevant service areas. A fifth HNA in relation to autism is currently in production and initial preparatory work for an adult mental health HNA has commenced.
- A health equity audit of service access, usage and (physical health) outcomes for people with learning disabilities (and potentially neurological conditions) will commence shortly.

4. Examining the outcome, action by action

Theme: Emotional wellbeing

Sheffield children, young people and adults to be emotionally strong and resilient, and for emotional wellbeing to be promoted across the city.

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.

Section completed by Chris Nield, Consultant in Public Health and Bethan Plant, Public Health Principal, Sheffield City Council

1. **What progress has been made with this action over the past year?**

- The Emotional Wellbeing Steering Group has been established to plan and deliver the Joint Health and Wellbeing Strategy's emotional wellbeing work programme.
- There have been a focus on the promotion and increased knowledge and awareness of Emotional Wellbeing and resilience including a '5 Ways to Wellbeing' campaign was undertaken in Sheffield City Council; a public 'wellbeing festival' on took place on Fargate in July; the recently awarded opiates contract includes a recommendation that '5 ways to wellbeing' is included in the brief interventions offered to clients.
- We have continued to develop capacity to identify mental health problems across the population through the training in Mental Health First Aid and Mental Health skills for line managers
- Community Wellbeing Programmes use a community asset based approach to reduce health inequalities and improve health and wellbeing by increasing social capital and community resilience. Last year there were 21,258 beneficiaries and 68,173 points of contact. The Community Wellbeing Programme along with the related Health Trainers and Community Health Champions programmes has continued to develop and achieve positive mental health and wellbeing outcomes.
- We have continued to develop a programme to be a Dementia friendly city. This work is undertaken by the Sheffield Dementia Action Alliance was established in April 2013.
- Children and Young People's Emotional Wellbeing and Mental Health is one of the work streams for the Children's Health and Wellbeing Partnership Board. Work has included a comprehensive Health Needs Assessment; the Right Here programme; redesign of Best Start with a focus on Emotional Wellbeing and Mental Health, Schools Emotional Wellbeing Pilot; Bullying Review and PSHE Review. They have also informed the commissioning of an Emotional Health and Wellbeing Service (see Action 2.2).

2. **What are the main issues and opportunities for this action?**

- There is an opportunity to influence this agenda strategically. Wellbeing adds years to life; improves recovery from illness; is associated with positive health behaviours in adults and children, and with broader positive social outcomes; and affects how staff and health care providers work. The opportunity is to embed this understanding within strategic thinking and commissioning strategies. Public Health England is due to issue a new framework which will support this approach.

- The Council is including a corporate approach to 5 ways to wellbeing in development of the corporate plan. This will increase awareness and understanding and will help influence services to maximise their impact on wellbeing.
- Suicide Prevention emotional wellbeing and early intervention are important in preventing crisis. There is an opportunity to link this work to plans to develop a city wide approach to suicide prevention.
- Over 12,000 of Sheffield's most socially isolated older people will benefit from a £6 million grant from the Big Lottery Fund. This 6 year programme starts in 2015 and is led by South Yorkshire Housing Association will in partnership with other organisations.
- The Children and Young People's Emotional Wellbeing Health Needs Assessment found that Universal EWBMH provision and early intervention or 'early help' is broad and complex. There is a challenge to articulate this better within universal services so that the impact of interventions can be better understood. The boundaries and pathways between different levels of provision are not clear.
- There is a challenge to protect investment (human and financial resource) in universal Emotional wellbeing, prevention and early intervention as the whole system is under-capacity.

3. **What can the Health and Wellbeing Board, or its members, do over the next year?**

- Board members could champion the importance of emotional wellbeing and use their strategic influence to embed this approach in policies and strategies.
- Board support for development of citywide work on suicide awareness and prevention would help to progress this important area of work.
- Facilitate joint working across children's and adults services, including joint strategic leadership.
- Support the involvement and participation of children and young people in the design, commissioning and evaluation of children and young people's services as a matter of principle.

Action 2.2: 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.

Section completed by Bethan Plant, Public Health Principal, Sheffield City Council

1. **What progress has been made with this action over the past year?**

- A Children's Emotional Wellbeing and Mental Health Needs Assessment has been published.
- An Emotional Wellbeing School Pilot was carried out.
- MAC UK (mental health charity specialising in working with gangs and youth violence) led a stakeholder review of the mental health system in Sheffield from the perspective of the most vulnerable children and young people. This found a strong consensus for a team around the keyworker approach to support mental health, where the worker 'bridges' a relationship to another professional as opposed to referring them on.
- Findings from the Right Here programme were published.
- The above work has informed the development of a specification for universal and targeted emotional wellbeing provision due to commence in April 2015. The service will continue the Emotional Wellbeing pilot in 3 families of schools as part of the MAST Integrated Hubs in order to inform continued learning and development. The service will also provide a citywide targeted service linked to Community Youth teams and the Young Carers Support Service.
- The Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee have reviewed Child and Adolescent Mental Health Services (CAMHS) provision and produced a comprehensive report and recommendations (November 2013). Sheffield City Council, NHS Sheffield Clinical Commissioning Group and Sheffield Children's NHS Foundation Trust are responding to the recommendations and a CAMHS Action Tracker has been developed in order to monitor progress. Council Members have requested a written response/paper to the Health and Wellbeing Board as a result of the scrutiny process, detailing how changes are going to be implemented and improvements made, with a particular focus on transition and delivery of an age appropriate 16-17 year old CAMHS service.

2. **What are the main issues and opportunities for this action?**

- The emotional wellbeing service is being commissioned in a period of strategic and operational changes in the provision of emotional wellbeing and mental health services for children and young people. The rationale for the service model is to protect existing levels of provision for vulnerable children and young people while enabling development work through the continued schools pilot. The service will be expected to be flexible and adapt to changes in the local system.
- There is a clear opportunity to develop a working model for universal and targeted emotional wellbeing and mental health provision that sits within both the wider mental health system and the wider health and social care prevention and early intervention system.
- There is a clear need to develop age appropriate CAMHS/emotional wellbeing and mental health provision for 16-17 year olds.

3. **What can the Health and Wellbeing Board, or its members, do over the next year?**

The Health and Wellbeing Board can support this work by supporting a 'system-wide' approach to Emotional Wellbeing and Mental Health which encompasses universal, targeted and specialist provision across children's and adult's services.

Action 2.3: 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.

Section completed by Candi Lawson, Service Manager, Sheffield City Council

1. **What progress has been made with this action over the past year?**

Work has been progressing on the Parenting Strategy:

- The Best Start Sheffield redesign of Early Years provision is focusing on positive parenting and developing resilient families.
- Evidence Based Parenting Programmes are delivered across the city, predominately by the MAST team. These include:
    - Generic universal parenting programme for parents of children 0-12.
    - Generic universal parenting programme for parents of teenagers.
    - A targeted parenting programme for parents of children 0-12 who are deemed as needing additional support. The programme addresses family adversity such as parental depression, stress and relationship conflict.
    - A targeted programme for parents of children 0-16 who require intensive support particularly focused on developing specific coping strategies for managing difficult emotions including parental anger, depression, anxiety and high levels of parenting stress at high risk times.
    - A targeted parenting programme for parents of children 0-12 who have a child with disability.
    - A targeted programme for parents of children 0-16 who are in conflict including those who are separating or who are separated.
    - A universal programme for parents of children 0-12 months.
    - A universal programme for parents of children 1-2 years.
    - A universal parenting programme for parents of children aged 2-8 years.
- The range of programmes on offer enable us to respond to specific needs. Each programme is evaluated using a range of routine outcome measures, which are in the form of questionnaires used to measure impact at the beginning and end of the programme.
- We are progressing work to ensure that we deliver high quality evidence based parenting programmes across the city, making best use of staffing resources and identifying unmet needs that need to be responded to. New developments detailed below respond to identified need in the city. I.e. support for families where a parent is in prison, and work with parents and young people where there is violence.
- We plan to build upon partnerships with Schools, GPs and community and voluntary sector organisations in order to target programmes for specific communities. Programmes are currently targeted where there is an identified need and this year the service has delivered programmes for the Bangladeshi community in Darnall, the Somali Community, and targeted programmes into schools. Interpreters are used where needed and where transportation or childcare is a barrier to attendance, parents have been supported with this.

Work has been progressing on the Parent Matters Strategy:

- IAPTS (Improving Access to Psychological Therapies): In 2014/15 this project will see 2 Specialist workers trained in the Parenting element of IAPTS at Northumbria University and working with the management team in Sheffield to look at opportunities for service transformation.

- Children affected by parental imprisonment: Barnardo's has been commissioned to develop a guide for professionals in working with the families of people in prison. This will be launched in the coming months together with a strategy for supporting families across city. A 'Hidden Sentence' training programme to raise awareness of the impact on families of parental imprisonment has been rolled out across city. We continue to develop this with further training planned for MAST and partners over the next 12 months.
- Teenage Violence Against Parents: MAST, Community Youth, and Youth Justice teams are working in partnership to develop a new programme for teenagers and their parents where there is violent behaviour from the teenager towards the parent. This programme is set to launch with a pilot in February 2015.
- Domestic Abuse: One full time Parenting Specialist with a lead for Domestic Abuse has been employed within the MAST team. We are now in the process of exploring options for Parenting Programmes to target parents of children who have experienced domestic abuse. Work is ongoing between MAST, Community Youth, and the Safeguarding Training team to deliver awareness raising training regarding peer on peer abuse. This work is in conjunction with the Misunderstood Project.
- Family Group Conferencing Team: Between April 2013 and the end of March 2014 the team had received 60 requests for support, 32 of which have progressed to conference. Work is now underway to explore the options for expansion of the team as a preventative model.
- Workforce Development: A programme of workforce development is available for staff to support their delivery of one to one case work and Parenting Programme delivery.

2. What are the main issues and opportunities for this action?

- The delivery of Parenting in Sheffield is well established. There is now an opportunity to develop targeted programmes and projects that respond to local need. We also have an opportunity to consider the marketing and promotion of parenting programmes to ensure the service is accessible to families from all backgrounds.
- An ongoing challenge to the delivery of Parenting Programmes is the availability of accessible and affordable venues.
- We are currently exploring opportunities for working more closely with a range of partners such as other council departments and services, GP surgeries, early years and health services, and schools.

3. What can the Health and Wellbeing Board, or its members, do over the next year?

- Note the progress made and acknowledge the value of support to parents in order to develop resilient families and communities.

Theme: Living Longer

Sheffield children, young people and adults to be living healthily – exercising, eating well, not smoking nor drinking too much alcohol – so that they are able to live long and healthy lives.

Action 2.4: Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.

Section filled out by Ollie Hart, GP and Chair of the Move More Board

1. What progress has been made with this action over the past year?

- A Move More plan has been co-produced by city wide stakeholders and signed off by the Food and Physical Activity Board. It is a well evidenced blueprint for a 5 year culture change program. It underpins the city's vision to develop into the most physically active city in the UK by 2020.
- We have recruited a full time Move More Officer, with sole remit of implementing the plan.
- There is a Move More board with 21 volunteer members, that provides oversight and scrutiny for the implementation process.
- The Move More plan details 6 main workstreams:
    - Empowering communities: We conducted training for 90 key people to agree and embed an asset based approach to developing physical activity in the communities of the city. Out of this has sprung a Move More ambassadors program. We feel that empowering communities is key to a bottom up ownership of the vision.
    - Physical activity as medicine: This is an ambitious plan to use the 3 National Centre for Sports and Exercise leisure centres to provide platforms for co-location of health clinics within centres of excellence for physical activity. Much work has been done to agree and implement building of these centres (first already onsite and due completion by March 2015; the other two are at planning stage and due to complete in March 2016). In parallel we are looking to see clinics relocating from hospital trusts into these centres. We are also commissioning redesign work around musculoskeletal conditions, with improving physical activity levels being identified as a key outcome measure in a new 'outcome based' contract for this significant program budget area.
    - Active Schools and pupils: We are piloting an innovative system to engage schools in using feedback from movement sensors, and mobile phone technology. Teachers are looking at ways to incorporate this learning into the curriculum. We are working with Sheffield Institute of Education at Sheffield Hallam University on a PE in primary school strategy
    - Active workplaces / workforce: The last year has seen a pilot of wellness at work program for NHS employees (n=300). This has been recognised by NHS England who are interested in national roll out. Learning from this is being rolled out in a wider offer to businesses in the city.
    - Active people: All of the other areas contribute to this workstream. Much work has been done through the Move More officer to develop online resources to support information sharing and networking. This includes an activity finder, asset mapping of the city, and promotion of groups and events. The communications and promotions have been co-ordinated under the 'Move More brand'.
    - Active environments: This workstream requires adoption of the principles of the Move More plan into the development of the physical infrastructure of the city. We know this

will take time, but at the moment this area lacks penetration into the key departments in the Council and private sector. This area stands to have a significant impact in creating environments that encourage and facilitate movement.

2. What are the main issues and opportunities for this action?

- Universal buy in and ownership of the Move More vision and plan across a wide spectrum of organisations and businesses.
- The project needs champions at senior level in all organisations to sustain the initial momentum generated.

3. What can the Health and Wellbeing Board, or its members, do over the next year?

- Use its influence to promote and embed the vision and plan in all areas of policy and society. This work now needs widespread drive.
- We would like to see the Health and Wellbeing Board hold the city accountable to achieving targets to increase physical activity, and realise the associated health, wellbeing and economic benefits.

Action 2.5: 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.

Section filled out by Lynsey Bowker, Public Health Principal, Sheffield City Council

1. What progress has been made with this action over the past year?

A comprehensive programme of tobacco control to reduce smoking prevalence within Sheffield was launched on 1 April 2014. The three year programme is based on best evidence from the World Health Organisation, a comprehensive consultation with key stakeholders and based on local health need. The programme comprises six services, which together, in partnership aim to reduce smoking prevalence amongst adults, pregnant women and children (in line with the Public Health Outcome Framework indicator targets). The services are delivered by a range of private, public and VCF provider organisations. The providers are brought together on a quarterly basis in a 'Tobacco Control Hub' to share learning and develop a common tobacco control brand for the city.

The newly commissioned tobacco control programme is as follows:

1) Smokefree Service, with prioritised action amongst population groups with the highest smoking prevalence, most addicted and need the most support to quit smoking, including residents living in the 20% most deprived areas of the city, certain BME groups and those with a diagnosed mental health condition
2) Smokefree Spaces Service, to protect children under five and families from exposure to harmful tobacco smoke in homes and cars and help denormalise tobacco use within communities
3) Smokefree Children and Young People, to reduce smoking prevalence amongst young people by introducing a 'whole school approach to tobacco control' including Smokefree lessons and support for young people and staff who smoke.
4) Community development action for illegal tobacco, raising the harm caused within communities and how illegal tobacco encourages and actively enables young people to become 'hooked' on cigarettes, and remain smoking into adulthood.
5) A programme of marketing and communications for tobacco control, cross cutting all strands of the tobacco control programme. The provider is commissioned to deliver three campaigns each year. This service is delivered in partnership with Doncaster and Rotherham Councils.
6) A stop smoking relapse prevention service for pregnant women – to help women remain Smokefree post pregnancy (please note, the procurement programme for this service is currently underway, with the service due to launch 1 January 2015).

This programme sits alongside a number of pre-established tobacco control initiatives, the stop smoking service for pregnant women, delivered by STHFT Maternity Services and tobacco control enforcement action for illegal tobacco, provided by Sheffield City Council, Trading Standards.

2. What are the main issues and opportunities for this action?

The introduction of a comprehensive programme of tobacco control will ensure the city has comprehensive strategy in place to reduce smoking prevalence and the harm caused by tobacco across all communities in Sheffield.

An increase in the use of e-cigarettes has had a considerable impact on numbers accessing the Smokefree Services for support to quit. Obviously this is not unique to Sheffield but is an issue being faced across the country. In Sheffield, at this stage, we are not considering stop smoking service as being non-viable because evidence clearly points to them providing the best overall success rates and we cannot let down those smokers whose lives would be saved by them. However we are working locally with tobacco control partners to harness the potential health gain associated with e-cigarettes as a harm minimisation tool. Alongside which we are also working to improve service uptake by increasing marketing and communications whilst introducing 'new routes to quit', including telephone support, quitting online and a greater use of social media to make the service more accessible to smokers who want to quit.

The reduction in the number of smokers accessing stop smoking services as a means of quitting requires us to identify alternative approaches to tobacco control. It also provides us with an opportunity to redirect resource into proven cost effective areas such as media work and enforcement activity.

3. What can the Health and Wellbeing Board, or its members, do over the next year?

In line with recommendations included in the Health Inequalities Action Plan, Health and Wellbeing Board members should ensure that as a city we uphold principles outlined in the Local Government Declaration on Tobacco Control, signed by Sheffield City Council in January 2014. Key actions for Board members should include:

- Continually 'Making Every Contact Count' acting at a local level to reduce smoking prevalence, this could include routinely promoting the benefits of stopping smoking and Smokefree issues to help denormalise tobacco use within communities and promote 'Smokefree' as the new social norm and referring to stop smoking services.
- Raise the profile of the harm caused by smoking in communities, including the impact of the sale and distribution of illegal tobacco.
- Continue to develop plans with our partners to address the causes and impacts of tobacco use.
- Support new ways to address the scourge of tobacco, using any resource released from a reduction in stop smoking services activity.
- Ask the South Yorkshire Pensions Authority to review its investment in tobacco.

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.

Section filled out by the Drugs and Alcohol Coordination Team and Janine Dalley, Young People's Commissioning Manager for Substance Misuse, Sheffield City Council

1. What progress has been made with this action over the past year?

- Sheffield Drugs and Alcohol Coordination Team (DACT) has successfully implemented the Commissioning and Procurement Plan for community drug and alcohol services. The Cabinet approved the DACT's plan for three end to end services for Opiates, Non-Opiates and Alcohol in January 2014 and they were successfully awarded in July 2014. Services for Opiates and Non Opiates went live on 1st October 2014. A decision has been reached to delay the tender for Alcohol Services to allow opportunities for integrated commissioning with the CCG to be explored and a waiver has been secured to this end.
- The Drug Interventions Programme (DIP) continues to provide an effective link between the criminal justice and substance misuse systems with 26% of all clients in structured treatment in Sheffield coming from the criminal justice system. DIP and other DACT interventions provide identification, assessment, harm reduction and engagement services into both drugs and alcohol services.
- The Children and Young People's Public Health Team are continuing to coordinate and contract manage the young people's substance misuse service which is currently delivered as part of an integrated delivery model with Community Youth Teams. This service provides targeted and specialist substance misuse treatment and interventions as part of holistic packages of care that aim to minimise harm and reduce associated risks and presenting issues.
- The Novel Psychoactive Substances (NPS 'legal highs') multi-agency steering group has developed a strategic plan which coordinates activity across key agencies and all age groups. This aims to reduce the supply of, and minimise harm from NPS across the city.
- What About Me (Hidden Harm) is a therapeutic programme of harm reduction and resilience building for children and young people where familial or significant others substance/alcohol misuse is having a direct negative impact on their lives. This service is currently out to tender for a three year contract as one 'lot' of a 'vulnerable children young people' tender process. The new service will commence April 15.

2. What are the main issues and opportunities for this action?

- The new contract for What About Me (Hidden Harm) will offer further development of a 'whole family approach' to improving outcomes for children affected by familial substance/alcohol misuse.
- Sheffield is performing significantly better than the national average in the number of alcohol specific hospital admissions for under 18's but worse in alcohol specific mortality amongst males, admission episodes for alcohol related conditions and binge drinking[1]. – Liver disease is the only major cause of death the incidence of which is increasing.
- There are opportunities to use licensing powers, as well as planning consents and other regulatory approaches, to limit the availability and increase the price of alcohol in the City.

[1] Local Alcohol Profiles for England (LAPE)

- The development of integrated commissioning between the Council and the CCG in the Better Care Fund offers a new opportunity to refresh our approach to commissioning alcohol prevention and treatment services.
- Recent changes to provider organisations including the division of the Probation Service and the subsequent changes to delivery structures has led to a number of strategic reviews of integrated working with partner organisations, more effectively targeting a broader range of substance misusing offenders.

3. What can the Health and Wellbeing Board, or its members, do over the next year?

- Continue to support the DACT in fulfilling its remit, undertaking the procurement as agreed by Cabinet.
- Request that a new alcohol strategy be prepared and a refreshed approach to the commissioning of alcohol treatment and prevention services be developed.

Action 2.7: 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.

Section filled out by Sheila Paul, Consultant in Public Health, Sheffield City Council

1. What progress has been made with this action over the past year?

- An extensive consultation was carried out with potential providers and stakeholders prior to completing children and young people and adult healthy weight management service specifications and procuring the following services:
    - 0-4 Early Years: the evidence-based HENRY (Health Exercise and Nutrition for the Really Young) intervention is now being delivered via CYPF early years services to enable babies and young children to have a healthy start in life with a specific focus on exercise, nutrition and parenting skills. This is a new service as a result of securing resource to provide support and offer a 0-17 weight management service pathway.
    - 5-17 Tier 1 and Tier 2 children and young people's service: the specification includes the requirement to work with primary and secondary schools (targeted using NCMP data) to support them to develop whole school approaches on food and physical activity. Plus lifestyle weight management support for overweight children and families.
    - Tier 1 and Tier 2 adult weight management service: Brief intervention support and training for front line staff plus lifestyle weight management support for overweight adults.
    - Tier 3 adult weight management service: clinical service for adults with high BMIs.
    - The procurement process currently underway with services expected to commence April 2015.

- The National Child Measurement Programme (NCMP) has continued. Sheffield rates of participation in academic year 2013/14 have increased:
    - 98.3% of children aged 4-5 participated compared to 96.9% last year.
    - 97.3% of children aged 10-11 participated compared to 96.9% last year.

- To support the joint plan and integrated pathway to tackle childhood obesity prevalence, the Sheffield School Nursing Service continues to provide pro-active feedback to parents/carers informing them of their child's NCMP results. Those children who are identified as very overweight are offered direct referral into the lifestyle weight management services. An additional (CQUIN) target has been set for the School Nursing Service to prioritise and support 15 primary schools with high obesity prevalence, to develop whole school approaches on food and physically activity. This includes providing advice to parents/carers and supporting schools to implement NCMP.

2. What are the main issues and opportunities for this action?

- From 1st April 2015 Sheffield will have a Healthy Weight Management pathway which covers pre-conception through to adulthood.
- To commission this pathway as a whole, public health spend has been rebalanced to focus more on prevention and earlier intervention. Remaining services are in the process of being commissioned.
- Once in place, integrated pathways will be developed to ensure links to Move More, Activity Sheffield, Health Trainers, Food Strategy and others.

- By having a comprehensive Tier 1 and Tier 2 service for Adults and Tier 1 and 2 service for children, all frontline staff working with children, young people and adults will receive training and education which will ensure a consistent message is given, overweight and obesity is identified early and people are referred and supported quickly and at an appropriate level to their needs.

3. What can the Health and Wellbeing Board, or its members, do over the next year?

- Continue to advocate for healthy weight as a city priority.
- Promote and support the work taking place which directly relates to healthy weight management. For example, enable frontline staff (e.g. GP practice staff, secondary care Nurses) to attend brief interventions training and to incorporate this into practice.
- Support public health initiatives that indirectly contribute to the agenda, for example, 20mph areas, playing out schemes, including regular road closures to allow for active play, improvements to school food, ensuring that public sector catering provides healthy and sustainable food etc.

Action 2.8: Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.

Section filled out by Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield CCG

1. What progress has been made with this action over the past year?

- In relation to both cardiovascular disease and cancer prevention, all of the City Council-led public health work to reduce tobacco consumption, increase physical activity and improve diet in the Sheffield population is highly contributory to reducing preventable years of life lost to these diseases in the city. Indeed much of the progress with reducing the impact of these diseases is attributable to improvements in these causal risk factors.
- In terms of cardiovascular disease specific action, over the past year the CCG has focused efforts in three areas of especially high risk that have strong evidence for early preventive impact: i) stroke prevention in atrial fibrillation (AF), ii) improved detection and treatment of chronic heart failure (CHF), and iii) improved detection and treatment of familial hypercholesterolaemia (FH).
- Atrial fibrillation is a relatively common cardiac condition that puts people at significantly increased risk of suffering a stroke, but for which a range of effective anticoagulation (blood thinning) treatments are available that can measurably reduce stroke incidence within a year or two. However, there are complications with the use of these drugs and nationally only around half of the high risk individuals receive effective anticoagulation. The CCG's medicines management and development nurse teams have been supporting all practices in the city over the last year with improving their rates of effective prescribing, the result of which has been to increase the proportion from 50% to 63.5% currently (previous efforts having seen only single percentage point increases). Regarding CHF, the CCG has continued to build on a new diagnosis and treatment pathway, evaluation of which has demonstrated increased detection of heart failure and improved treatments. This last year has seen the introduction of a new service for families having FH, an inborn genetic disorder that carries a very high cardiovascular risk. This has involved establishing a specialist hospital clinic (supported by a grant from the British Heart Foundation), which provides genetic testing and screening for families carrying the genetic risk (expected population prevalence of 1 in 500).
- With reference to cancer, there are nationally run screening programmes for breast, cervical and bowel cancer, and regionally co-ordinated work on implementation. The CCG has supported the Be Clear on Cancer campaign which in February to March this year focussed on breast cancer in women aged over 70, and in March ran on lung cancer, in the national press, radio and out of home media. There has also been a Blood in Pee campaign in October to November 2014 and the CCG supported this through press releases and via general practice.
- Bowel Scope Screening Programme is a new national screening programme and men and women will be invited for a 'one off' Bowel Scope Screening around the time of their 55th birthday. Bowel Scope Screening is via a flexible sigmoidoscopy which looks at the inside of the lower bowel and it will be offered in addition to the Bowel Cancer Screening Programme which starts at 60 years. This starts in Sheffield in December 2014 and is strongly supported by the CCG.
- Working in partnership with Sheffield Action for African-Caribbean Health (SAACH), Public Health has received funding from Prostate Cancer UK to explore a strategy for engaging African-Caribbean men and their partners in an effective way. They are working with pre-existing social networks to encourage men to discuss prostate cancer with each other so that ultimately men within networks will be more likely to encourage each other to look after themselves. They also hope to do follow up work to assess whether the initiative has made any impact on men's help-seeking behaviour but will need to secure additional funding to do this.

- Sheffield GPs also have direct access to a number of diagnostic services, including Non-obstetric ultrasound (for ovarian cancer), Chest X-ray (for lung cancer), and Flexible sigmoidoscopy (for colorectal cancer) which supports early diagnosis.

2. What are the main issues and opportunities for this action?

Preventable years of life lost in Sheffield has been improving at a rate broadly in line with England. Cardiovascular disease accounts for the largest share of the preventable mortality burden in the city but within this, life years lost to coronary heart disease has remained persistently above England and the gap is not closing.

Amenable cancer on the other hand is in line with England, but the rate of decline is not nearly as rapid as for coronary heart disease. It is relevant therefore to maintain a focus on heart disease in particular and cancer, the modifiable risk factors, and high-risk groups such as people having mental illness who are at especial risk of the disease.

3. What can the Health and Wellbeing Board, or its members, do over the next year?

It is recommended that the Board maintains the focus on cancer and cardiovascular disease. Smoking remains the biggest modifiable risk factor for both disease groups, and for inequalities in the diseases. Therefore partners should consider how they can contribute to levering up actions to tackle smoking and tobacco consumption in the city in a measurable way, particularly amongst disadvantaged groups.

NHS partners should include in their plans further actions to improve cardiovascular disease and cancer prevention through commissioning opportunities, and through improvements in treatments and clinical quality. The CCG will encourage more joint work between screening programmes and general practice, with a focus on more disadvantaged groups. Specific account should be taken in relation to improving the physical health of people living with mental illness; smoking being a significant factor here too.

5. Appendix – More information about the outcome indicators

1. **Indicator:** Men's life expectancy
   Definition: Average life expectancy at birth in years (males)

	2008-10	2009-11	2010-12
Sheffield	78.1	78.4	78.7
England	78.6	78.8	79.2
Core City Rank (1 is best)	1	1	1

2. **Indicator:** Women's life expectancy
   Definition: Average life expectancy at birth in years (females)

	2008-10	2009-11	2010-12
Sheffield	81.8	82.1	82.4
England	82.6	82.8	83.0
Core City Rank (1 is best)	3	2	2

3. **Indicator**: Preventable mortality
   Definition: Mortality from causes considered preventable. Directly age standardised rate per 100,000 population

	2008-10	2009-11	2010-12
Sheffield	206.6	202.6	196.4
England	201.5	193.8	187.8
Core City Rank (1 is best)	1	1	1

4. **Indicator**: Infant Mortality
   Definition: Three year pooled rate per 1,000 live births (based on year of death) Infants under 1 year.

	2008-10	2009-11	2010-12
Sheffield	4.8	4.9	4.6
England	4.4	4.3	4.1
Core City Rank (1 is best)	3	5	4

5. **Indicator**: Depression[1]
   Definition: Percentage of patients aged 18 years and over with a new diagnosis of depression in the preceding 1 April to 31 March (Quality and Outcomes Framework).

	2011-12	2012-13	2013-14
Sheffield	N/A	6.93%	7.43%
England	N/A	5.84%	6.52%
Core City Rank (1 is best)	N/A	7	7

[1] The method for calculating prevalence of depression has changed. Only the figures for 2012-13 and 2013-14 are directly comparable.

6. **Indicator**: Smoking[2]
   Definition: Estimated prevalence of smoking in the adult population (18 years and over) from the Integrated Household Survey.

	2010	**2011**	**2012**
Sheffield	23.8%	19.5%	23.2%
England	20.8%	20.2%	19.5%
Core City Rank (1 is best)	4	1	4

[2] The method for calculating prevalence of smoking was introduced in 2010. There were known methodological problems in 2011 which will account for the apparent drop that year. The estimate for 2012 is considered more reliable.

7. **Indicator**: Eleven year olds overweight and obese
   Definition: Percentage of Y6 children (aged 10-11 years) who are overweight or obese

	2010-11	**2011-12**	**2012-13**
Sheffield	34.5%	33.6%	33.7%
England	33.4%	33.9%	N/A
Core City Rank (1 is best)	3	2	N/A

8. **Indicator**: Alcohol related admissions to hospital
   Definition: Directly age standardised rate per 100,000 population.

	2010-11	**2011-12**	**2012-13**
Sheffield	698.3	672.9	706.1
England	651.9	652.8	636.9
Core City Rank (1 is best)	1	1	3

9. **Indicator**: Breastfeeding at 6-8 weeks
   Definition: Percentage of babies receiving breast milk at 6-8 weeks after birth

	2011-12	**2012-13**	**2013-14**
Sheffield	49.5%	50.9%	49.5%
England	47.2%	47.2%	N/A
Core City Rank (1 is best)	3	2	N/A

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield CCG and Joe Fowler, Director of commissioning, Sheffield City Council
Date:	11 December 2014
Subject:	Update on the Integrated Commissioning Programme (Better Care Fund)
Author of Report:	Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield CCG

Summary:

Attached is a brief update on progress with integrated commissioning. Key points to note are:

- Sheffield has been successful in a bid to the Government "Transformation Challenge Award" that will bring around £1m into Sheffield to support the Keeping People Well in their Communities work.
- Business cases for change in three of the four areas are being developed for consideration by the Integrated Commissioning Programme Board on 18th December.
- A draft version of the Pooled Budget Agreement, which will set out how we make decisions, manage the pooled budget and share risk and benefits, will also be considered by the ICP Board on that date.

Recommendations:

The Health and Wellbeing Board notes progress and confirms its support for the establishment of integrated commissioning and a pooled budget, as set out in the report.

INTEGRATED COMMISSIONING PROGRAMME (BETTER CARE FUND)

1. Introduction

Sheffield CCG and Sheffield City Council have agreed to establish a pooled budget in 2015/16 to cover four key areas of work, with the aim of improving service user experience and outcomes and making the best decisions about the use of the resource available between us. The four areas of work are:

- Keeping People Well in their Community
- Independent Living Solutions
- Active support and Recovery
- Long Term High Support

The proposed pooled budget includes our current expenditure in those areas, including CCG expenditure community equipment, intermediate care services, community nursing and Continuing Health Care. It also includes our expenditure on non elective admissions (other than surgical admissions) as our plans should result in movement of money – and savings – from this area.

This report summarises the current position on developing the pooled budget and the service plans the pooling of budgets will enable.

2. Key Developments

Keeping People Well in their Communities

Sheffield has been successful in our bid for around £1m from the Government's Transformation Challenge Award, which will support the development of capacity in communities to help people stay well and reduce the risk of problems that could result in increased demand for health or social care. The business case and implementation plan for the use of this money will be considered by the Integrated Commissioning Programme Board in December. The implementation plan will be based on identifying local practice/VCF partnerships to work with to form coherent local arrangements designed to help people keep well.

Independent Living Solutions

The tendering process for this re-designed service – replacing the current Sheffield Community Equipment Loans Service and expanding the offer to include more 'self-help' information and advice – is now underway. A new service will start on 1st July 2015.

Developing the section 75 agreement

It is, of course, critically important that we agree and document how we will make decisions and share risk on the pooled budget. Senior officers from both organisations are discussing a number of issues, to be able to propose arrangements to Governing Body and SCC's Cabinet, to be presented in January or February 2015.

Integrated Commissioning Programme Board

A formal Programme Board has now been established to oversee the development of the commissioning projects and the pooled budget arrangements. This met for the second time on 23 October and agreed the scope for the Active Support and Recovery project (covering intermediate care and other community services, potentially including community nursing) and the Long Term High Support project (proposing integration of assessment and care management, procurement and contract management, initially focussing on gains to be achieved in contracting).

The meeting on 18th December will consider business cases for change in three of the service areas (the case for change for Independent Living Solutions having been considered and approved already) and will consider a draft of the section 75 agreement.

National Assurance

Sheffield submitted details of our plans, in line with Department of Health requirements in September. We have now received confirmation that our plans have been Approved With Support, with final approval – and therefore release of the part of the CCG's allocation that is the Better Care Fund funding –subject to us providing details of our cases for change, our risk sharing arrangements, how we are engaging with providers, and final metrics for the scheme. All of these are in hand, and are necessary in any event to enable informed decisions locally about final agreement. We expect to receive final approval in January 2015.

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield CCG (and Chair of the Mental Health Partnership Board)
Date:	11 December 2014
Subject:	Sheffield Strategy for Mental Health (Draft)
Authors of Report:	Robert Carter (Clinical Commissioning Group) and Stephen Todd (Sheffield City Council)

Summary:

Attached is the draft of the *Sheffield Strategy for Mental Health* developed by the Mental Health Partnership Board. This strategy covers both the promotion of good mental health and treatment and care for people with mental health problems. It builds upon on the previous city strategy for mental health, published in 2009, and the national guidance that has been published in recent years.

Questions for the Health and Wellbeing Board:

Does the Board recognise the principles and priorities set out for the city and consider that the document as drafted will inform and guide the provision of appropriate mental health service provision over the next 5 years?

Recommendations:

That the Board endorses the work of the Mental Health Partnership Board in developing the Sheffield Mental Health Strategy, offers comments on the draft, and supports the work of the MHPB in finalising and publishing this strategy.

Background Papers:

Draft Sheffield Strategy for Mental Health

SHEFFIELD STRATEGY FOR MENTAL HEALTH (DRAFT)

1. Introduction

The draft of the *Sheffield Strategy for Mental Health* was developed by the Mental Health Partnership Board. This strategy covers both the promotion of good mental health and treatment and care for people with mental health problems. It builds upon on the previous city strategy for mental health, published in 2009, and the national guidance that has been published in recent years.

The Health and Wellbeing Board work programme on mental wellbeing is recognised and identified as a priority in this strategy, and the Mental Health Partnership Board will oversee the development and delivery of that work programme, as requested by the Health and Wellbeing Board.

The strategy does not contain an action plan. Instead, the Mental Health Partnership Board (MHPB) plans to ask all mental health organisations to respond to the strategy, stating what they will do to achieve its ambitions, and to act as a forum for organisations to hold each other to account for delivery of those actions, and for users/carers to hold us all to account.

The Strategy identifies a set of core principles (p22) that should be applied in all development and change for mental health services and a set of priorities (p23-25) that commissioners and providers need to address to take Mental Health Services forward over the next 5 years.

The key priorities identified in the strategy are:

- Parity of Esteem – Equal emphasis on physical and mental health
- Promote Prevention
- Promote Mental Wellbeing
- Appropriate Response in a Crisis
- Accessible care when needed
- Seamless integrated Services

The strategy has been developed with extensive consultation with mental health service users and members of the public, who, through various media were asked *"If you could change three things about mental health services and support what would they be?"* (asking that the respondent uses their own personal experience if they could).

A survey was posted online on the NHS Sheffield CCG website (www.sheffieldccg.nhs.uk) and circulated by local partners working across the health and social care economy (primarily by Healthwatch Sheffield). This was also circulated to 626 members of the NHS Sheffield CCG, 'Involve Me' Public Membership Database.

A media release was issued at the beginning of the engagement period to promote involvement. This was picked up positively by the Sheffield Star who ran two articles. The survey was also promoted via social media on the CCG Facebook and twitter pages on a regular basis throughout the engagement period. Healthwatch Sheffield carried out several discussion forums both prior to and during the engagement period to gain feedback from a number of local groups. An 'awareness stand' was set up at the Mental Health and Wellbeing event organised by Sheffield MIND on 18 July 2014 on Fargate in the City Centre

Overall a total of 397 comments were received from the various engagement activities which were passed to the authors of the document.

2. Next Steps

Engagement and consultation

- A second phase of engagement will be carried out to ascertain views on the draft strategy over a one month period running from early December 2014 to early January 2015 and this will be publicised alongside the summary report detailing feedback from the first phase of engagement. A copy of the report will be sent directly to all respondents from the first phase of engagement that have provided their contact details along with further information as to how they can provide feedback regarding the draft strategy.
- The timing of the second phase of engagement is not ideal due to the requirement for this to take place over the Christmas period. However, it was felt to be preferable to undertake a further period of engagement focused specifically upon the content of the draft strategy to ensure that any further patient and public views could be taken into consideration before the strategy is signed off.

Document drafting

- Any feedback received from the second phase of engagement will be collated into a summary report and fed back to the MHPB. Any fundamental issues raised which indicate a need for amendment of the draft strategy will be actioned.
- The draft strategy document will be finalised and formatted for presentation to the MHPB. The finalised document will include an executive summary.

3. Questions for the Health and Wellbeing Board

Does the Board recognise the principles and priorities set out for the city and consider that the document as drafted will inform and guide the provision of appropriate mental health service provision over the next 5 years?

4. Recommendations

That the Board endorses the work of the Mental Health Partnership Board in developing the Sheffield Mental Health Strategy, offers comments on the draft, and supports the work of the MHPB in finalising and publishing this strategy.

5. Reasons for Recommendations

The Mental Health Partnership Board was tasked with revising and updating the 2009 Sheffield Strategy for Mental Health and Well-Being. Through extensive consultation with mental health service users and members of the public, and discussion at Board meetings and at subgroup meetings, the Board has risen to the challenge and produced a strategy document that embraces feedback received through the consultation, whilst reflecting national policy and guidance.

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Sheffield Mental Health Partnership Board

DRAFT
Sheffield Strategy for Mental Health

revised 2014

Version 28/11/14

Sheffield Strategy for Mental Health

Contents

1. Mental health is still everybody's business

All of us have mental health needs and most of us will have mental health problems of some sort in our lives. These problems have a range of causes and need to be tackled by all of us. At home, at work, mental health is everybody's business.

Health and social care agencies have an important role in promoting mental health and well-being, including making sure treatment and support is available when required. This Strategy is about how the health and social care agencies in Sheffield should work together to do that over the next 3 - 5 years.

Sheffield needs to promote and improve mental health across the life span of all its citizens. The Strategy's focus is mainly on the mental health of adults, including older adults, but aims to support the improvement of mental health services for people of all ages. It provides direction to inform decision makers including commissioners, providers, professionals, elected representatives and all those concerned with mental health in Sheffield

What do we mean by mental health?
Mental health is about the way we think and feel and our ability to deal with the ups and downs of life. When we talk about mental health in this document we therefore mean our personal intellectual and emotional wellbeing and our resilience to deal with difficulties and challenges as they come our way.

What do we mean by mental health problems?
The range of mental health concerns from the worries we experience as part of everyday life to much more serious long-term conditions that require intensive support and help.

What do we mean by mental illness or ill-health?
Symptoms of significant mental health problems that are classified by clinicians to assist them to identify the appropriate care and treatment for the condition.

What do we mean by mental health well-being?
The Government's strategy, "No health without mental health" (2011) defines this as, "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment".

2. What does the Strategy look like?

The Strategy first identifies the sources it has drawn upon – city-wide plans, previous planning for mental health services, local and national guidance and the evidence of what works. It goes on to look at what we know about mental health and illness in Sheffield, the progress and change made since the last strategy and what people have said they want to see for the future. It draws out from all of these things a vision of what services should be like, some fundamental aims and a model of services for the future (how services need to fit together). It ends by summarising the main priorities for change over the next 5 years. The Glossary on page 22 explains abbreviations and terms used.

3. Not a blank sheet of paper!

We have not started with a blank sheet in developing the Strategy. The Strategy draws on the following:

- **City-wide Strategies**

  Joint Health and Wellbeing Boards were established in April 2013. They now have the leading role in improving the health and wellbeing of the citizens of Sheffield and for the NHS and Sheffield City Council (SCC) to work in partnership with each other and other important stakeholders including HealthWatch to achieve this.

The Board is responsible for the Joint Strategic Needs Assessment and has developed the *Sheffield Joint Health and Wellbeing Strategy (2013-2018*). The Strategy has 5 broad objectives for Sheffield:

- a healthy and successful city
- health and well-being is improving
- health inequalities are reducing
- you can get the help and support you need
- a health and wellbeing system that is innovative and affordable.

To support this, there are 5 work programmes: A good start in life; Building Mental Wellbeing and Emotional Resilience; Food, Physical activity and active lifestyles; Health, Disability and Employment; and Supporting People at or closer to home.

There is a declared commitment to joint working across health and social care including integrated commissioning of services through the *Sheffield Better Care Fund* initiative.

Right First Time. As part of a programme to reduce the dependence on hospital based treatment and care, Sheffield has a comprehensive Right First Time programme. It has a particular workstream on physical health and mental health because of the established relationship between to two. Improving the physical health of people with mental ill-health and improving the mental wellbeing of people with physical ill-health

- **Previous work on planning mental health services for adults in Sheffield**

"The Sheffield Strategy for Mental Health and Wellbeing", agreed in 2008, confirmed a "stepped care approach" for delivering mental health support to make sure it was delivered in an appropriate and timely way. It also identified a series of priorities including: greater choice and control; improving access to employment and suitable housing; a focus on mental health promotion as well as treatment.

- **Sheffield Fairness Commission**

The Sheffield *Fairness Commission* reported in January 2013. It identified the following 10 principles
intended as guidelines for policy makers and citizens:

- Those in greatest need should take priority.
- Those with the most resources should make the biggest contributions.
- The commitment to fairness must be a long-term one.
- The commitment to fairness must be city-wide.
- Prevention is better than cure.
- Be seen to act in a fair way as well as acting fairly.
- Civic responsibility among all residents to contribute to the maximum of their abilities and ensuring all citizens have a voice.
- Open continuous campaign for fairness in the city.
- Fairness must be a matter of balance between different groups, communities and generations in the city.
- The city's commitment to fairness must be both demonstrated and monitored in an annual report.

- **National guidance**

There has been a range of important guidance and significant reports for mental health in the last 3 years that are important for us in 2014. A summary of some key points are included in Appendix 2

"No Health without Mental Health" DoH 2011
https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

The Abandoned Illness: A report by the Schizophrenia Commission – Schizophrenia Commission 2012
http://www.schizophreniacommission.org.uk/

Starting Today – the future of mental health services – Mental Health Foundation - 2013
http://www.mentalhealth.org.uk/publications/starting-today-future-of-mental-health-services/

Closing the Gap: Priorities for essential change in mental health – DoH - 2014
https://www.gov.uk/government/publications/mental-health-priorities-for-change

Joint Commissioning Panel for Mental Health – Commissioning Guidance – Royal Colleges of Psychiatrists and of General Practitioners – October 2013
http://www.jcpmh.info/

Living Well for Longer – *NHS (April 2014)*
See link via Rethink site who also produce a useful summary relating to mental health and their own report "Lethal Discrimination"
http://www.rethink.org/lwfl

Crisis Concordat *DoH Feb 2014*
http://www.crisiscareconcordat.org.uk/about/

Suicide Prevention Strategy *DoH Feb 2014*
https://www.gov.uk/government/publications/suicide-prevention-report

Transforming our health care system: Ten priorities for commissioners April 2013
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

Crossing Boundaries *Mental Health Foundation 2014*
http://www.mentalhealth.org.uk/publications/crossing-boundaries/

Achieving Better Access to Mental Health Services by 2020 -
https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020

- **Legislation**

The Care Act (2014)

The new Act sets out a number of reforms to care and support law and brings together existing duties under single legislation. This includes duties on statutory authorities to:

- Promote well-being
- Provide person-centred care and support planning with a legal entitlement to a personal budget for social care
- Provide information and advice about care and support being available for all

- Require health and social care authorities to develop integrated approaches by sharing funding through the Better Care Fund

Carers: As a carer there is already the entitlement to have your caring support needs assessed. The Care Act extends this to an entitlement to support, to meet those needs that are "eligible". This could include a personal budget to access that support.

Mental Health Act, Mental Capacity Act and Deprivation of Liberty (2009)

Legislation and case law have led to a closer alignment between mental capacity and mental health acts. Safeguards are now in place for people deemed to be deprived of their liberty in a care home or hospital where the mental health act is not appropriate

- **Evidence of what works**

Service change and development needs to be informed by evidence of what works. National Institute for Health and Clinical Excellence (NICE) guidelines on specific mental health conditions are important. The experience we have in Sheffield of what people have told us is helpful are further building blocks of our Strategy. In addition there are examples of good practice in other parts of the country to help inform us. See Appendix 3 for some examples.

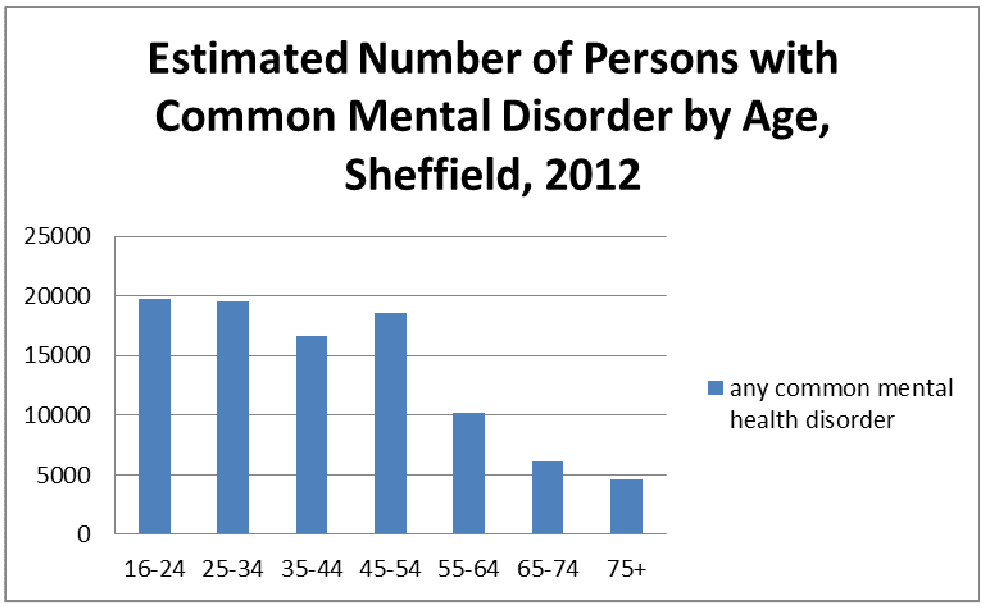
4. What we know about mental health and illness in Sheffield

This section summarises some of the key data and evidence about mental illness. It begins with some information about the prevalence of conditions and then some information related to the determinants of illness and its impacts.

Common mental health problems

⇒ It is estimated, from national survey data (APMS), that the prevalence of common mental health problems amongst adults (aged 16+) in Sheffield is 203 per 1000 adults. This is equal to 95,369 people[1]. Figure 1 shows how this is broken down by age group.

Figure 1



[1] Adult Psychiatric Morbidity Survey (APMS), (2007) and NPMS deprivation index for Sheffield (1.251)

⇒ The survey covers a range of disorders; the most common disorder across the age groups is mixed anxiety and depression.

⇒ The percentage of patients aged 18 years and over with a new diagnosis of depression in the year 2013 to 2014 in Sheffield was 7.43%, the England average was 6.52%. Compared with the 8 core cities Sheffield ranked 7 (1 is best).[2]

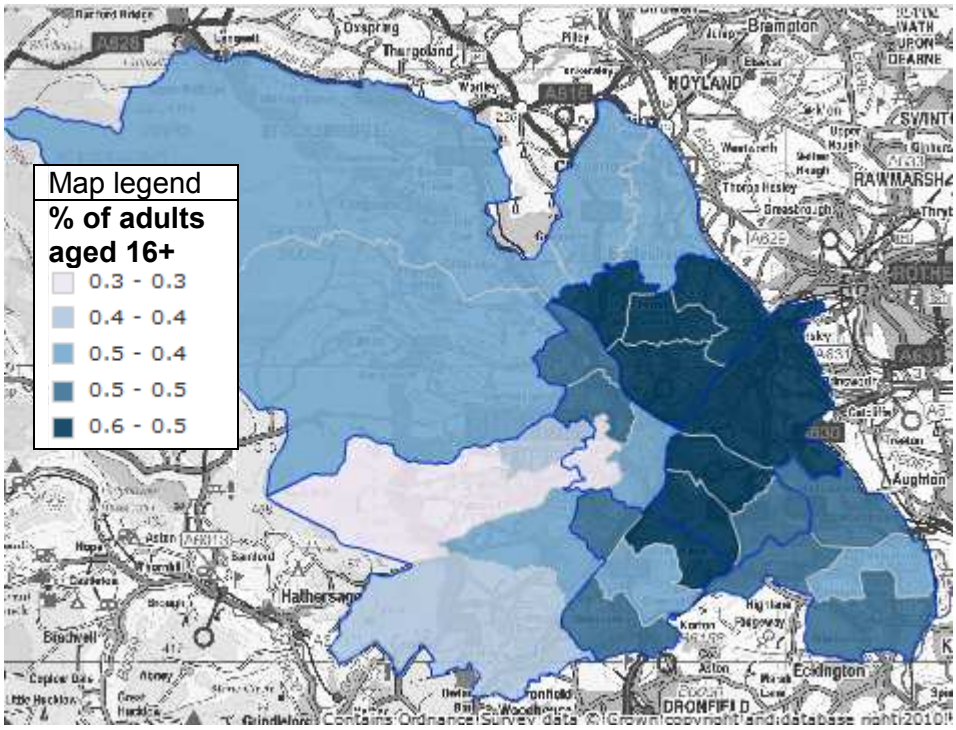
Severe mental illness

⇒ It is estimated, from national survey data, that the prevalence of psychosis amongst adults (aged 16+) in Sheffield is 50 per 1000 adults. This equates to 2,124 people in Sheffield in 2012 (APMS as above).

⇒ Prevalence is shown from the national survey to vary with levels of deprivation. Figure 2 shows this variation estimated across Sheffield. The estimated prevalence in Fulwood ward is 32 per 1000 adults, in Manor and Castle it is 52.

Figure 2

Map of Mental Health Prevalence Estimates for Psychotic Disorder in Adults (Age 16+) expressed as a % of adults aged 16+, 2011



Source: Adult Psychiatric Morbidity Survey (APMS) in England 2007, Population Health Register April 2011, Council Benefits dataset August 2010, MINI2000 Index. Produced by Public Health Analysis Team, SCC, Report: Ward and LAP Health Indicator Tool, Version: v1.3, 10th July 2014

⇒ In 2013/14 there were 106 new cases of psychosis served by the 'Early intervention Service'. As a rate per 100,000 people this is close to the average rate in England.[3]

⇒ The number of Sheffield people being treated under the Care Programme Approach within secondary mental health services at June 2014 was 1175. As a rate per population, this is lower than the England average. [4]

[2] Quality and outcomes framework.
[3] Severe Mental Illness Profile 2014, Public Health England
[4] Community Mental Health Profile 2014, Public Health England

⇒ The number of bed days for psychiatric treatment in hospital (expressed as a rate per population) is similar to the England average.[5]

⇒ In September 2014 there were 4,732 people on the registers of severe mental illness held by GPs in Sheffield.

⇒ The estimated number of people with Antisocial Personality Disorder for Sheffield is 2,181 (APMS as above).

Detention under the mental health act

⇒ Section 136 of the Mental Health Act 1983 provides a power for the police to detain an individual for up to 72 hours and take them to a place of safety for an assessment. Between 1st April 2012 and the 31st March 2013, the power was used in Sheffield by the police 260 times.[6]

⇒ The local rate of detentions under the Mental Health Act for treatment is similar to the average for England. The number of detentions in 2012/2013 in Sheffield was 306.[7]

Children and Young People

⇒ This strategy focusses on the needs of, and services provided to, the adult population. The needs of children and young people are considered in detail in a separate report[8]. Extracts from that report are given below as comment on the needs of our young people is essential here.

⇒ Research indicates that adolescents have experienced the least improvement in health status of any age group in UK in last 50 years (Davies et al 2012). Specifically in relation to mental health 50% of lifetime mental illnesses arise by age 14; and 40% of young people experience at least one mental disorder by age 16 (JCPMH 2013).

⇒ The most recent British surveys carried out by the Office of National Statistics of children and young people aged 5-15 in 1999 and 2004 found that 10% had a clinically diagnosable mental health disorder. This equates to approximately 7000 children in this age group in Sheffield.

⇒ The widening gap between physical and sexual maturity and adult social and financial independence has been offered as an explanation for growing mental health and behavioural issues amongst young people. The gap between puberty and adult social and financial independence has widened from around 6 years in the 1950s to 15 years today (Davies et al 2012).

The Social Determinants and Impacts of Mental Illness

Deprivation

⇒ The Index of Multiple Deprivation (IMD), combines a number of the other indices, and gives an overall score for the relative level of multiple deprivations experienced in small geographical areas. To produce the overall IMD 38 separate indicators are combined and weighted. As such, relative IMD can give an indication of cumulative risk factors for poor emotional wellbeing and mental illnesses[9].

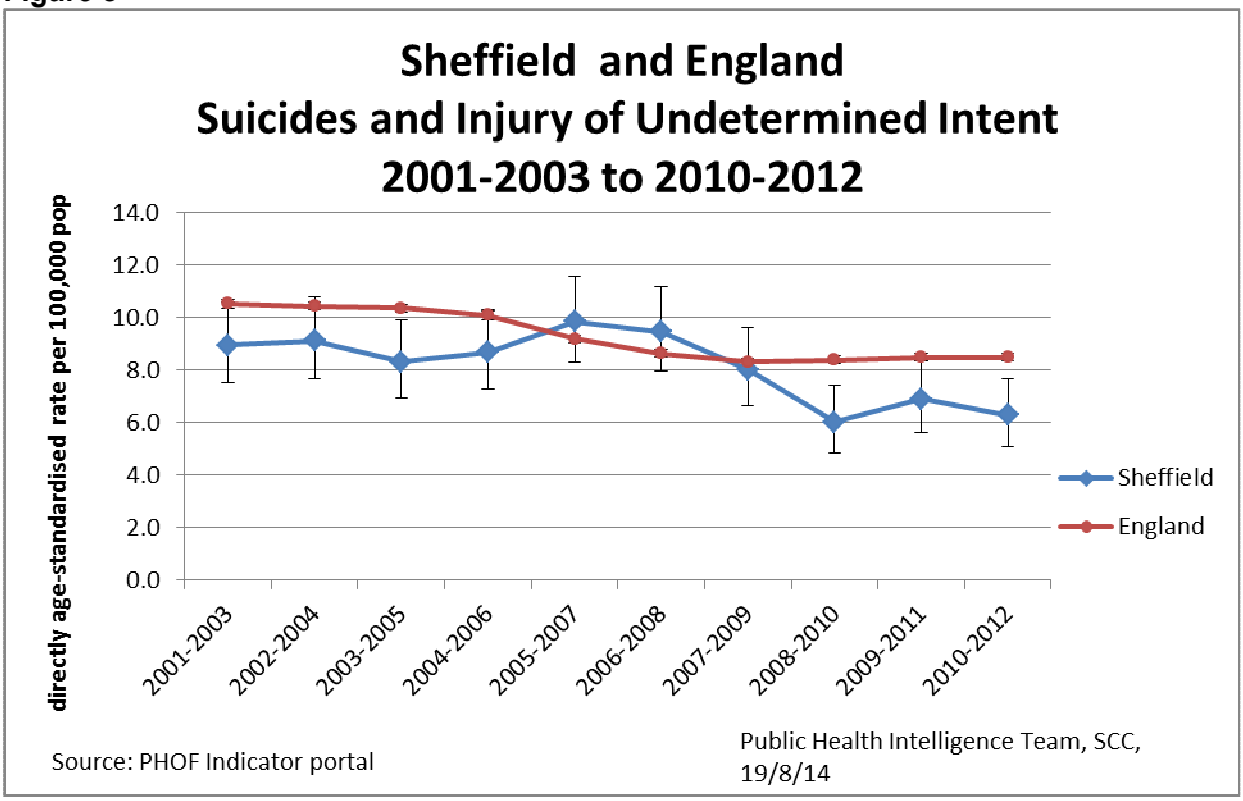
[5] Community Mental Health Profile 2014, Public Health England
[6] Sarah Banks/Jo Sykes, SCC, Report to Sheffield First Safer & Sustainable Communities Partnership Board; August 2014
[7] Severe Mental Illness Profile 2014, Public Health England
[8] Children's and Young people's Emotional Wellbeing and Mental Health: Health Needs Assessment, 2014 C&YPs PH team SCC.
[9] Children's and Young people's Emotional Wellbeing and Mental Health: Health Needs assessment, 2014 C&YPs PH team SCC.

⇒ There are 125,000 [22%] Sheffield people living within most deprived areas ranked as being in the worst tenth of areas nationally, and 47,000 [8%] living within least deprived areas ranked as being in the best tenth nationally.

⇒ Compared to other nearby urban local authorities Sheffield is of a similar deprivation rank. Out of the 8 Core Cities, Sheffield is 6th least deprived.

Suicide and self-injury

Figure 3



⇒ Deaths by suicide and undetermined injury in Sheffield, have generally been lower than the England average, however this changed temporarily with a rise in 2007 (figure 3). On average, between 2008 and 2013, 38 people died each year in Sheffield by suicide.

⇒ Local audit of suicides (2001-2010, n=333) showed that 77% of those who died by suicide were men, and that the rate was highest amongst men in mid-life. This is in line with the national picture. More recent data suggests that there may be an increase in the proportion of men locally, but it is too soon to be clear whether this is a trend.[10]

⇒ In an audit of 171 suicides (2006-2010) depression was cited as a key factor in 68 cases (40%).[11]

⇒ The national suicide rate among 10–19 year olds is 2.20 per 100,000; Sheffield rates are slightly lower than national rates. Recent research has shown a significant fall in the rates among young men in the period 2001–2010. [12]

Employment and other social factors-

⇒ Poor mental health impacts on our employment rates, welfare spending and wider health inequalities. Poor mental health costs Britain £70 billion a year through productivity

[10] Local Suicide audit 2010, for MHPB July 2012, J Southworth NHSS.
[11] Local Suicide audit 2010, for MHPB July 2012, J Southworth NHSS.
[12] Children's and Young people's Emotional Wellbeing and Mental Health: Health Needs Assessment, 2014 C&YPs PH team SCC

losses, higher benefit payments and the increased cost to the NHS – equal to 4.5 per cent of Gross Domestic Product (GDP).[13]

⇒ Between 10 per cent and 16 per cent of people with mental health conditions, excluding depression, are in employment.[14] However, between 86 and 90 per cent of this group want to work.[15]

⇒ Mental health problems are the cause of 40 per cent of the 370,000 new claims for disability benefit each year nationally.[16]

⇒ In Sheffield in 2013-14, 157 of the 493 service users on Modus (Sheffield's Domestic Abuse Case Management system) stated that they had mental health problems (that is, 32%).[17]

⇒ A systemic review of domestic violence and mental disorders published in 2012 by Trevillion, Oram and Feder considered 41 studies and concluded that "There is a high prevalence and increased likelihood of being a victim of domestic violence in men and women across all diagnostic categories, compared to people without disorders".[18]

⇒ In Sheffield it is estimated that at least 60% (number) of cases referred to the PRAM (Sheffield's Anti-Social Behaviour Risk Assessment Conference) have mental health elements, ranging from victims and perpetrators of ASB suffering from depression to those with more serious issues which can sometimes single them out for ASB. [19]

⇒ National guidance indicates, however, that dual diagnosis affects a third of psychiatric service users and approximately half of substance misuse service users; and that certain groups of service users have higher rates of dual diagnosis, for example, prisoners, with an estimated rate of 70%.[20]

⇒ Illustrating this, a recent study found that an average of 46% of mental health service users had dual diagnosis and that the number of people with dual diagnosis differed by type of mental health service, ranging from 12% of clients in contact with an acute home treatment team to 71% of clients in an assertive outreach team (Schulte and Holland 2008). 21

⇒ Evidence highlights that mental ill health (anxiety and depression) are *likely* to be *present alongside* informal caring. It is *likely* that informal caring on a continuing basis increases the chance of carers experiencing mental ill health and possibly prolongs periods of mental ill health if people had symptoms of this prior to caring. A number of national and international studies suggest that prolonged periods and long hours of caring per week may have a detrimental effect on mental health and that over time continuing poor mental health in turn can lead to physical illness, such as back strain or hypertension. Estimating the numbers of informal carers in Sheffield who experience mental health issues is complex. It's likely that a large proportion of carers, at some point in their caring role, have experienced stress, anxiety or worry. [22]

⇒ In the 2011 census over 57,000 people in Sheffield identified themselves as unpaid carers. Within this group 14,500 provide more than 50 hours per week unpaid care.

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[13] Organisation for Economic Co-operation and Development (Feb 2014), *Mental health and work: United Kingdom.* http://www.oecd.org/els/emp/mentalhealthandwork-unitedkingdom.htm

[14] HM Government (2009), *Work, recovery and inclusion: employment support for people in contact with secondary mental health services.*

[15] Stanley, K and Maxwell, D (2004) *Fit for purpose?* IPPR.

[16] Organisation for Economic Co-operation and Development (Feb 2014), op. cit.

[17] Sarah Banks/Jo Sykes, SCC, Report to Sheffield First Safer & Sustainable Communities Partnership Board; August 2014

[18] SarahBanks/Jo Sykes, SCC op.cit.

[19] SarahBanks/Jo Sykes, SCC op.cit.

[20] SarahBanks/Jo Sykes, SCC op.cit.

[21] Schulte S, Holland M. Mental Health and Substance Use: dual diagnosis. Dual Diagnosis in Manchester, UK: practitioners' estimates of prevalence rates in mental health and substance misuse services. *Mental Health and Substance use: dual diagnosis.* 2008; 1; 2: 118-124.

[22] Carers in Sheffield, health needs assessment, Elise Gilwhite, Public Health Sheffield 2012.

Ethnicity

⇒ Within SHSC during 2013/14 ethnicity was recorded for 8,912 (87.5%) users of mental health community and inpatient services. Ethnicity for 1,275 users (12.5%) is unknown; this is significant in considering the data. Comparing the known group to Sheffield population census data 2011, the White British group appears to be represented at a similar level. There appear to be fewer people from Asian groups using mental health services compared to the census, particularly Chinese and Pakistani Asian groups. People from the group Black/African/Caribbean/Black British appear to be slightly overrepresented, although there is not direct read across of all ethnic categories.[23]

Attitudes to mental Illness

⇒ Wider societal attitudes are changing for the better. Increasingly, people are starting to regard mental illness as an illness like any other. Time to Change's latest *Attitudes to mental illness* report [24] found that attitudes have markedly improved in a number of different areas. For example, acceptance of people with mental illness taking public office has grown. The percentage agreeing that 'anyone with a history of mental problems should be excluded from public office' decreased from 29 per cent in 1994 to 18 per cent in 2012.

Physical health of people with mental illness

⇒ People with severe mental illness tend to die at a younger age than the population as a whole. The rate of premature mortality (that is, before age 75) of people with severe mental illness in Sheffield has followed a downward trend from 2008/09 to 2011/12. In 2012 the rate (1282 per 100,000) was equivalent to the rate for England overall. Compared with premature mortality rates across the population in general, in Sheffield people with SMI are over 3.5 times more likely to die early, although this difference has been reducing. Liver disease and respiratory illnesses account for most of this inequality in rates.[25]

⇒ In September 2014 there were 4,732 people on GPs severe mental illness registers, of these 48% have at least one other long term illness. Depression and vascular disease are the main conditions also present.[26]

Self-reported personal wellbeing

⇒ When asked in the Annual Population Survey (APS) 2013/14 about levels of anxiety, 20% of UK wide respondents reported high levels of 'anxiety yesterday', compared to 23% of those in South Yorkshire. Reported levels of low 'anxiety yesterday' were more similar, with 39.4 % of UK respondents compared to 38.1% of those in South Yorkshire. The proportion of people reporting high levels of 'happiness yesterday' in South Yorkshire (33.3%) compared favourably with UK levels (32.6%), although the report of low levels of happiness was worse, 11.8% in South Yorkshire and 9.7% in the UK.[27]

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[23] Supplied by SHSC November 2014

[24] Time to Change (2013), *Attitudes to mental illness 2012 research report.*

[25] Right first time, John Soady DPH Office, Sheffield City Council, 2014.

[26] Right first time, John Soady DPH Office, Sheffield City Council, 2014.

[27] ONS October 2014, http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2013-14/sb-personal-well-being-in-the-uk--2013-14.html#tab-3--Personal-well-being-in-the-UK--2013-14

⇒ The annual Every Child Matters Survey in 2013 collected information from just under 9,000 children in Sheffield. In response to questions about emotional wellbeing the majority of young people in Y10 (aged 14-15) said they feel happy most of the time. Around 10% said they hardly ever or never feel happy.[28]

5. Progress on improving services and challenges that remain

The 2009 strategy identified 13 priority areas:

- Develop and implement a plan that makes sure choice and self-determination is at the heart of mental health services
- Make sure people in all parts of the city and across all communities have equal access to mental health services
- Work with partners to improve access to employment, training and other aspects of living a quality life
- Develop and implement outcomes that address "quality of life" as the basis for future commissioning and service provision
- Work with partners to improve the physical health of people with mental health problems and address the mental health needs of people with physical illness
- Fully implement the stepped care approach, including access for most people to local mental health services working closely with primary care
- Work with partners to develop programmes that promote mental health across all parts of the community
- Within the stepped care framework, make sure there are high quality specialist mental health services for people who need them
- Develop and implement "care pathways", making sure there are clear routes for people to access services and move between them
- Work with partners to improve availability of housing and accommodation with support
- Develop joint planning of mental health services with service users and carers
- Make sure people with a dual diagnosis can access high quality mental health services
- Deliver appropriate mental health services for younger and older people

In the light of these priorities and other developments there has been progress in a number of areas. However there continues to be significant challenges. The following tables summarise this

Progress and change since 2009:

Stepped Care and improving access to mental health support at primary care.	The Improving Access to Psychological Therapies (IAPT) programme in Sheffield was established in 2008. It is now delivering treatment to approximately 1000 people each month Reconfiguration of Community Mental Health Teams (CMHTs). There has been a significant reorganisation of CMHTs to improve the support to primary care and provide focused support for people with longer term mental health issues
Quality in specialist mental health care and implementing care pathways	Acute and Non-Acute (Standard) care pathways have been established within the Mental Health Service. In addition devolving the budget responsibility for out of city acute care has had a significant impact on led reducing the occupancy of acute inpatient beds and less people needing a bed outside of Sheffield. An important part of this change was the commissioning of a Crisis House

[28] Children's and Young people's Emotional Wellbeing and Mental Health: Health Needs Assessment, 2014 C&YPs PH team SCC

	by SHSC and operated by Rethink – opened 2013 Care Pathways and Packages (CPP). The national project to identify people who access secondary mental health services into clinically based clusters to support effective treatment planning and future payment arrangements has been progressed. Most people who use services are now placed within a cluster and the commissioning of health services will be based on these clusters from 2015.
Choice and Self-Determination	Personalisation has developed significantly across adult social care since 2009. Self Directed Support (SDS) was introduced to support people to determine their own support and care needs and to access them through personal budgets. This was a huge change for everyone from users and carers to mental health clinicians and professionals to support providers. In 2013 SDS processes were significantly revised to make them more efficient in terms of time and resources. However, accessing social care support to meet eligible social care needs through a personal budget remains an important option The experience in social care provides many useful lessons for the extension of personal health budgets.
Partnership working. Integrated health and social care service	Established in 2001 there continues to be integrated health and social care in adult mental health in Sheffield currently delivered by Sheffield Health and Social Care NHS Foundation Trust. This is an achievement given that a number of such partnerships have not been sustained across England and Wales
Improving the availability of housing and support	In 2015 a new 20 flat scheme will be available for people with mental health problems. In addition a new "generic" housing support service will be established to increase the availability of property and support eg through private landlords and social housing.
Physical health and mental health	The Right First Time programme has a workstream focusing specifically on mental health and physical health. It has worked across primary and secondary care to promote better access to physical health checks, cardio metabolic interventions and physical and social activity for people with serious mental illness. The project has piloted an approach targeting those at risk of hospital admission; commenced a smoking cessation project and is working on an e-learning training package.
Partnership working to improve choice, innovation and prevention	Third sector organisations continue to provide a wide range of services both commissioned and supported through other means. With the introduction of personal budgets in social care there has been a significant change in how some of these services are commissioned It has continued to be an area of innovation including the Mind and Body projects and taking on the challenge of new prevention initiatives including Social Cafes
Mental Health Act – Revised 2007 Mental Capacity Act – came into force 2007	The introduction of the MCA has had a significant impact on the delivery of treatment, care and support across health and social care. It requires assessment of a person's capacity and consideration of "Deprivation of Liberty". The revised Mental Health Act introduced Community Treatment Orders as well as the right to access an Independent Mental Health Advocate (IMHA). IMHA service commissioned.
Support for Carers	Health and social care recommissioned Carer Support Services in 2012. This was a change for mental health from a number of small contracts to commissioning 2 providers to support Carers across all areas of need.
Promoting – prevention and personal resilience in Mental Health	The Recovery Education Programme including psycho-educational groups has been established. It provides an educational approach and is now the first point of assistance for people for 250 people a quarter. It focuses on building up skills and personal resilience. 3 Social Cafes have been developed across the city to support people

	who are one or two steps away from needing specialist mental health services. Sheffield Mental Health Information Service recommissioned to develop an accessible service that supports self-management and awareness. Time-limited project to promote self-help
Anti-Stigma and mental wellbeing	Local organisations have been promoters of the national *Time to Change* campaign and *"20 years too soon"* a campaign increasing awareness of early deaths of people with mental health problems and learning disabilities; established the *Sheffield Wellbeing Festival*.

Continuing pressures and challenges:

However, we know services could and should be radically better. Some of these are areas identified in the 2009 Strategy.

Improving response in a crisis	The introduction of the Crisis House has been a significant additional option for support in a crisis, however, there continues to be examples of ineffective responses at A&E as well as difficulties with access to appropriate places of safety for people under S136. People should not be waiting unreasonably for a mental health assessment in A&E. Services that are responsive services 24/7 South Yorkshire Police and SHSC have established the Street Triage pilot to improve joint working. Indications are that it is having a very positive impact on the use of S136.
Equalities	There continues to be over representation of people from some black and minority ethnic communities in the acute services
Appropriate mental health services for younger people	Transition between children and adult mental health services. Adult services are not the right response for many people
Partnership working. Integrating Health and Social Care	Although there is a long established integrated mental health service in Sheffield there are still important challenges. This is particularly around access to residential and nursing care and support for people with long term needs e.g. Section 117 aftercare; Continuing Health Care; people in out of city placements. Work has commenced on developing a single approach which is in line with the future direction of health and social care (see Care Act)
Improving the availability of housing and support	There continues to be a shortage of supported housing for people with mental health problems available in a timely manner. This can impact on a move from inpatient treatment creating a delay or leading to an inappropriate placement. A new supported accommodation unit will be opened in early 2015
Quality Specialist mental health care and implementing care pathways	A lot of work has been done to develop CPP and the clustering this requires. However, it continues to be a challenge and the impact it will have on the commissioning of services is not yet fully understood.
Mental Health and Physical Health	The impact of mental health on physical health and vice versa continues to be a significant challenge including: - the negative impact of psychiatric illness and medication on physical health including oral health - the importance of healthy living approaches - increase in physical conditions that can have a direct impact on mental health e.g. obesity - parity of esteem between physical and mental health within health

	services
Quality in specialist mental health care	Alternatives to hospital admission and continued improvement in the environment in hospital in-patient wards to promote recovery. Care pathways that are about the individual rather than the professional Treating people with respect. Services struggle to provide effective support for people with substance misuse and mental health problems, leading to regular but ineffective call on services..
Suicide and self-harm	There is not yet an effective suicide prevention strategy in place to focus on those at most vulnerable to harming themselves or taking their own life
Support for Carers	Carer support services are in place, but there is more that needs to be done to support those who need to deal with the crises or ongoing support.
Mental Wellbeing: promoting – recovery, prevention and personal resilience	Tackling Social Isolation and opportunities to build supportive social networks Improving awareness about mental health and promoting your own mental well being Employment and training opportunities
Tackling Stigma	Misunderstanding to prejudice
Financial challenges	There continue to be financial pressures on NHS services. These are even greater for local authorities with a direct impact on social care. There is a corresponding pressure on third sector organisations, particularly those with a more localised or focused purpose.

6. What people have said about current mental health services and how they should change

The following are the themes identified from the consultation

- The attitude and skills of staff within mental health services is fundamental to the experience of care received. A willingness to listen is needed.
- Seeing the person as a whole being, not just as symptoms. Treatment, care and support that helps people access community initiatives, physical activity etc.
- Increasing awareness of mental health and mental illness. Discrimination about mental health
- A diversity of support to meet a diversity of need across the range of communities in Sheffield
- Services informed by the experience of users including carers
- Talking therapies make a difference. More 1:1 listening and talking therapies
- Helping people develop the tools they need to manage their own mental health
- Crucial role of General Practice to both access help but also to have a greater ability to recognise and support mental health conditions
- Better training for GPs on mental health
- Training for all NHS workers to be knowledgeable about mental health
- Increasing mental health awareness and training with the workplace
- There is a gap between primary and secondary care
- Care planning is not wholistic, person centred or coordinated. “Do care plans still exist?”
- “The system makes me feel a nuisance”
- Accessing help for particular needs e.g. women with young children
- More support and advice at evenings and weekends (“out of hours”)
- A&E need to be much better at responding to mental health crises
- Better help in a crisis
- It takes too long to get the help and advice needed from getting help in a crisis to waiting for counselling

- Earlier diagnosis of mental health conditions. A greater focus on early intervention and prevention
- Less resource on beds, more help in the community
- Better provision for young adults (16-18 years) and the transition from CAMHS to adult psychiatric services
- Improve working across organisations. Much better communication, coordination, information sharing across agencies: housing, mental health, community/voluntary sector, local support e.g. GP
- There are too many parts to the service so people fall through the gaps. No one takes responsibility
- Acute mental health wards can be intimidating. Not therapeutic. “No one to talk to”.
- Consider family and friends – support for carers and the vital role they play; include carers in the recovery process
- Better information for carers when a crisis occurs
- Better coordination between mental health and physical health
- Care should be about the person. Not just tick boxes. What is important is “the whole person”. Your relationships and context you live within are important for supporting recovery. Three pillars of good recovery: being able to help yourself; building good support networks; getting the appropriate treatment/therapeutic help.

There are some consistent themes from the 2009 Strategy

- Access to help and support when people need it
- The gap between primary care and secondary care - joining up care
- Supporting recovery
- Care and support based on the individual
- Respect for people within mental health services
- Services responsive to the range of communities

7. Vision and aims of the strategy

The fundamental aims of the Strategy remain to:

- Promote mental well-being
- Prevent mental ill health
- Promote recovery from mental ill health
- Reduce mental health inequalities

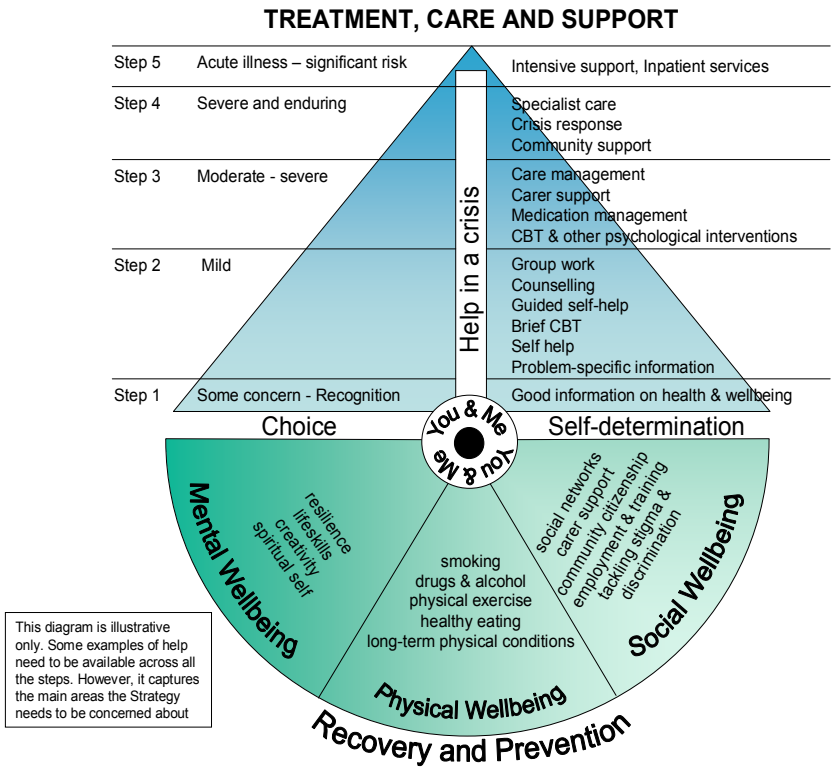
It is our vision to achieve these things for the people of Sheffield by:

⇒ Making help available at an early stage to prevent or reduce the impact for the individual and their family
⇒ Having services that are accessible and responsive. Help available in the right places and in the right ways.
⇒ Providing services that people want to use because they find them helpful and where they are dealt with respectfully
⇒ Supporting people with mental ill health to have a better life through maintaining connections to family and friends; participating in their community and have opportunities for work and leisure.
⇒ Helping to make Sheffield a place that supports and improves the mental health of all its people

8. WHAT IS THE FUTURE DIRECTION?

Who should services be constructed around? – A Service Model

This diagram is a means of describing both the approach we want to achieve for mental health services and how it can fit together.



The word “service” describes how we organise things rather than the outcomes we expect them to help us achieve. What is important therefore is that it is you and me at the heart of it, with our own mental and physical wellbeing and our own particular social circumstances. What abilities and insights we already have need to be the starting point.

It is about getting help when we need it, including specialist help based on clinical knowledge and expertise, from those we need to have confidence in. We need confidence in their ability to listen and understand, in their skills and knowledge of helpful treatments, care and support.

We also need confidence in the systems a service creates so that wherever possible we are in control of the decisions about our treatment, care and support, so that we don’t get forgotten, lost in referral procedures or waiting lists, or treated as a ‘diagnosis’ or ‘cluster’ rather than a person with abilities and insights.

The Stepped Care approach should build on a person’s abilities. It should make sure the right skills and options are available at the right time for you rather than for the system. It should be about empowerment rather creating harmful dependency, about increasing a person’s insight and skills for self-management through to a responsive approach to providing help in a crisis that is highly skilled and proportionate.

The suffering mental ill health can cause means that sometimes action has to be taken to ensure the safety of the sufferer or others, but the person with their abilities should still be at the heart, treated with respect and the encouragement to recover and rebuild.

People with the right skills in the right places

The awareness and skill to help a person (you or me) with mental health problems is not, of course, the sole preserve of specialist mental health services.

The feedback talks about being forgotten, feeling isolated. We need to empower all sorts of people to have a greater awareness of mental ill health and how to respond in ways that help. Primary care is of course the main point most of us go to get help. But there are other places where people struggling with their mental health emerge: housing services, advice and debt counselling, relationship counselling.

There is not the confidence that enough GPs and other staff in primary care have the confidence or ability for assisting people with mental health problems without referring on to specialists? Do GPs and other primary care staff have the right level of mental health awareness and skills?

Talking therapies and the need for more 1:1 listening comes up consistently. There has been a significant increase in services that improve access to psychological therapies (IAPT) in the last 6 years but the need for more "listening" shouts out. Are the skills we have available used to the greatest effect? How can the skills and opportunities be more widely shared and made available? If the skills are not in the places where we go to for help and not available when we need them we are missing something fundamental.

Care pathways that focus on the person not the professional and don't just start at the door of the clinician.

Having the right information in the right places

If knowledge and information is power and empowerment is vital to mental health, then it should be made as accessible as possible and not hoarded. This is about valid information on diagnoses and treatments to assist with the support from your clinician; information about how to get the help you think you need, what options there are and what to expect from them.

It also includes tools for self-management.
"Self-management of mental health conditions and daily living is an essential part of the future of mental health care … it will … empower people, leading to a more appropriate balance in the relationship between professionals and "patients…"
P27 "Starting today – the future of mental health services – Mental Health Foundation

Of course self-help is not the solution for all mental health conditions, but it always has a role. Supporting access to information and self-help tools is already an important role in IAPT, in the Recovery Education programme and the approach of third sector organisations e.g. Sheffield Mind and Rethink, but can more be done to continue to move information out from being the preserve of the experts? This is about continuing to promote and develop the use of on-line tools and appt technology and supporting ways for people to establish their own networks of support.

Access in a crisis

If you are in a mental health crisis, you know you need help and can no longer manage, or you know a person you care for needs help and can no longer manage. Where do you go?

It is generally recognised that we don't deal well enough with mental health crises. The national Crisis Concordat was published in February 2014. It requires partnership work across mental health services, police and ambulance services, local authorities and others to make sure the approach is coherent.

In Sheffield there have been some innovative developments over recent years including the Crisis House and the street triage scheme where police are working with Approved Mental

Health Professionals and Nurses. But the response people receive in Sheffield continues to be a concern. A&E doesn't have the right skills available at the right time. There is a "place of safety" available on an inpatient ward for people picked up by the Police under S136, but its availability is seen to be inadequate and inconsistent.

What should I expect if I, or people who depend on me, need help in a mental health crisis? The Concordat identifies some basic expectations to meet from timely help, feeling safe while getting help, being treated with respect and learning from the crisis to help manage it differently.

Mental health and physical health

The impact of our physical health on our mental health is well established. The impact of mental health on our physical health and life expectancy is well established. The impact of psychiatric medication on our physical health including dental health is well established. Why therefore do we persist in making a distinction between where we receive our help and support for physical health from our mental health? What would services look like if this wasn't the case?

Primary care is currently the place where physical and mental health can be seen together. It is also where there is often a connection and understanding to the personal and social community a person lives within.

Whether the help and assistance provided is for physical health or mental health needs, it must be provided in a way that supports and promotes good psychological and emotional health.

"Primary Care" and "Secondary Care" is the language of services and commissioners not of the people who need them

IAPT is placed in primary care, Access Community Mental Health Teams are now much more responsive to referrals from primary care and the Recovery Education Programme is developing to provide rapid access to support, but the gap between primary and secondary care continues to be a concern. People experience "falling through gaps". Is this gap about organisational arrangements or the needs of those who are seeking help? Is there any added benefit for dividing up the wholistic advice, treatment, care and support we need into primary care and secondary care? What would mental health services look like if we had no separation?

Integration

We have had an integrated health and social care mental health service for adults since 2001. This has made sure the challenges of looking at both health and social care needs are dealt with by the integrated service and not passed on to the person who just wants help. It is only managers, professionals and commissioners that question the value of integration, not those who use the services or care for someone who does.

The national direction through the Care Act and the Better Care Fund is to progress integrated working further so that duplication of effort that adds nothing to the user experience is removed. This is about commissioning, management, processes and systems, budgets, pathways and teams of buildings, but the outcome must be to achieve a seamless experience of advice, treatment, care and support when we need it or it won't help. This requires changes in attitudes, a willingness to do things differently and to see the experience as a whole.

Choice and self-determination

We know there are times when we need specialist advice and assistance. This may well lead to treatment, care and support, but for where ever it is possible we want to be able to have the information we need, help to understand it and the consequences, help to have and understand the choices, and to be a full partner to the plan, a plan about my care that is my plan.

Services are built on diagnosing or assessing problems and needs, looking for solutions or assistance that would help, agreeing a course of action and keeping an eye on it. The Care Programme Approach still provides the basis on which to make sure a person with serious mental health problems continues to have that support. However, feedback that asks whether care plans still exist tells us there is something not working.

Empowerment is jargon for making sure I have control of what is happening to me, that I have options and make choices. It is also jargon for owning the choices and their consequences.

Personal budgets are a means to provide the choice, control and ownership. They are already introduced in social care and the direction of national policy is to introduce them more widely in health where they are seen to have particular benefit in mental health. How can we build greater choice? Can personal health budgets be integrated with social care budgets to ensure more effective treatment, care and support?

"A stitch in time"

Identifying whether someone has serious mental health problems early and making sure they can get advice and assistance we know can reduce both the impact of the illness and also the other significant effects it can have on relationships with family and friends, maintaining education or work, keeping a place to live. Having the means to pick up the signs of deeper fears and troubling experiences is of benefit to everyone … the person, the family, the specialist services. To this end there is rightly great emphasis in national policy on targeting skills and opportunities to particularly vulnerable groups and vulnerable times e.g. young adulthood. This requires awareness and skills within schools, colleges and with employers. The views from the consultation are of acute wards that are intimidating and lonely places and so preventing or limiting the need for them has to be a priority.

Suicide does not always have a connection to mental illness, but often tragically does. It certainly has a connection to serious emotional distress and such manifestations as self-harm and experiences e.g. unemployment and debt. The need for a suicide prevention strategy that includes all those agencies called upon at such times is highlighted in the national strategy.

But this is also about our mental health intelligence, what we can do, what things we need to change, what skills we need to develop. There is now a lot of support for mental health problems that affect mood, managing anxiety and phobias, poor sleep, living with pain. The IAPT programme has been a significant development since the last Strategy, targeted to primary care and other community resources, but is it enough? How can the skills and knowledge be made more available, more common place, particularly to those at greatest risk? This is about preventing people who are one or two steps away from needing more intensive assistance or treatment from being drawn unnecessarily into the mental health "system" when it can be avoided. It is about looking to places where problems begin to emerge e.g. at work, the advice centre, the housing management, A&E as well as primary care.

Promoting Mental Wellbeing

We all know that feeling when we think we are not coping and when we feel specific problems or general anxieties are getting on top of us and we are not reacting to them well. Mental wellbeing is about how we are able to cope with those experiences. What is it that helps us develop own

our abilities to cope, our resilience? In the spirit of “five a day” for health eating the “Five Ways to Wellbeing” (Appendix 1) provide a basis for looking at how we can help ourselves.

But they also provide a basis for how we can help each other, including through how we commission and deliver assistance, care and support. From the consultation the experience of isolation, loneliness, “no one to talk to” are highlighted. The importance therefore of being able to make connection to others, finding and establishing that supportive network through shared concerns or interests, getting to know others who live nearby are vital and can be life-saving.

In addition, being able to contribute through work, or voluntary opportunities, or other means are also important for promoting and sustaining our mental health and mental resilience.

Building up that mental resilience needs to start young. If there is any significant preventative work it is to be done in early years and adolescence, building up awareness of your own mental health and wellbeing, increasing your ability to deal with stress and anxiety and to share your fears and worries. A good start in life is a national priority in “No Health without Mental Health”.

10. Major Themes and Priorities for the Next 5 Years

This strategy sets out to identify the direction for change and development needed to improve the experience and effectiveness of mental health services in Sheffield.

This review has identified many improvements that could be made and where their priority needs to be seen in relation to available resources. However, there are also fundamental challenges that, if faced, can transform the way mental health is seen, and how assistance, support and treatment are approached.

In addition it has identified a number of principles that must inform all change and development across mental health services in Sheffield over the next 5 years if the requirements and aspirations of this strategy are to be met.

Principles

The following should be provided consistently and constantly in all service provision regardless of who delivers it

Principles	What matters to me most?
Respect at the heart	Whatever my difficulties, I am treated with dignity and respect
Built on Equality	I get the right help regardless of who I am
Supports Recovery	All assistance, support and treatment is focused on working with me to manage my mental health difficulties, to make progress, make change and take control
Responds to individual need	Treatment and support built around my needs not those of professional help and services
Coproduction of service	Services developed with those who need to use them I know how I can get involved in decisions about Sheffield's mental health services
Choice and control	I know the range of options available to me and there is the means for me to exercise them wherever this is possible
Efficient use of resources	Support that helps me manage my own mental health I don't have to keep telling different people my problems and experiences Expensive professional skills and knowledge are used effectively
Communicate! Communicate! Communicate!	I know what my options are and what is happening. People are talking to me, sharing information, treating me with respect

Priorities:
(A ***Priority*** is an important Mental Health focus that Commissioners and Providers will seek to deliver in the 3-5 years of this Strategy.)

Priority	What it means for me	What it means for commissioners and services
Parity of Esteem – Equal emphasis on physical and mental health	My mental health is treated with the same priority as my physical health The impact of my physical health on my mental health and vice versa is taken seriously, including the effect of medication	Not just reducing but removing the distinction between treating physical and mental health separately Mental health services delivered through Primary Care. Greater skills and support available through Primary Care Coordination of physical and mental health delivered through primary care
Promote Prevention	I can talk to someone who will listen and who will help me find ways to manage my mental health I can get access to information and advice at an early stage so I can understand and manage my own mental health and prevent it getting worse There are opportunities for me to make contact with others, to share experience and support	Improved access to knowledge and support through social media and mobile technology Improved access to talking therapies Sharing specialist skills and knowledge and promoting self-help initiatives Training and Employment opportunities Support to access social networks
Promote Mental Wellbeing	There is greater awareness and understanding of mental health across communities. I am not treated unfairly, stereotyped or stigmatised because of my mental illness	Building up mental health awareness and resilience in early and teenage years Information and understanding about mental health and wellbeing is abundant: available on the high street, at school and college, in the workplace. “5 ways to wellbeing” integral part of commissioning Promoting the benefits of physical health Demystifying mental illness and tackling stigma
Appropriate Response in a Crisis	I know when I need to ask for help to avoid a crisis and what to	Individual planning to deal with crises – including carers and carer

	do. I know where to go when I cannot manage myself or someone I care for I know how to avoid crises in future	support Clear pathway to help in a crisis across all partners (health/social care/police/ambulance etc.). Tacking organisational boundaries and cultures that get in the way. Effective information sharing Improving the experience in A&E - Effective skills and response times in A&E Adequate crisis alternatives – *place of safety* Improving the responsiveness of mental health crisis services – response time etc. Information available in a way that engages and at places that are easy to access Greater Mental Health awareness and skills at places where people present with need (Advice/Debt advice / Housing resources / Police)
Accessible care when needed	Help from the right people with the right skills in the right places I am at the heart of my treatment and support. A care plan that is mine and not owned by those helping me or a tick box system requirement Information and advice available to assist me to understand and	Greater mental health skill and awareness in primary care. Greater flexibility of professional roles – sharing skills and knowledge. Greater Mental Health awareness and skills at places where people present with need (Advice/Debt advice / Housing resources / Police) Professionals as partners. Revision of the Care Programming: Care Coordination; integrating with Support Planning (Social Care) Using Personal Health and Social Care Budgets to support choice Information available in a way that engages and at places that are

	access the help I need	easy to access Sharing specialist skills and knowledge
Seamless integrated Services	The route to getting assistance, support and treatment is clear. I get the help I need nearest to the point where I first sought it There is no duplication of interest or passing me on to someone else without good reason	Integrated commissioning and service delivery across health and social care: single point of access to services etc. Removing the service gap between primary and secondary care Transition from young person to adult mental health service Assessment and care planning takes account of the person's whole experience from symptoms to social context – Review of Care Programme Approach and Care Coordination Identifying where service and professional boundaries hinder people's "recovery" Effective information sharing

Glossary of abbreviations and terms

Adults	All people aged 18 years and over
Older Adults	All people aged 65 years and over
Functional mental illness	Disorders of mood and thinking that are **not** related to dementia
Stepped care model	A model of mental health services whereby services are delivered at five “steps” according to people’s level of need
Care pathway	How people access and move between services
Self-directed support	An approach encouraging people to plan and manage their own services
DH	Department of Health
IAPT	Improving Access to Psychological Therapies
ONS	Office of National Statistics
CPA	Care Programme Approach - system of multi-disciplinary care planning and monitoring for people with severe mental illness
NICE	National Institute for Health and Clinical Excellence
GP	General Practitioner
CBT	Cognitive behavioural therapy
Primary care	GP and related services that can be accessed directly
Secondary care	Services that are accessed by referral from primary care
Care navigator	Someone to help advise and access the support needed
A & E	The Accident and Emergency Department

Appendix 1

What do we mean by mental health?

"Mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions. The majority of people who experience mental health problems can get over them or learn to live with them, especially if they get help early on.

Mental health problems are usually defined and classified to enable professionals to refer people for appropriate care and treatment. But some diagnoses are controversial and there is much concern in the mental health field that people are too often treated according to or described by their label. This can have a profound effect on their quality of life. Nevertheless, diagnoses remain the most usual way of dividing and classifying symptoms into groups.

Most mental health symptoms have traditionally been divided into groups called either 'neurotic' or 'psychotic' symptoms. 'Neurotic' covers those symptoms which can be regarded as severe forms of 'normal' emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as 'neuroses' are now more frequently called 'common mental health problems.'

Less common are 'psychotic' symptoms, which interfere with a person's perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no one else can.

Mental health problems affect the way you think, feel and behave. ….

Although certain symptoms are common in specific mental health problems, no two people behave in exactly the same way when they are unwell.

Many people who live with a mental health problem or are developing one try to keep their feelings hidden because they are afraid of other people's reactions. And many people feel troubled without having a diagnosed, or diagnosable, mental health problem - although that doesn't mean they aren't struggling to cope with daily life.

With Thanks to the Mental Health Foundation

Intellectual Health

Intellectual health refers to how well our cognitive and thinking functions are working. It is part of our mental or emotional wellbeing and includes the ability to think clearly and realistically, to think positively, to pay attention appropriately, to have good short and long term memory, and to continue to learn.

The Five Ways to Wellbeing

Connect
Feeling close to, and valued by, other people is a fundamental human need and one that contributes to functioning well in the world Social relationships are critical for promoting wellbeing and for acting as a buffer against mental ill health for people of all ages.

Be active
Regular physical activity is associated with lower rates of depression and anxiety across all age groups. Exercise is essential for slowing age-related cognitive decline and for promoting well-being.

Take notice
Reminding yourself to 'take notice' can strengthen and broaden awareness. Studies have shown that being aware of what is taking place in the present directly enhances your well-being and

savouring ‘the moment’ can help to reaffirm your life priorities. Heightened awareness also enhances your self-understanding and allows you to make positive choices based on your own values and motivations.

Learn

Continued learning through life enhances self-esteem and encourages social interaction and a more active life. Anecdotal evidence suggests that the opportunity to engage in work or educational activities particularly helps to lift older people out of depression. The practice of setting goals, which is related to adult learning in particular, has been strongly associated with higher levels of wellbeing.

Give

Participation in social and community life has attracted a lot of attention in the field of wellbeing research. Individuals who report a greater interest in helping others are more likely to rate themselves as happy. Research into actions for promoting happiness has shown that committing an act of kindness once a week over a six-week period is associated with an increase in wellbeing.

With thanks to NEF and Mind

http://www.mind.org.uk/for-business/mental-health-at-work/taking-care-of-yourself/five-ways-to-wellbeing/

See also the 10 ways to look after your mental health (Mental Health Foundation)
http://www.mentalhealth.org.uk/help-information/10-ways-to-look-after-your-mental-health/

Appendix 2

"No Health without Mental Health" DoH 2011
https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

This outlines the Government's plans for improving the mental health and wellbeing of people in England. Mental health is everybody's business. It considers mental health across all ages and from tackling stigma to prevention to delivering care and support. It is built around 6 fundamental objectives:

More people will have good mental health
The impact of a good start in life from parenting to building up the mental resilience and awareness of young people

More people will recover
A focus early intervention and a recovery approach that builds on individual objectives and strengths and helps increase personal resilience.

More people with mental health problems will have good physical health
Tackling the relationship between mental health and physical health including the poor physical health of people with mh problems

More people will have a positive experience of care and support
The person is at the centre of their treatment and care planning. This includes choice and control including the use of personalised budgets in both health and social care. People who use services and their carers are respected.

Fewer people will suffer avoidable harm
This is about the quality of services that respect human rights and ensure the individual's safety and dignity. Tackling self-harm and suicide.

Fewer people experience stigma and discrimination
Tackling stigma and discrimination through information, education and legal duties

The Abandoned Illness: A report by the Schizophrenia Commission – Schizophrenia Commission 2012
http://www.schizophreniacommission.org.uk/

The independent commission on schizophrenia and psychosis identified a number of priorities including: share decision making for a person about their care and treatment; alternatives to acute hospital care; greater role for primary care; early intervention; carer support; physical health of people with a serious mental illness; use of personal budgets and increasing access to talking therapies.

Starting Today – the future of mental health services – Mental Health Foundation - 2013
http://www.mentalhealth.org.uk/publications/starting-today-future-of-mental-health-services/

Key messages from the report include: providing a personalised service; building capacity for self-management; mental health services primary care led – removing the distinction between primary and secondary care; more effective crisis care; integrating mental and physical health care; importance of early years for building mental resilience.

Closing the Gap: Priorities for essential change in mental health – DoH - 2014
https://www.gov.uk/government/publications/mental-health-priorities-for-change

Closing the Gap identifies the immediate government priorities. It highlights in particular:

- Commissioning services that focus on recovery
- More effective information on mental health and mental wellbeing of the population
- Tackling waiting times for services; tackling inequalities and discrimination in mental health services
- Importance of talking therapies including for people with serious mental illness and personality disorders
- Improving mental wellbeing amongst children and young people through support to parents and work in schools; more choice and control for people in their treatment and support including personal health budgets alongside those already available in social care
- Tackling the use of restraint and restrictive practices
- Getting better feedback on services and tackling poor quality
- Support for carers
- Integrated physical and mental health care
- Better response in a crisis (Crisis Care Concordat), including self-harm; more effective approaches to mental health across the justice system
- Employment supporting good mental health
- Tackling discrimination and stigma.

Joint Commissioning Panel for Mental Health – Commissioning Guidance – Royal Colleges of Psychiatrists and of General Practitioners -
http://www.jcpmh.info/

These are a range of commissioning tools for specialist mental health services from acute care and crisis to community mental health teams and primary care based on the current models of mental health services

Living Well for Longer – *NHS (April 2014)*
See link via Rethink site who also produce a useful summary relating to mental health and their own report “Lethal Discrimination”
http://www.rethink.org/lwfl

These reports highlight the stark impact on physical health of mental ill health, and vice versa. It includes tackling smoking, the importance of physical activity, as well as the impact of psychiatric medication and the priority for health checks.

Personal Health Budgets
The Introduction of Personal Health Budgets in the NHS, including for mental health.
http://www.personalhealthbudgets.england.nhs.uk/index.cfm

http://www.mind.org.uk/news-campaigns/news/mind%E2%80%99s-personal-health-budgets-research-published-today/

Crisis Concordat *DoH Feb 2014*
http://www.crisiscareconcordat.org.uk/about/
The Concordat sets out how response to mental health crises needs to improve. It is based on 4 core principles: Access to support before a crisis; Urgent and emergency access to crisis care; Quality of treatment and care when in crisis; Recovery and staying well. It addresses issues around A&E, Place of Safety; role of Police and Ambulance services.

Suicide Prevention Strategy *DoH Feb 2014*
https://www.gov.uk/government/publications/suicide-prevention-report
The Strategy looks at trends and lessons to inform actions that are required to help reduce suicide and self-harm including mental health awareness, early intervention and effective responses at A&E.

Transforming our health care system: Ten priorities for commissioners April 2013
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

The priorities include:
- Developing an integrated approach to mental and physical health problems
- Systematically detecting early stages of disorders and intervening early
- Taking action that reduces incidence including targeting high risk groups
- Creating patient-centred care. Coordinated care, navigation etc.
- Integrating approaches to urgent and emergency care: joint planning, information sharing etc.

Crossing Boundaries *Mental Health Foundation 2013*
http://www.mentalhealth.org.uk/publications/crossing-boundaries/

Research that looks at the need to integrate care, identifying that the boundary between mental and physical health is artificial and detrimental. We need to better understand the "individibility and unitary nature of physical and mental health". It proposes ways to achieve this including focusing on: information sharing; co-location; joint commissioning across health and social care; multidisciplinary teams; liaison services.

Achieving Better Access to Mental Health Services by 2020 -
https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020

Timely access to services and then for treatment is one of the most obvious gaps in parity between physical and mental health services – whilst there are waiting time standards for physical health services, for mental health services, these standards simply don't exist. This plan sets out the immediate actions we will take this year and next to end this disparity and achieve better access to mental health services and our vision for further progress by 2020. An additional £40 million funding boost for mental health services is committed in 2014-15 and a further £80 million in 2015/16.

Appendix 3

Managing Patients with Complex Needs - City & Hackney Primary Care Psychotherapy Consultation Service (PCPCS) *Centre for Mental Health 2014*

The service supports GPs in the management of patients with complex needs through case discussion, training and direct clinical services including brief psychological interventions. Shown to significantly improve health outcomes and reduce use of both primary and secondary care. A typical course of treatment lasts for 12 sessions, at an estimated average cost of £1,348 per patient. The subsequent savings from reduced health service use are equivalent to a third of this cost. Based on the cost-effectiveness framework used by NICE the PCPCS treatment has a cost per QALY (quality-adjusted life-year) of around £10,900 compared to the NICE threshold range of £20,000 - £30,000.

Long Term Conditions and Mental Health *Kings Fund* 2012

The work emphasises the prevalence of co-morbid mental health problems with the current separation of mental and physical health leading to fragmented approaches in which opportunities to improve quality and efficiency are often missed. Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively.

There is a growing evidence base which suggests more integrated ways of working with collaboration between mental health and other professionals offer the best chance of improving outcomes for both mental health and physical conditions. It also evidences that the costs of including psychological or mental health initiatives within disease management or rehabilitation programmes can more than outweighed the savings arising from improved physical health and decreased service use. The cost implications are significant to primary care and the wider economic impact of mental health problems having an effect on employment and workplace productivity and the costs of informal care borne by family members.

The effects of socio-economic deprivation are an issue in Sheffield and the paper notes that social deprivation strengthens the association between mental and physical ill health. It suggests that improving care for people with long-term conditions and co-morbid mental health problems will require closer working between mental and physical health care services, and also social care, public health and the range of other social support services provided by VCF organisations. In summary, the paper suggests Clinical Commissioning Groups should play an important role in working with local providers to encourage the growth of more integrated forms of care, developing care pathways that support emotional, behavioural and mental health aspects of physical illness as a standard component of care for people with long-term conditions.

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of: Jeremy Wight, Director of Public Health

Date: 11 December 2014

Subject: Pharmaceutical Needs Assessment for Sheffield 2015-18

Author of Report: Louise Brewins, 0114 205 7455 *and members of the PNA Steering Group*

Summary:

In accordance with the National Health Service (NHS) (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, this latest (draft) version of Sheffield's PNA sets out our assessment of pharmaceutical services in light of the health and wellbeing needs of the Sheffield population. It identifies that: Sheffield is well-served by its pharmacies and dispensing doctors; community pharmacies have good links with other NHS services within the City; local pharmacies are already contributing extensively to raising awareness and understanding of health risks, promoting healthy lifestyles, providing advice and signposting/ referral to treatment and providing services; and further development of the public health role of pharmacy and commissioning of relevant services could secure additional improvements in health. The final PNA is due for publication on 1st April 2015.

Recommendations:

Health and Wellbeing Board members are invited to:

- Raise any questions or clarification on any points of process or content
- Pay particular attention to the key findings of the PNA
- Request a final version of the PNA for approval in March 2015.

Background Papers:

Draft Pharmaceutical Needs Assessment for Sheffield 2015-18

Sheffield Health and Wellbeing Board
Update on the Pharmaceutical Needs Assessment for Sheffield (2015-18)
December 2014

1. Background

The Pharmaceutical Needs Assessment (PNA) provides a framework to enable the strategic development and commissioning of pharmaceutical services to help meet the needs of the local population. It is used by NHS England to deal with applications to provide pharmaceutical services under the 'Market Entry' process. It should also highlight any gaps in pharmaceutical service provision so that relevant local health and social care commissioners can take appropriate steps to remedy these and ensure the local population has appropriate access to pharmaceutical services.

The duty to produce a PNA was placed on Health and Wellbeing Boards by the Health and Social Care Act 2012 with the first PNA to be produced by 1st April 2015. The PNA must be produced in accordance with the National Health Service (NHS) (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. The regulations stipulate the purpose, scope and content of PNAs, the process by which a document and live map of local pharmacies should be produced and, how the PNA should be published and disseminated.

In April 2014 the Board established a Steering Group to develop the Sheffield PNA on its behalf in line with the 2013 regulations including conducting a 60-day consultation with relevant stakeholders and ensuring (online) publication by 1st April 2015. The document attached represents the latest version of the PNA (Version 2) produced by the Steering Group following the stakeholder consultation. It is provided as a progress update to members of the Board, prior to final approval in March 2015.

2. Introduction

The Steering Group produced a first full draft of the PNA (Version 1) in July 2014. It sought to align the health and wellbeing needs of the local population (via reference to the Joint Strategic Needs Assessment) with service data obtained from NHS England, Sheffield Clinical Commissioning Group and Sheffield City Council. In so doing an assessment was made as to: current contribution of local pharmacies in meeting health and wellbeing needs; any key gaps in service provision and; potential for further development of pharmacy's role in improving health and wellbeing outcomes in the City.

In line with regulations, a stakeholder consultation on the first draft of the PNA took place for 60 days from 1st August to 30th September 2014. Results from the consultation were analysed and the PNA amended accordingly. A copy of the consultation report is included as Appendix A to the PNA document. In addition, key information about pharmacies and the services commissioned from them were updated in autumn 2014. Neither the results of the

consultation or the process of updating the service information altered the key findings of the PNA.

3. Key findings

i. Sheffield is well-served by its pharmacies and dispensing doctors with good coverage and choice across the different areas of the City and good availability and access arrangements, including out of hours, generally high levels of patient satisfaction and no gaps in provision.

ii. Pharmacy has good links with other NHS services within the City both in relation to primary care (especially GP practices) and acute hospital services. Nevertheless, it is recognised that there is potential to develop this much further, particularly in the context of developing integrated primary care services.

iii. Local pharmacies are already contributing extensively to raising awareness and understanding of health risks, promoting healthy lifestyles, providing advice and signposting/ referral to treatment and providing services, often in more accessible and acceptable settings.

iv. Demographic and cost pressures from patients with long-term conditions is only likely to increase in the coming years and pharmacy's continuing role in helping to meet this need is acknowledged. Further development of the public health role of pharmacy and commissioning of relevant services could therefore secure additional improvements in health.

v. Known future other developments are unlikely to generate a significant level of need/demand for additional pharmaceutical provision over the next 5 years.

4. Next steps

The Steering Group will amend the PNA in light of comments from the Board and finalise for approval at the meeting on 26th March 2015. Text will be added to the JSNA web page on the Council's website to provide the location for publicising the PNA and live map online and details of who to contact for printed copies. The documents will be uploaded to the website by 31st March 2015 and emails sent to all stakeholders publicising the link. A copy of the PNA document will be attached to the email.

5. Recommendations and reasons for recommendations

Health and Wellbeing Board members are invited to:

- Raise any questions or seek clarification on any points of process or content
- Pay particular attention to the key findings of the PNA
- Request a final version of the PNA for approval in March 2015.

The Health and Wellbeing Board must seek assurances that the PNA has been produced in line with the 2013 regulations; that relevant needs and services have been assessed and gaps, as appropriate, identified; and the PNA is on track to be published by 1 April 2015.

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Sheffield Pharmaceutical Needs Assessment 2015-18

Date: 24th November 2014
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Table of Contents

1 Executive Summary

The Pharmaceutical Needs Assessment (PNA) provides a framework to enable the strategic development and commissioning of pharmaceutical services to help meet the needs of the local population. It is produced by the Sheffield Health and Wellbeing Board in accordance with the National Health Service (NHS) (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

The document sets out in section 2: the process that was followed by the Sheffield Health and Wellbeing Board in meeting its statutory duty to produce and publish a robust PNA including the results of the consultation undertaken; in sections 3 and 4 it describes the key demographic features and health and wellbeing needs of the Sheffield population (taken from the Joint Strategic Needs Assessment) and; in section 5 it assesses whether pharmaceutical services delivered via essential, advanced and enhanced services and future developments are sufficient to meet the needs of the population.

In conclusion the PNA identifies that:

- Sheffield is well-served by its pharmacies and dispensing doctors with good coverage and choice across the different areas of the City and good availability and access arrangements, including out of hours, generally high levels of patient satisfaction and no gaps in provision.

- Pharmacy has good links with other NHS services within the City both in relation to primary care (especially GP practices) and acute hospital services. Nevertheless, it is recognised that there is potential to develop this much further, particularly in the context of developing integrated primary care services.

- Local pharmacies are already contributing extensively to raising awareness and understanding of health risks, promoting healthy lifestyles, providing advice and signposting/ referral to treatment and providing services, often in more accessible and acceptable settings.

- Demographic and cost pressures from patients with long-term conditions is only likely to increase in the coming years and pharmacy's continued role in helping to meet this need is acknowledged. Further development of the public health role of pharmacy and commissioning of relevant services could therefore secure additional improvements in health.

- Known future other developments are unlikely to generate a significant level of need/demand for additional pharmaceutical provision over the lifetime of the PNA (2015-18).

2 Introduction

2.1 Background

The Health and Social Care Act (2012) transferred responsibility for the development and updating of pharmaceutical needs assessments (PNAs) from Primary Care Trusts to Health and Wellbeing Boards with effect from 1st April 2013.

The legislative basis for developing, updating and using a PNA is set out in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. In short these state that the Health and Wellbeing Board must publish its first PNA by 1st April 2015. The regulations set out how the PNA should be produced, what it should cover, who should be consulted, and how it should be used. Responsibility for production of the PNA, on behalf of the Health and Wellbeing Board, rests with the Director of Public Health of the relevant local authority.

2.2 Purpose

The PNA provides a framework to enable the strategic development and commissioning of pharmaceutical services to help meet the needs of the local population. It plays an essential role in equipping NHS England to deal with applications to provide pharmaceutical services under the Market Entry process; it should also highlight any gaps in pharmaceutical service provision so that relevant commissioners can take appropriate steps to remedy these and ensure the local population has appropriate access to pharmaceutical services.

The production of a robust PNA is set within the context of the local Joint Strategic Needs Assessment (JSNA) which requires that Health and Wellbeing Boards manage knowledge and undertake regular needs assessments that establish a full understanding of current and future local health needs and requirements. The Sheffield JSNA has therefore been used to provide the evidence of need for this PNA with pharmaceutical needs including dispensing of medication and provision of advice and clinical pharmaceutical interventions, delivered via essential, advanced and enhanced services.

2.3 Definitions

The pharmaceutical services to which each PNA must relate are all the pharmaceutical services that may be provided under arrangements made by NHS England for:

(a) the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list

(b) the provision of local pharmaceutical services under a Local Pharmaceutical Service (LPS) scheme (but not LP services which are not local pharmaceutical services) or

(c) the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by NHS England with a dispensing doctor).

Pharmaceutical services are defined by reference to the regulations and directions governing pharmaceutical services provided by community pharmacies (which may be LPS providers), dispensing doctors and appliance contractors. Whether a service falls within the scope of pharmaceutical services for the purposes of the PNA depends on who the provider is and what is provided. For the purposes of this PNA we have adopted the following scope:

- Pharmacy contractors
  For pharmacy contractors the scope of the services that need to be assessed is broad and comprehensive. It includes the essential, advanced and enhanced service elements of the pharmacy contract whether provided under the terms of services for pharmaceutical contractors or under Local Pharmaceutical Services (LPS) contracts. There are 128 pharmacy contractors in Sheffield. This includes three distance selling pharmacies and one essential small pharmacy (under LPS arrangements). In addition, there are 43 pharmacy contractors outside of the Sheffield boundary that provide services to Sheffield residents.

- Dispensing doctors
  In some areas GP practices may dispense prescriptions for their own patients and the PNA takes these into account. It is not concerned with assessing the need for other services dispensing doctors may provide as part of their national or local contract arrangements. Sheffield has two dispensing doctors based in Deepcar and Oughtibridge both of which are in the Stocksbridge and Upper Don electoral ward.

2.4 Pharmaceutical Services

The Community Pharmacy Contractual Framework is made up of various service types. These are:

2.4.1 Essential services

These are set out in schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. All pharmacy contractors must provide the full range of essential services which include dispensing medicines and actions associated with dispensing and promotion of healthy lifestyles.

2.4.2 Advanced services

Any contractor may choose to provide Advanced Services. There are requirements which need to be met in relation to the pharmacist, standard of premises or notification to NHS England. Services include Medicines Use Review (MURs) and New Medicines Service (NMS).

2.4.3 Enhanced and locally commissioned services

Only those contractors directly commissioned by NHS England can provide enhanced services. Community pharmacy contractors may also provide services commissioned by local authorities and Clinical Commissioning Groups (CCGs). Although these are not enhanced services, they mirror the services that could be commissioned and are therefore

included within the list of pharmaceutical services in order to provide a full picture of current provision in the City.

2.4.4 Exclusions and exceptions from the assessment

Pharmaceutical services and pharmacists are evident in other areas of work in which the local health and wellbeing partners have an interest but which are *excluded* from this assessment. These include prisons and hospitals where patients may be obtaining a type of pharmaceutical service that is not covered by this assessment.

The 2013 Regulations set out the process for dealing with applications for new pharmacies under the regulatory system known as 'market entry'. The market entry test describes the system whereby NHS England assesses an application that offers to:

- Meet an identified current or future need(s)
- Meet identified current or future improvement(s) or better access to pharmaceutical services
- Provide unforeseen benefits i.e. applications that offer to meet a need that is not identified in the PNA but which NHS England is satisfied would lead to significant benefits to people living in the relevant area.

There are two types of application that can be made by a pharmacy or dispensing appliance contractor; routine applications and excepted applications. The regulations allow the following automatic *exceptions* to the test:

- Relocations that do not result in a significant change to pharmaceutical service provision
- Distance selling premises
- Change of ownership
- Temporary listings arising out of suspensions
- Persons exercising a right of return to a pharmaceutical list
- Temporary arrangements during emergencies or because of circumstances beyond the control of the NHS chemists

2.5 Process

The Sheffield Health and Wellbeing Board set up a steering group in April 2014 to lead the production of its PNA and to ensure stakeholder engagement including patient and public involvement. The group comprised:

- Health and Wellbeing Board sponsor – Director of Public Health
- Representatives from Sheffield Clinical Commissioning Group (Medicines Management)
- Representatives from Sheffield City Council (Public Health)
- Representative from Healthwatch Sheffield (Patient and Public involvement)
- Representative from NHS England (South Yorkshire and Bassetlaw Area Team)
- Local Pharmaceutical Committee (LPC) representative
- Local Medical Committee (LMC) representative

The requirements for the PNA were considered by the PNA Steering Group in light of the 2013 Regulations, the data collected by the commissioners of pharmaceutical services for Sheffield and the most recent PNA for Sheffield (2010) including any supplementary statements issued subsequent to publication of the 2010 PNA.

A consultation on the first full draft of the PNA took place for a period of 60 days from 1st August to 30th September 2014, in line with the 2013 Regulations. The following stakeholders were consulted:

- Sheffield LPC
- Sheffield LMC
- Community pharmacy contractors in Sheffield
- Dispensing doctors in Sheffield
- LPS chemists with whom NHS England has arrangements to provide local pharmaceutical services in Sheffield
- NHS England (South Yorkshire and Bassetlaw Area Team)
- Healthwatch Sheffield
- All Sheffield NHS Foundation Trusts
- Neighbouring Health and Wellbeing Boards (Derbyshire, Barnsley and Rotherham)

The consultation responses were collated and analysed and the PNA amended accordingly by the Steering Group. The full consultation report is available at Appendix A. The final version of the PNA (2015) was approved by the Health and Wellbeing Board at its meeting on 26th March 2015. Papers from that meeting may be accessed here link will be inserted when PNA approved and papers are published.

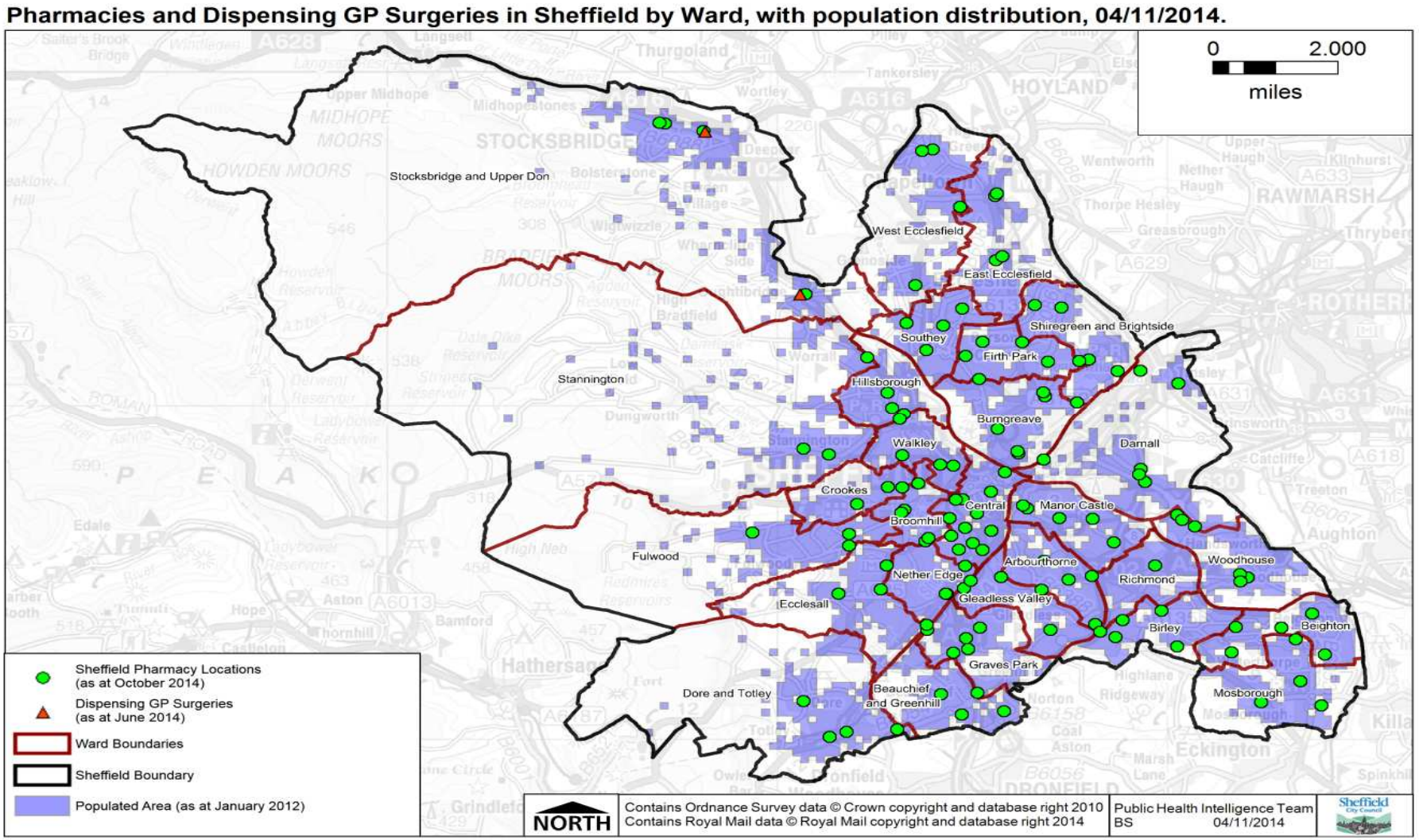
3 About Sheffield

3.1 Locality

Sheffield is one of England's largest cities, nestled in a natural bowl created by seven hills and the confluence of five rivers and is both geographically and demographically diverse. It is largely an urban area, with population densities highest in the centre and to the immediate southwest and more open estates and suburbs further out. Around half of the area within Sheffield's boundary, on the western outskirts, is rural or semi-rural. Lying directly to the east of Sheffield is Rotherham, from which it is separated by the M1 motorway. On its northern border is Barnsley and to the south and west is the county of Derbyshire.

The boundary of Sheffield City Council (SCC) is coterminous with the Sheffield Clinical Commissioning Group (SCCG) and the City is divided into 28 electoral wards. The PNA uses both city-wide and ward based data when looking at the health needs and pharmaceutical provision of the population. The map in Figure 1 identifies the wards and locations of community pharmacies and dispensing doctors within Sheffield. A comprehensive list of wards and associated pharmaceutical services provided is available at Appendix B.

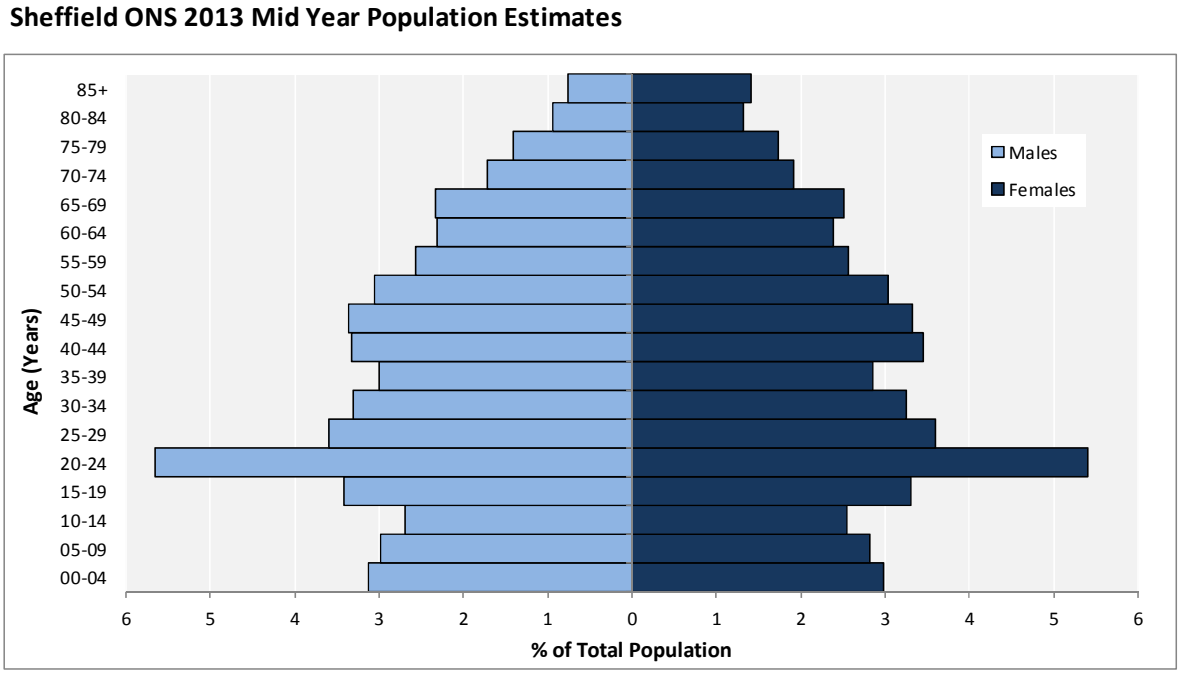
Figure 1: Map of pharmacies and wards in Sheffield



3.2 Population

The 2011 Census revealed that Sheffield has a population of approximately 552,700 people which represents a 7.7% increase since the 2001 Census. Latest estimates from the Office for National Statistics (ONS mid-year estimates 2013) put this at approximately 560,000. Sheffield's growing population results from an increasing birth rate, higher net inward migration and longer life expectancy. The population pyramid and table in Figure 2 set out the current profile of Sheffield's population.

Figure 2: Sheffield population by age group and gender



Age Band	Males		Females		Persons	
	Number	%	Number	%	Number	%
00-04	17,513	3.13	16,733	2.99	34,246	6.11
05-14	31,786	5.68	30,048	5.36	61,834	11.04
15-24	50,798	9.07	48,806	8.71	99,604	17.78
25-44	74,169	13.24	73,734	13.16	147,903	26.41
45-64	63,226	11.29	63,379	11.32	126,605	22.60
65-74	22,658	4.05	24,768	4.42	47,426	8.47
75-84	13,148	2.35	17,184	3.07	30,332	5.42
85+	4,228	0.75	7,907	1.41	12,135	2.17
All Ages	**277,526**	**49.55**	**282,559**	**50.45**	**560,085**	**100.00**

Data Source: ONS 2013 Mid Year Estimates PH Intelligence Team, SCC, 03/07/2014

The number of births rose from 5,715 in 2001 to 6,916 in 2012. Births are projected to rise to 7,000 in 2015 and 7,700 in 2020. The proportion of people from black and minority ethnic (BME) communities also increased from around 9% of the total population in 2001 to 16% in 2011. The City has also experienced an increase in people aged over 65 years. In particular, the number of over 85 year olds rose by 11% over the period 2001 to 2011, although it should be noted that this increase was lower than the national trend. Population characteristics at individual ward level can vary quite considerably however, as the three graphs in Figure 3 to Figure 5 show.

Figure 3: Under 5 population by electoral ward

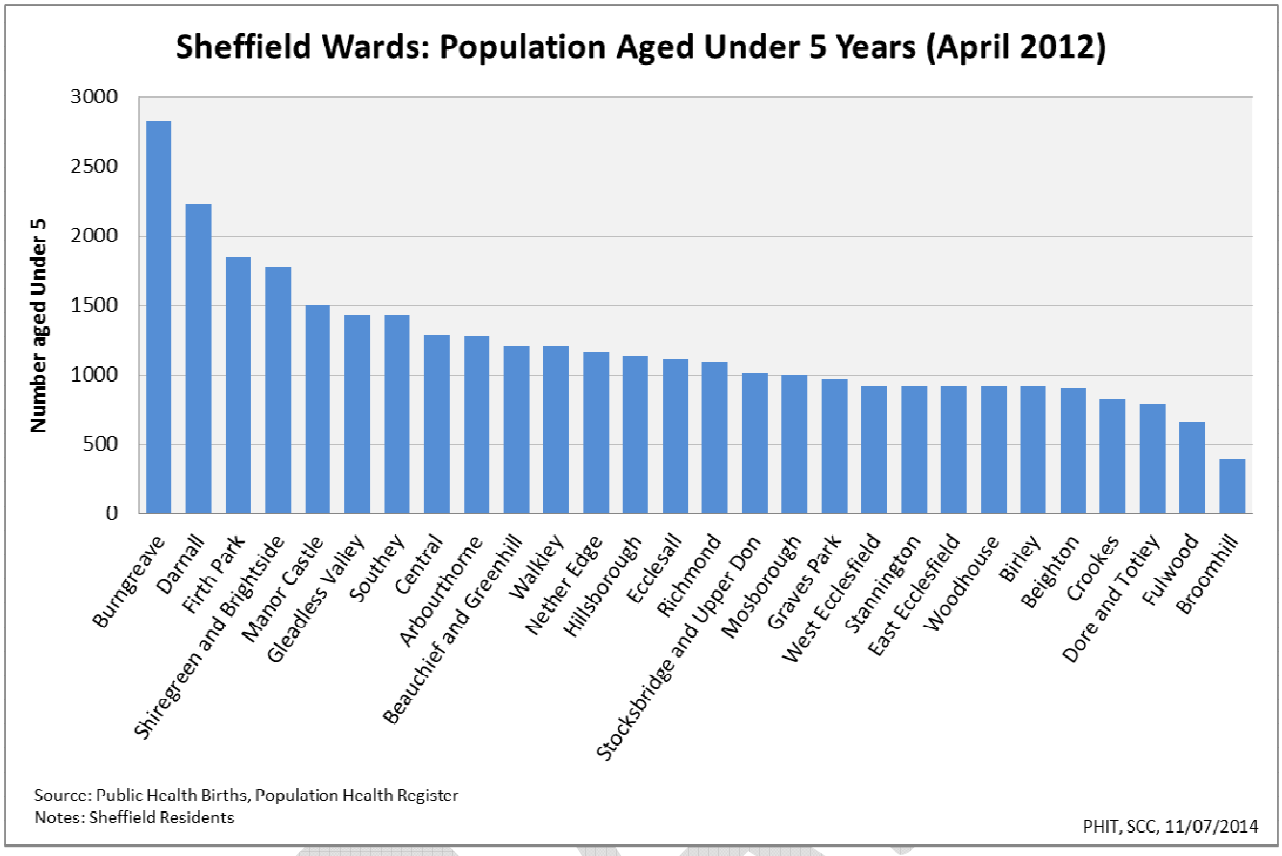


Figure 4 : Over 75 population by electoral ward

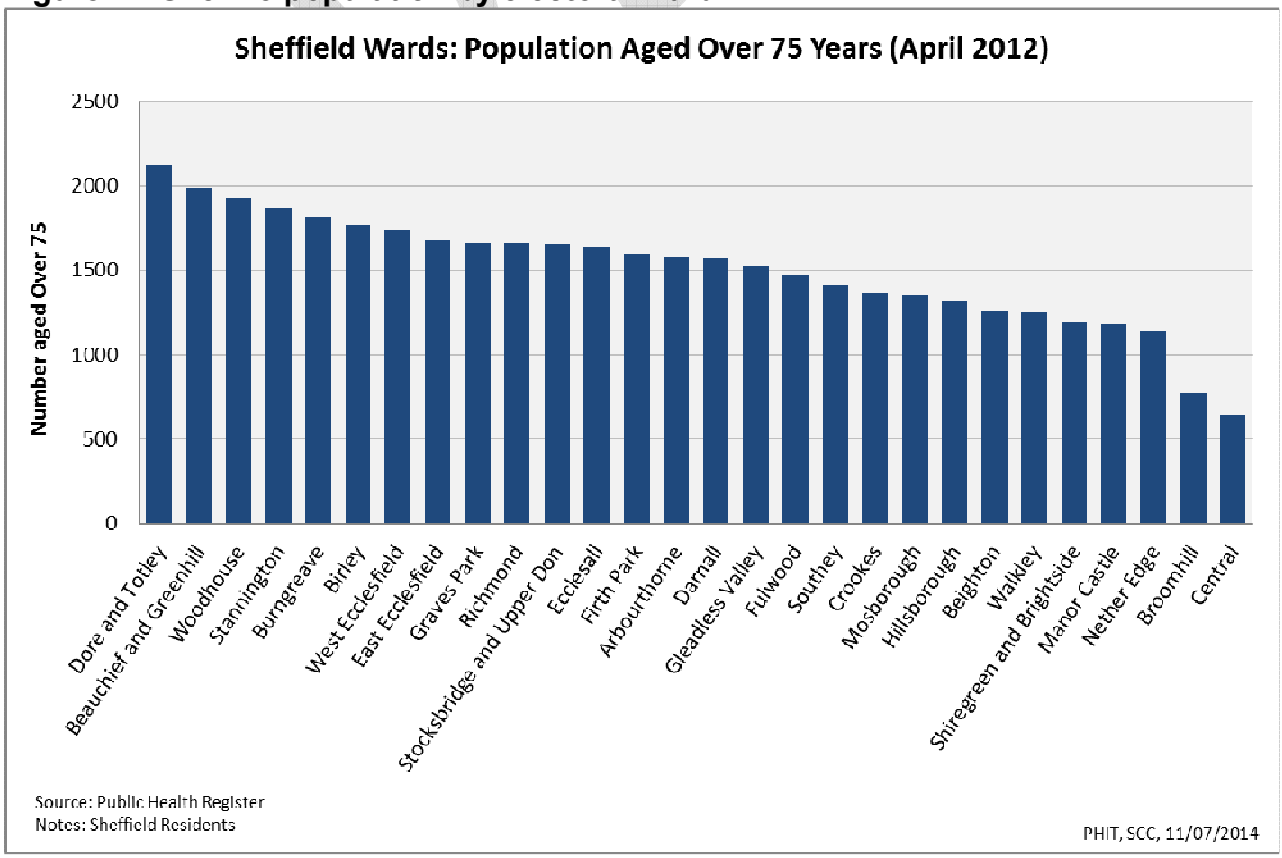
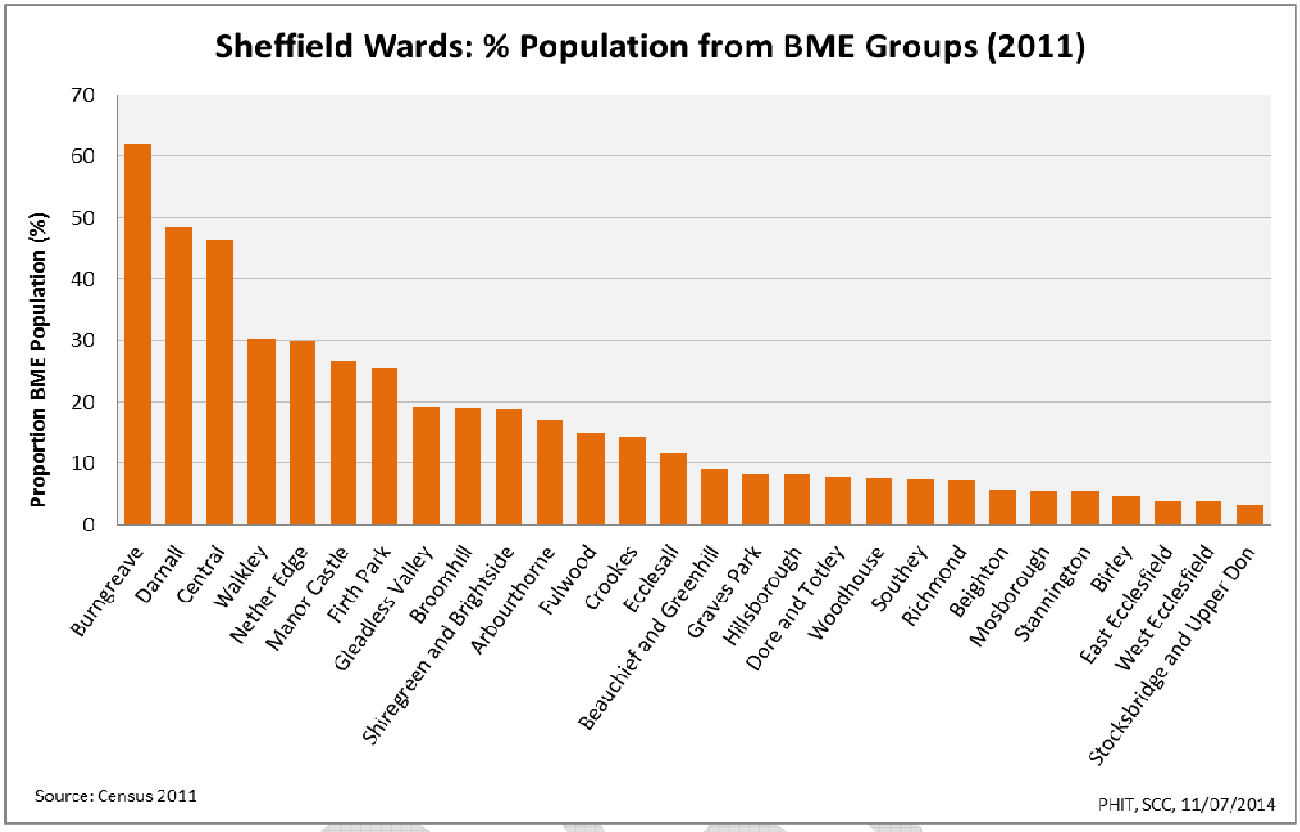


Figure 5: BME population by electoral ward

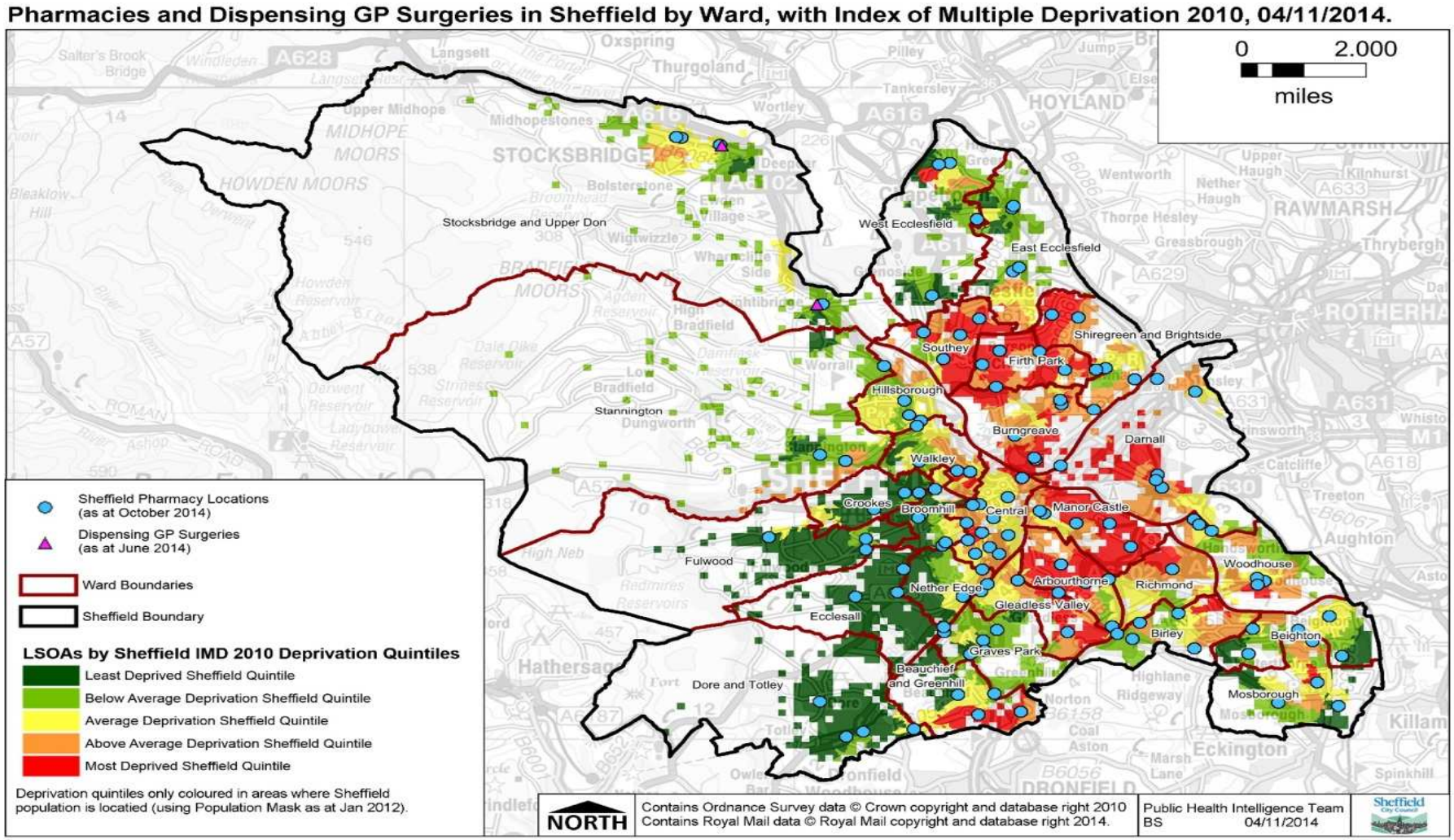


3.3 Deprivation and health inequalities

Sheffield is characterised by stark inequalities between different groups of people and between different geographical communities. People in the most deprived parts of the City still experience a greater burden of ill-health and early death than people in less deprived areas, demonstrating that inequalities in health and wellbeing are linked to wider social, cultural and economic determinants. It is acknowledged that putting additional support into the most deprived and disadvantaged areas and raising standards there will have a beneficial effect on the whole community.

The Index of Multiple Deprivation (IMD) is used to measure inequalities in the wider determinants of health. It is made up of seven indices of deprivation that are grouped together and weighted to produce the overall index (higher scores indicate greater level of deprivation). The seven indices cover: income; employment; health and disability; education, skills and training; barriers to housing and services; crime; and living environment. As the map in Figure 6 shows, there are clear geographical inequalities in the wider determinants of health in Sheffield.

Figure 6: Map of Index of Multiple Deprivation in Sheffield



Another measure of inequality is the Slope Index of Inequality in Life Expectancy. This is a modelled estimate of the gap (measured in years) in life expectancy between the most and least deprived communities within an area. Based on death rates for the period 2010-2012 the gap in life expectancy between the most and least deprived men in Sheffield is 10.0 years and 7.2 years for women. Whilst this represents a significant health inequality, it is similar to the health inequalities experienced within the other English Core Cities. Figure 7 shows the detail.

Figure 7: Gap (in years) in life expectancy between the most and least deprived areas in each core city by gender (2010-2012)

Core City	Men	Women
Birmingham	8.4	5.7
Bristol	8.2	6.1
Leeds	11.0	8.2
Liverpool	10.0	9.0
Manchester	9.6	8.2
Newcastle	11.9	9.1
Nottingham	9.2	8.7
Sheffield	10.0	7.2

Source: Public Health England 2014 Health Profiles

The main trends within Sheffield are:

- Sheffield experiences significant inequality as a result of deprivation
- Overall the northern and eastern areas of Sheffield stand out as being more deprived than the Sheffield average with the southern and western areas less deprived.
- There are small but distinct pockets of deprivation within less-deprived surroundings
- The gap between the most and least deprived areas in Sheffield remains relatively unchanged
- Generally, whichever measure of health status is used (e.g. life expectancy, premature mortality, prevalence of disease) the burden of ill health or early death is greater in those areas that experience higher levels of deprivation.
- The level of health inequality experienced within Sheffield is broadly comparable to that experienced by similar large cities in England.

4 Health and Wellbeing in Sheffield

A detailed analysis of health and wellbeing needs in Sheffield is set out in our Joint Strategic Needs Assessment (JSNA) published in July 2013. This can be accessed from the Council's website insert link In addition comprehensive health and wellbeing profiles for each of Sheffield's 28 electoral wards were produced last year, as part of the JSNA, and may be accessed from the same website. The profiles present data on population and ethnicity, deprivation and wider determinants of health, life expectancy and mortality, hospital and adult social care activity, lifestyles, key disease groups and mental health. The profiles may be accessed here insert link.

4.1 Headline health indicators

As the figures in Figure 8 show, overall Sheffield's health continues to improve and generally compares well with the national average. However, as the final two columns in the table show, the extent to which health varies across Sheffield's 28 wards is significant.

Figure 8: Headline health indicators for Sheffield

Headline health indicators for Sheffield									
Health Indicator	Period	Measure	Sheffield 2010-12	England 2010/12	Locally Calculated data and variation across Wards				
					Period	Measure	Sheffield	Worst ward	Best ward
Male life expectancy at birth	2010-2012	Years of life	**78.7**	79.21	2010-2012	Years of life	79.0	75.6	84.4
Female life expectancy at birth	2010-2012	Years of life	**82.4**	83.01	2010-2012	Years of life	85.5	76.9	87.3
Early deaths from heart disease and strokes (<75 yrs)	2010-2012	DASR per 100,000 (2013 European population)	**89.3**	81.1	2010-2012	DASR per 100,000 (pre 2013 European population)	63.3	91.6	23
Early deaths from cancer (<75 yrs)	2010-2012	DASR per 100,000 (2013 European population)	**159.0**	146.5	2010-2012	DASR per 100,000 (pre 2013 European population)	111.8	160.7	53.6
Infant deaths (Under 1 yr)	2010-2012	Rate per 1,000 livebirths (1)	**4.6**	4.1	2008-2012	Rate per 1,000 livebirths (2)	5.0	12.9	4.4
Killed or seriously injured in Road traffic accidents	2011	Rate per 100,000 population	**29.5**	40.9	2011	Rate per 100,000 population			

Source: Local calculations Public Health Intelligence team, SCC: Other data from HSCIC

(1) Death by year of occurrence , (2) Death by year of registration

4.2 Health and wellbeing priorities

Based on the information set out in the JSNA, which in turn supported the development of the Joint Health and Wellbeing Strategy for the five-year period 2013-18, various aspects of health and wellbeing were prioritised. Community pharmacy is involved in many of these to a greater or lesser extent as a provider of services, as a community asset and/or as an employer. The following areas represent those aspects of health and wellbeing where community pharmacy has the greatest contribution to make towards improving health in the City.

4.2.1 Cancer

Over 2,800 cases of cancer are diagnosed each year in Sheffield, which is broadly what we would expect for our population with 1 and 5 year survival rates generally similar to other large, urban areas. Almost 42% of all premature deaths in the City are caused by cancer, equivalent to 600 deaths per year. This makes it the leading cause of death in people under 75 years of age. Moreover, despite a reduction over the last 10-20 years, Sheffield's premature mortality rate from cancer remains significantly higher than the national average.

Over half of all premature deaths from cancer are considered preventable, which in Sheffield would equate to approximately 350 deaths a year. Common causes of cancer are smoking, poor diet, physical inactivity and alcohol consumption. A large number of premature cancer deaths could therefore be prevented by changes in lifestyle, as well as by earlier detection and treatment of the disease.

Current role of local pharmacies

- Promoting awareness of the common signs and symptoms of cancer
- Promote the benefits of and sign-posting to screening programmes for bowel, breast and cervical cancers.
- Provide access to palliative care medicines
- Promote and provide advice and support in relation to smoking cessation, alcohol consumption and maintaining a healthy weight (i.e. advice on taking regular exercise and following a healthy diet).
- Medicines optimisation[1]
- Seasonal influenza vaccination

4.2.2 Cardiovascular Disease

Cardiovascular disease (CVD) is a general term used to describe disorders that can affect the heart and/or the body's system of blood vessels (vascular). Many cardiovascular problems result in chronic conditions that develop or persist over a long period of time. However, it may also result in acute events such as heart attacks and strokes. The risk of CVD increases significantly after the age of 40 years. Around 46% of CVD deaths are from Coronary Heart Disease and almost a fifth (18%) from Stroke.

CVD occurs more frequently in people who smoke, who have high blood pressure, who have high blood cholesterol, who are overweight, who do not exercise and/or who have diabetes. Public health initiatives focus on decreasing CVD by encouraging people to follow a healthy diet, avoid smoking, control their blood pressure, lower their blood cholesterol if necessary, exercise regularly and, if they are diabetic, maintain good control of blood glucose. There are estimated to be around 52,500 people with CVD in Sheffield. Widespread changes in lifestyle choices (such as stopping smoking and improving diet), systematic identification of people at risk, and better treatment for cardiovascular disease has resulted in the premature mortality rate falling year on year in Sheffield, and at a faster pace than nationally. Nevertheless although the gap between Sheffield and the rest of the Country has narrowed, our cardiovascular premature mortality rate remains significantly

[1] General term for the various ways in which patients can be helped to gain the greatest possible benefit from their medicines.

higher than the national average. Over two thirds of premature mortality associated with cardiovascular disease is considered preventable. In Sheffield this equates to over 230 premature deaths per year.

The national 'Health Checks' programme aims to prevent heart disease, stroke, diabetes and kidney disease by inviting everyone aged between 40 and 74 years, who does not already have one of these diseases, to have their risk of developing such diseases assessed and to be referred on to appropriate services as required. The programme is currently delivered in Sheffield by GP practices although many areas commission other providers to deliver this service, including pharmacies. Together with the range of actions we are taking to ensure timely prevention and early intervention in relation to chronic disease, we anticipate further improvements in cardiovascular disease outcomes over the next few years.

Current role of local pharmacies

- Medicines optimisation
- Anti-coagulation monitoring
- Promoting awareness of the common signs and symptoms of CVD
- Promoting the benefits of and signposting to Health Checks
- Promote and provide advice and support in relation to alcohol consumption, stopping smoking and maintaining a healthy weight
- Seasonal influenza vaccination

4.2.3 Diabetes

Diabetes is a common life-long condition. When poorly controlled it can lead to a range of complications including blindness, heart attacks and strokes, kidney disease, amputation and depression as well as early death and reduced life expectancy. There are around 28,000 people with diagnosed diabetes in Sheffield with a further 6,000 estimated to have undiagnosed diabetes. Diabetes prevalence is expected to continue to rise for the foreseeable future. Lifestyle interventions (such as exercise combined with dietary advice) have been found to reduce the incidence of diabetes by almost 60% with earlier diagnosis and treatment reducing the risk of complications.

In spite of the rate of increase there is evidence that diabetes care is improving in the City. For example, the proportion of diabetes patients with good control of their blood sugar level, according to their GP record, improved from 63% in 2009 to 73% in 2012. This means that Sheffield has a favourable profile in terms of preventable morbidity and mortality outcomes and the individual disease contributions to that; especially so for a city population. The challenge for the City will be to at least maintain this favourable trend over the coming years in the context of economic and migration pressures, an ageing population and increasing obesity.

Current role of local pharmacies

- Medicines optimisation
- Promote and provide advice and support on maintaining a healthy weight.
- Seasonal influenza vaccination

4.2.4 Respiratory Disease

Respiratory disease is a general term used to cover a range of lung conditions including asthma and chronic obstructive pulmonary disease (COPD). Respiratory disease is the third leading cause of premature death in Sheffield (after cancer and cardiovascular disease) and COPD the main cause of respiratory mortality.

COPD is a progressive yet largely preventable disease, with around 85% of cases being caused by smoking. There are over 10,000 people in Sheffield with diagnosed COPD and probably the same number again with undiagnosed COPD. Asthma is more common; an estimated 35,600 people (all ages) in Sheffield have the condition. In Sheffield, approximately 70 respiratory deaths in people under the age of 75 years could be avoided each year. The single most important contribution to reducing respiratory disease is the Tobacco Control Programme designed to reduce the prevalence of smoking in the population.

Current role of local pharmacies

- Promote and provide advice and support in relation to smoking cessation.
- Medicines optimisation
- Seasonal influenza vaccination

4.2.5 Liver Disease

Liver disease is the only major cause of premature death in Sheffield for which the rate is increasing. People are also dying from it at younger ages. Premature mortality from liver disease in Sheffield now accounts for just over 70 deaths in people under the age of 75 years per year. It develops silently, often without symptoms, and many people have no idea they have a problem until it is too late.

Over 90% of deaths from liver disease are considered preventable. The common causes of liver disease are alcohol consumption, obesity and Hepatitis. Alcohol and obesity are considered in more detail later in this chapter.

Hepatitis is inflammation of the liver resulting from infection or exposure to harmful substances (such as alcohol). The types of Hepatitis most closely linked with liver damage and liver failure, are Hepatitis B and Hepatitis C. Hepatitis B is uncommon in England, being more widespread in East Asia and sub-Saharan Africa in particular. A small minority of people develop a long-term infection from the virus, known as Chronic Hepatitis B. In some people, Chronic Hepatitis B can cause cirrhosis of the liver and liver cancer. Hepatitis C is the most common type of viral hepatitis found in the UK and is commonly spread through sharing needles to inject drugs. Around 1 in 4 people will fight off the infection and remain free of it. Of the remaining 3 out of 4, the infection can become chronic where it can also cause cirrhosis and liver cancer.

Current role of local pharmacies

- Promote and provide advice and support in relation to alcohol consumption and on maintaining a healthy weight.
- Promote the benefits of and signposting to testing for Hepatitis B/C.
- Provide advice on and improve awareness of the transmission of Hepatitis B/C, including ways to reduce infection risk

- Medicines optimisation
- Seasonal influenza vaccination

4.2.6 Dementia

There are currently around 6,400 people living with dementia in the City today but this is expected to rise to over 7,300 by 2020 and 9,300 by 2030, with the biggest increase in people aged 85 years and over. The 'true' prevalence of dementia is unknown but based on national research we estimate there could be an additional 1,400 people in Sheffield with undiagnosed dementia.

The population distribution varies with age across Sheffield's wards with the majority of people aged 85 and over living in Chapeltown, Burncross, High Green, Mosborough and the south west of the City. Around one third of people with dementia currently live in largely private sector care homes, and the trend is towards entering care with more severe disease. Unpaid carers (mainly female family members) provide the majority of care in the community.

Early intervention can be cost effective and improve the quality of life for people with dementia and their families and carers, through enabling people to access suitable support services and in delaying or preventing premature and unnecessary admission to care homes. Sheffield has been chosen as an early adopter of the Prime Minister's Dementia Challenge where the focus will be on creating dementia friendly communities. This approach is being implemented first in Woodhouse.

Protecting and promoting brain health has been a relatively neglected concept until recently. The public health consensus is that what is good for the heart is good for the brain. In other words, effective public health policies to tackle the major chronic disease risk factors of smoking, physical inactivity, alcohol and poor diet across the population will also contribute towards reducing the risk of dementia in later life.

Current role of local pharmacies

- Medicines optimisation
- Dementia friendly pharmacies[2]
- Promote and provide advice and support in relation to stopping smoking, reducing alcohol consumption and maintaining a healthy weight.
- Advice to care homes
- Providing advice and support to carers
- Seasonal influenza vaccination

4.2.7 Mental Health

Those groups in the population most at risk of mental ill-health include: people who are at risk of being homeless; new and expectant mothers (e.g. post-natal depression); people

[2] Currently communities (and organisations within those communities) can register to be publicly recognised for their work towards becoming dementia-friendly. It shows that they are following common criteria, based on what we know is important to people affected by dementia and that will truly change their experience. More information is available from the Alzheimer's Society www.alzheimers.org.uk

misusing alcohol and other substances; people undergoing significant life stresses (such as debt or bereavement); people with a long term health problem or limiting illness; prisoners and people in contact with the criminal justice system; survivors of abuse or people who were in care as children; and asylum seekers and refugees. If we are to promote improved mental health and wellbeing within the general population, we need to combine universal approaches which raise awareness and understanding and reduce the stigma around mental illness with the need to identify those people within our local population most at risk of developing mental health problems and to develop and target health promoting interventions directly to them.

Mental health problems are common, with one in four people experiencing a mental health problem in their lifetime and around one in one hundred people suffering a severe mental health problem. In relation to common mental health problems, such as depression and anxiety, around 12.27% of Sheffield adults are estimated to have depression compared with 11.68% in England. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for individuals, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In terms of severe mental illness there are approximately 4,500 people with a psychosis (all ages) registered with a Sheffield GP practice. This is consistent with what we would expect to see for a population the size and shape of Sheffield.

Current role of local pharmacies

- Medicines optimisation
- Sign-posting to treatment

4.2.8 Smoking

Latest estimates (for 2012) indicate that 23.2% of Sheffield adults smoke compared with 19.5% nationally. This figure is significantly higher than the national average and has remained relatively unchanged for several years. Smoking is still the biggest, reversible cause of ill health and premature death, and inequalities in health between communities, both in Sheffield and nationally. In addition, smoking in pregnancy reduces birth weight, and contributes significantly to stillbirth and infant mortality. Reducing the prevalence of smoking within the population must continue to be a top public health priority for the City. Implementing and maintaining a comprehensive Tobacco Control Programme will be the key means by which to achieve required reduction in smoking prevalence in the population.

Tobacco control programmes include protecting people from exposure to second hand smoke, reducing the availability and supply of illegal tobacco products and help for those who want to quit. In relation to the latter, the Sheffield Stop Smoking Service supported over 1,800 Sheffield smokers to quit successfully for 4-weeks during 2013-14. Almost a third of these people were supported by pharmacies. We need to ensure smoking cessation support is accessible for patients, including offering a range of evidence based quit support (including Nicotine Replacement Therapy) and delivering support in a wide

variety of easily accessible locations, particularly in areas of relatively high need (i.e. where prevalence of smoking is higher than the City average)[3].

Current role of local pharmacies

- Provision of the Stop Smoking Service
- Provision of the Nicotine Replacement Therapy Voucher
- Dispensing of Champix via patient group direction
- General advice and promotion of healthy lifestyles including sign posting to other services as required and appropriate
- Public Health campaigns (variously related to Tobacco Control, Smokefree Homes and Cars and National No Smoking Day)

4.2.9 Alcohol

Alcohol is linked to over sixty different medical conditions including liver disease, mouth, throat and other cancers, neurological conditions (including dementia), poor mental health, reduction in fertility, as well as acute conditions resulting from accidents, self-harm and violent assault. In Sheffield, 85.8% of people aged over 16 years are estimated to drink alcohol, higher than the national average of 84.5% and the other Core Cities. Sheffield has an estimated 51,000 'high risk' drinkers and around 6,500 people are admitted to hospital each year due to alcohol-attributable conditions.

Our local alcohol strategy continues to focus on a range of approaches for tackling this issue, notably promoting screening and identification of people with alcohol related problems, including those from specific population groups (such as 18-25 year olds, Lesbian, Gay, Bisexual and Transgender people and people in the criminal justice system) to increase the number of individuals engaging with alcohol treatment alongside reducing the accessibility of alcohol, in line with government guidelines.

Current role of local pharmacies

- Provide brief interventions and signposting to treatment to address alcohol misuse.
- Support greater integration of alcohol screening with sexual health services

4.2.10 Drug Misuse

Drug misusers often suffer from multiple vulnerabilities including poor physical and mental health, offending behaviour, homelessness or inadequate housing, lack of education and unemployment. In the past drug misusers were at high risk of death from an overdose. More recently however there has been a shift in the pattern of cause of death towards people dying of long term conditions such as Hepatitis C or venous disease due to their substance misuse. The number of people screened for blood borne viruses in Sheffield

[3] Electronic cigarettes are often used by people who want to quit smoking. Tobacco is a highly addictive substance, making smoking a tough habit to break. E-cigarettes are not as effective as using NHS supported nicotine replacement therapy. Also, when people continue to smoke cigarettes and 'vape', there is not enough evidence that people quit smoking. In fact, the argument that e-cigarettes are a form of harm reduction is undermined by evidence that it does not reduce the chances of 'dual users' getting heart disease, and may mean people smoke for longer. For now, the best thing anyone who wants to stop smoking can do is to access NHS stop smoking services including those provided by pharmacies.

continues to increase with 94% of all new people arriving into structured treatment offered a Hepatitis B vaccination and 94% of injecting or previous injectors recorded as receiving a Hepatitis C test. Harm reduction must remain a priority, particularly in relation to increasing the numbers screened, tested and referred for blood borne virus treatment.

The latest data show there has been a reduction in the prevalence of people using opiates/crack cocaine in Sheffield (the second lowest rate of the Core Cities) with around 4,000 problematic opiate and/or crack drug users aged 15-64 years. In 2012-13 over 2,200 opiate users accessed structured drug treatment and over 300 individuals accessed treatment for non-opiate drug misuse. This represents a decrease of 4.7% between 2011/12 and 2012/13 and is larger than the 2% national average decrease. The emphasis on maintaining the numbers accessing drug treatment is therefore increasingly centred on the engagement of individuals using non-opiate drugs with treatment, particularly those using steroids, cannabis and the new psychoactive substances. A specific focus on certain population groups (i.e. young people, Lesbian, Gay, Bisexual and Transgender people) is required both in terms of recognising when drug use has become problematic and to ensure drug treatment services are accessible.

Further information about the commissioning plans of the Drug and Alcohol Commissioning Team (DACT) and health needs in relation to substance misuse (drugs and alcohol) can be obtained from the Sheffield DACT website

Current role of local pharmacies

- Needle exchange scheme
- Supervised administration of methadone and buprenorphine
- Promote the benefits of and signposting to testing for Hepatitis B/C.
- Provide advice on and improve awareness of the transmission of Hepatitis B/C, including ways to reduce infection risk
- Referral to treatment services
- Medicines optimisation

4.2.11 Obesity

Obesity, poor diet and increasingly sedentary behaviour are associated with higher risk of hypertension, heart disease, diabetes and certain cancers. By 2015 it is estimated that obesity will cost Sheffield £165 million per year. In terms of childhood obesity, in 2012/13, 19.6% of 4-5 year olds and 33.7% of 10-11 year olds were classed as overweight or obese. In terms of adults, in Sheffield 59.9% are estimated to be overweight or obese. Although lower than the national average of 63.8%, this level of excess weight is extremely worrying and poses a major risk to health.

Obesity is typically caused by unhealthy food choices and sedentary behaviour. Sheffield has poor levels of diet and nutrition and physical activity. It is estimated that only 25% of Sheffield adults eat five or more portions of fruit or vegetables a day, lower than the national average of 28% and around 30% are physically inactive. Estimates suggest that around 580 deaths in Sheffield a year could be prevented if diets complied with national nutritional guidelines (i.e. low in fat, added sugar and salt and high in fruit and vegetables, oily fish and fibre). Low levels of healthy eating and physical activity are the key drivers of Sheffield's increasing prevalence of obesity.

Current role of local pharmacies

- Promote and provide advice and support in relation to maintaining a healthy weight.

4.2.12 Sexual Health

The consequences of poor sexual health include unplanned pregnancy, avoidable illness and mortality from sexually transmitted infections (STIs) and HIV/AIDS. Approximately 4,350 acute STIs are diagnosed in Sheffield residents per year, of which 70% are in 15-24 year olds. The burden of sexual ill health is not equally distributed in the population but concentrated amongst the most vulnerable including men who have sex with men, young people and people from BME communities.

The City has seen a substantial and sustained reduction in the rate of teenage conceptions from 52.8 per 1000 15-17 year old girls in 2001 to 30.3 in 2012. Nevertheless, although the gap is narrowing, Sheffield's rate is still significantly higher than the national average (27.7 per 1000), and it is important therefore that this remains a priority area. An emergency hormonal contraceptive service for teenagers (girls aged 14-17 years) is commissioned by Sheffield City Council from community pharmacy, including signposting for long-acting reversible contraception and condom provision.

Evidence from our local health needs assessment indicates we should maintain focus on reducing teenage conceptions, unplanned pregnancies and prevalence of STIs/HIV through increasing access to contraception and STI/HIV testing, specifically for high risk groups, alongside health promotion and education to improve public awareness and encourage safer sexual behaviour. Key to achieving good sexual health outcomes is the commissioning of universal open access sexual health services via a 'hub and spoke' model which focuses on the development of community based outreach sexual health services. Services need to be fully integrated to offer patients a single point of access, pathways between primary and secondary care services should be prioritised and organisations should work collaboratively to look at how new and existing services and interventions can meet the needs of our local population.

Current role of local pharmacies

- Providing emergency hormonal contraception
- Advice on and signposting to Long Acting Reversible Contraception (LARC)
- Providing chlamydia screening.
- Referral to relevant treatment and advice services
- Supporting integration with alcohol screening
- Public Health pharmacy campaign (variously related to being prepared/keeping safe from STI/unwanted pregnancy, provision of condoms and self-testing kits for chlamydia and gonorrhoea).

4.2.13 Health of children and young people

There is now overwhelming evidence that conception through to the early years is a crucial phase of human development and is the time when focussed attention can bring huge rewards for society. Infants thrive when they feel safe, secure and loved. Therefore the foundations for children's communication, social and emotional development and nutrition lie in the quality of the parent-infant relationship, and the interactions they experience.

Supporting parent-infant relationships is a priority for Sheffield. We know that the mental and physical health of mothers during and immediately after pregnancy can have lifelong impacts on the child. Factors such as nutrition, smoke exposure and decisions about immunisation will impact on the child's future health and wellbeing. Key priorities continue to include reducing maternal obesity, improved support for post-natal depression, increasing breastfeeding, reducing smoking in pregnancy, reducing teenage pregnancy and improving uptake of childhood vaccination & immunisation.

The Sheffield Every Child Matters Survey (2012) identified that the number of 14 and 15 year olds saying they feel sad or depressed 'most of the time' has increased from 9% in 2011 to 14% in 2012. Also, fewer of them said they would know where to go for help or support to deal with their feelings. 30% have thought about running away and 10% said they had actually run away. The main reasons given were problems at home and feeling unable to cope with things. We also know that over half of all adults with mental health problems will have begun to develop them by the time they are 14 years old. Vulnerable young people (such as those living in poverty, those 'Not in Education, Employment or Training' (NEETs), or those who are homeless or in care) are more likely to suffer poor emotional health than other young people. They are also more likely to misuse alcohol and other substances.

Current role of local pharmacies

- Promoting the importance of breastfeeding and immunisation and vaccination, including signposting to relevant support.
- Raising awareness of the potential consequences of leaving children unprotected, especially within vulnerable communities.
- Promote and provide advice and support in relation to stopping smoking, reducing alcohol consumption and maintaining a healthy weight, particularly during pregnancy.
- Sign-posting to and advice about treatment
- Promoting and providing advice in relation to adolescent health needs – particularly as these relate to sexual health, mental health, smoking, alcohol consumption and drug misuse.
- Minor ailments scheme
- Seasonal influenza vaccination (pregnant women)

4.2.14 Older people's health

People are living longer. In the last 10 years, Sheffield has experienced a 24% increase in the number of people aged over 75 years and a 39% increase in people in the over-85 year age group. Compared with the other main cities in England (excluding London), Sheffield has the highest proportion of its population aged 65 years or over (15.5%). The fact that people are generally living much longer is an important achievement and something that we should celebrate. However, with increased longevity comes the increased potential for poorer health and frailty, and we face a key challenge in ensuring increases in life expectancy are not accompanied by a longer time spent in ill health.

Currently around 11,000 to 12,000 older people (approximately 14% of all people over 65) receive some adult social care support in Sheffield. By 2025 it is estimated that there will

be a 23% increase in people aged over 75 years living alone, and an increase of 21% in people over 65 years old unable to manage at least one self-care activity on their own. At present, it is also estimated that nearly 7% of people aged over 65 years are living with some form of dementia. The growing population of older people is estimated to increase demand for care homes by around 1% per year. The changing age profile of residents is anticipated to change the support required with individuals already presenting with increasingly complex, high dependency needs. National evidence suggests we can expect to see a gender difference in dependency, with higher numbers of women experiencing severe disability or requiring help with self-care tasks.

In the context of an ageing population therefore greater attention will need to be paid to the way in which we provide prevention and early intervention and increasingly integrated, community-based support when problems occur that will help to maintain the independence of the older person. Key health needs relate to mental health (particularly depression), sensory impairment, frailty/disability, dementia, multiple morbidity (and related medicine use) and health and social care service use.

Current role of local pharmacies

- Medicines use reviews
- Medicines optimisation
- Minor ailments scheme
- Access to palliative care medicines
- Advice to care homes
- Falls care pathway
- Seasonal influenza vaccination
- Dementia Friendly Pharmacy
- Providing support and advice for carers
- Provide support and advice around maintaining independence
- Promoting the benefits of and signposting to screening for sight/hearing problems including Public Health pharmacy campaign related to preventable sight loss.

5 Pharmaceutical Services and Need

5.1 Pharmaceutical Provision in Sheffield

5.1.1 Types and locations

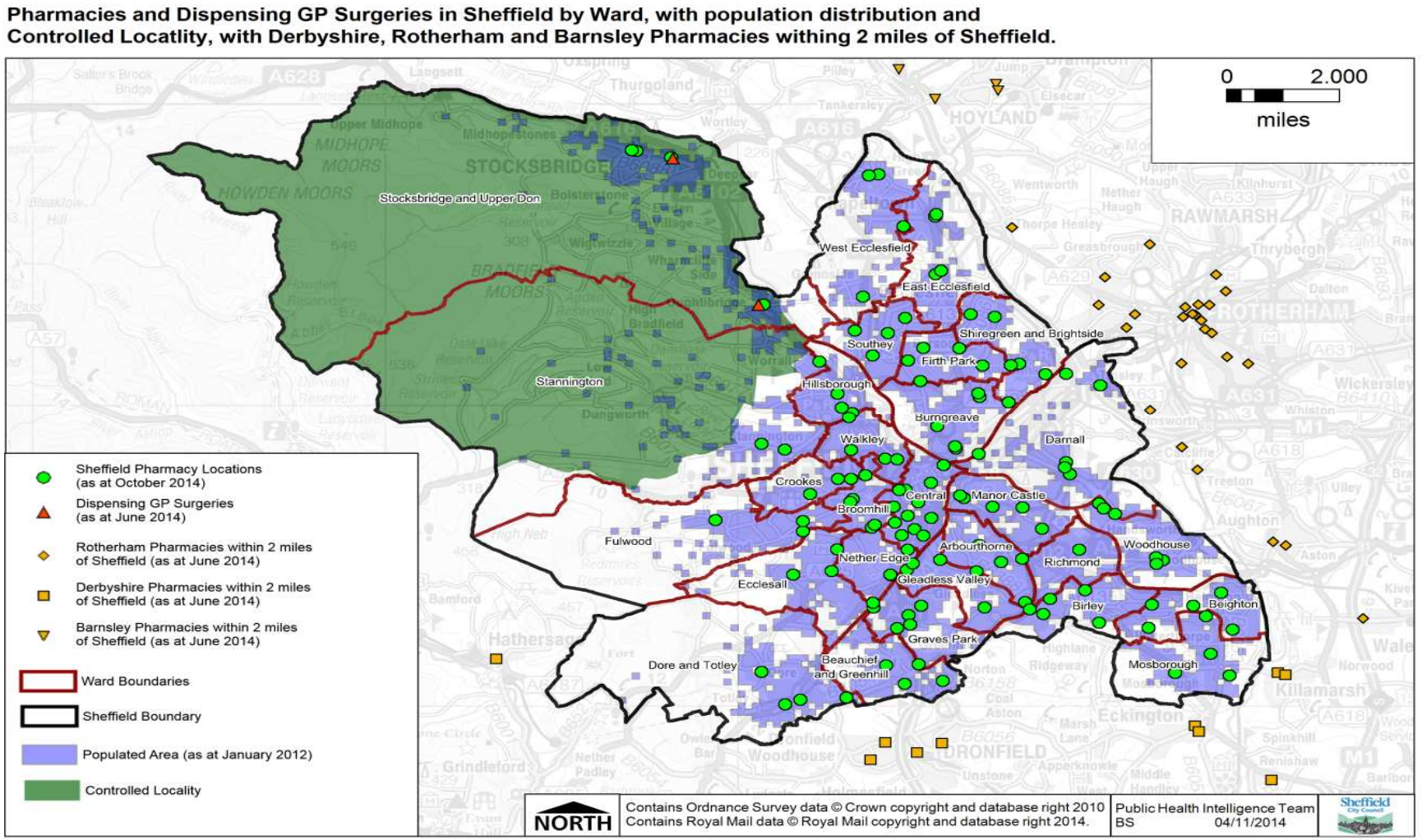
There are 128 pharmacy contractors in Sheffield. This includes three distance selling pharmacies based in the Woodhouse, Nether Edge and Darnall wards respectively, and one essential small pharmacy (under LPS arrangements) in the Dore and Totley ward. In addition, there are 43 pharmacies outside of the Sheffield boundary that provide services to Sheffield residents (10 in Derbyshire, 28 in Rotherham and 5 in Barnsley). Sheffield also has two dispensing doctors based in the areas of Deepcar and Oughtibridge both of which are in the Stocksbridge and Upper Don ward. The map in Figure 9 illustrates this provision.

These pharmacies together with the two dispensing practices dispense prescriptions mainly generated from the 87 general practices in Sheffield (114 locations, taking main and branch surgeries into account), 84 dental practices and 48 opticians, as well as some prescriptions generated from outside the City. In 2012-13 the average number of prescriptions items dispensed per month per pharmacy in Sheffield was 7,792 compared to 6,628 items per pharmacy per month in England[4]. These figures do not take account of the variation in prescribing frequencies or presence of large retail centres (such as Meadowhall in the east of the City).

The two dispensing practices in the Stocksbridge and Upper Don ward operate within a ‘Controlled Locality’. NHS legislation provides that in certain rural areas classified as controlled localities, general practitioners (GPs) may apply to dispense NHS prescriptions. Permission is granted to GPs providing there is no "prejudice" to the existing medical or pharmaceutical services. The controlled locality in Sheffield was determined in the 1980s to cover the largely rural area in the north west of the City. Patients who live in a controlled locality are entitled to have their prescriptions dispensed by the dispensing practice at which they are registered.

[4] Health and Social Care Information Centre General Pharmaceutical Services Report 2003-04 to 2012-13 (published November 2013).

Figure 9: Map of pharmacies and locations in and around Sheffield



There are three NHS foundation trusts in the City; Sheffield Teaching Hospitals Foundation Trust (STHFT) which includes an A&E department, community nursing and intermediate care services as well as acute hospital provision, Sheffield Children's Hospital Foundation Trust (SCHFT) – which includes an A&E department and Sheffield Health and Social Care Foundation Trust (SHSCFT).

Other providers include Claremont and Thornbury which are both private sector general hospitals and St Luke's Hospice all three of which are based in the south west of the City. These are shown, together with GP practices, in the map in Figure 10.

In addition, the Sheffield Clinical Commissioning Group (SCCG) employs a clinically focused, multidisciplinary Medicines Management Team to improve the care of patients and the outcomes they achieve via the use of safe, clinically effective and cost efficient medicines.

5.1.2 Access

Analysis shows that 99.2% of Sheffield's resident population lives within 1 mile of a pharmacy and that there are no GP practices more than 0.5 miles from a pharmacy. There is at least one pharmacy located in each of Sheffield's 28 electoral wards. On average 4,547 people in Sheffield are served per pharmacy which is lower than the average for England (4,654 population per pharmacy)[5]. This represents slightly better coverage than the national position.[6]

The Contractual Framework requires community pharmacies to have monitoring arrangements in place in respect of compliance with the Equality Act (2010) in terms of facilities and patient assessments. All pharmacies in Sheffield either have wheelchair access or another mechanism for enabling access. Access arrangements are assessed by NHS England as part of its contract monitoring visits.

5.1.3 Opening times (Monday to Friday, Saturday and Sunday)

Most of Sheffield's pharmacies open between 8.30am-9.00am Monday to Friday with some opening much earlier (between 6.00am and 7.00am). The majority of pharmacies close between 5.00pm and 6.00pm. The majority of pharmacies are also open on a Saturday (90) although many close by 1.00pm and 28 are open on a Sunday. The charts in Figure 11 illustrate this provision.

[5] All figures exclude the three distance selling pharmacies and 2 dispensing GP practices and are therefore based on a total of 125 pharmacies

[6] GP registered population data as at January 2012 and pharmacy data from the Health and Social Care Information Centre General Pharmaceutical Services Report 2003-04 to 2012-13 (published November 2013).

Figure 10: Map of hospital and GP practice providers in Sheffield

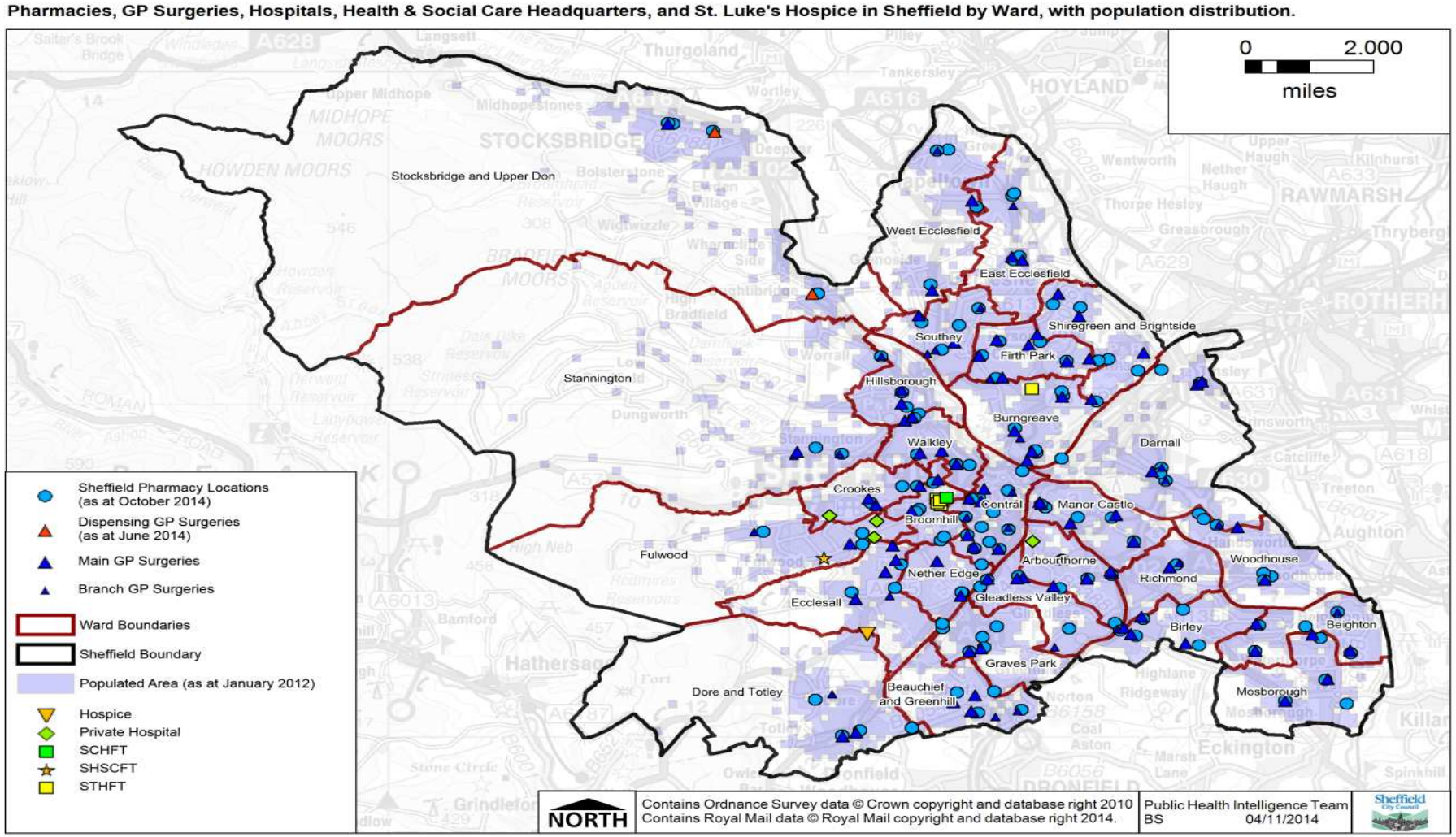
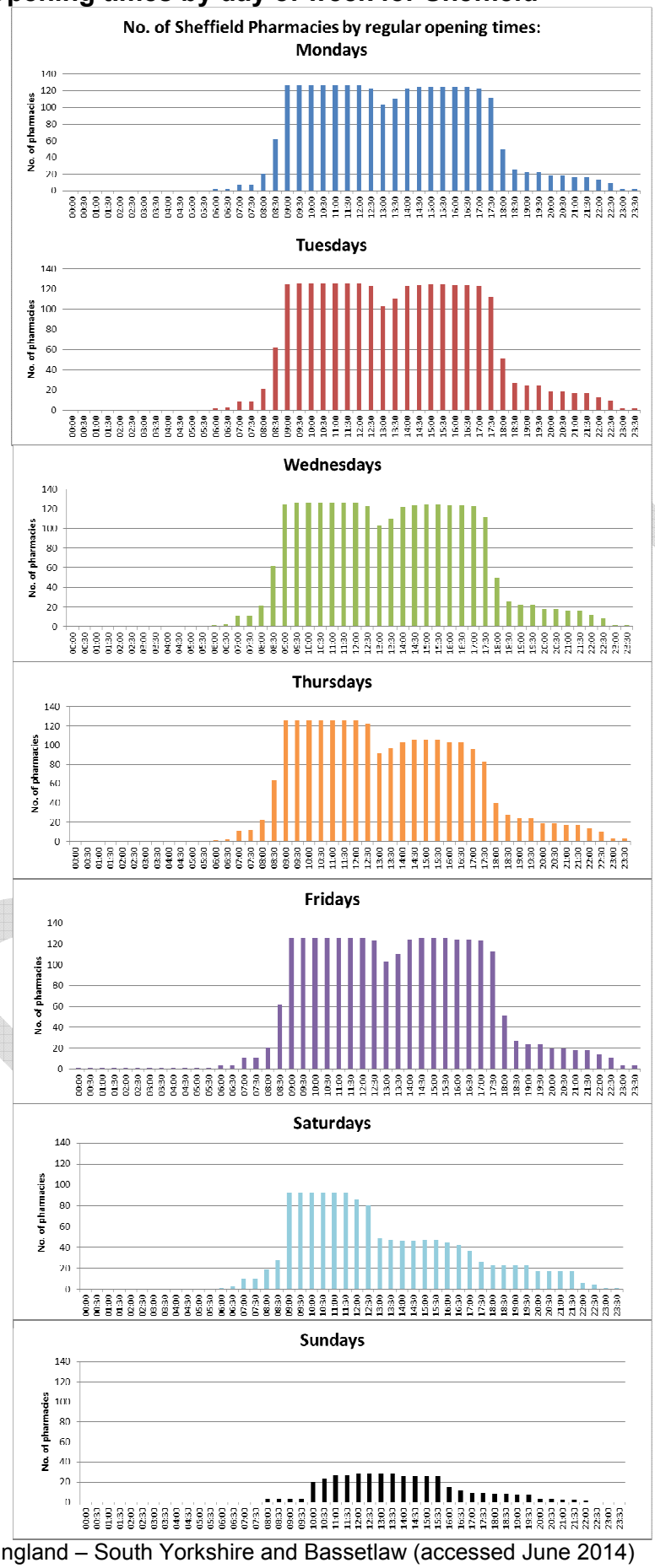


Figure 11: Opening times by day of week for Sheffield



Source: NHS England – South Yorkshire and Bassetlaw (accessed June 2014)

5.1.4 Out of Hours (bank holidays and evenings)

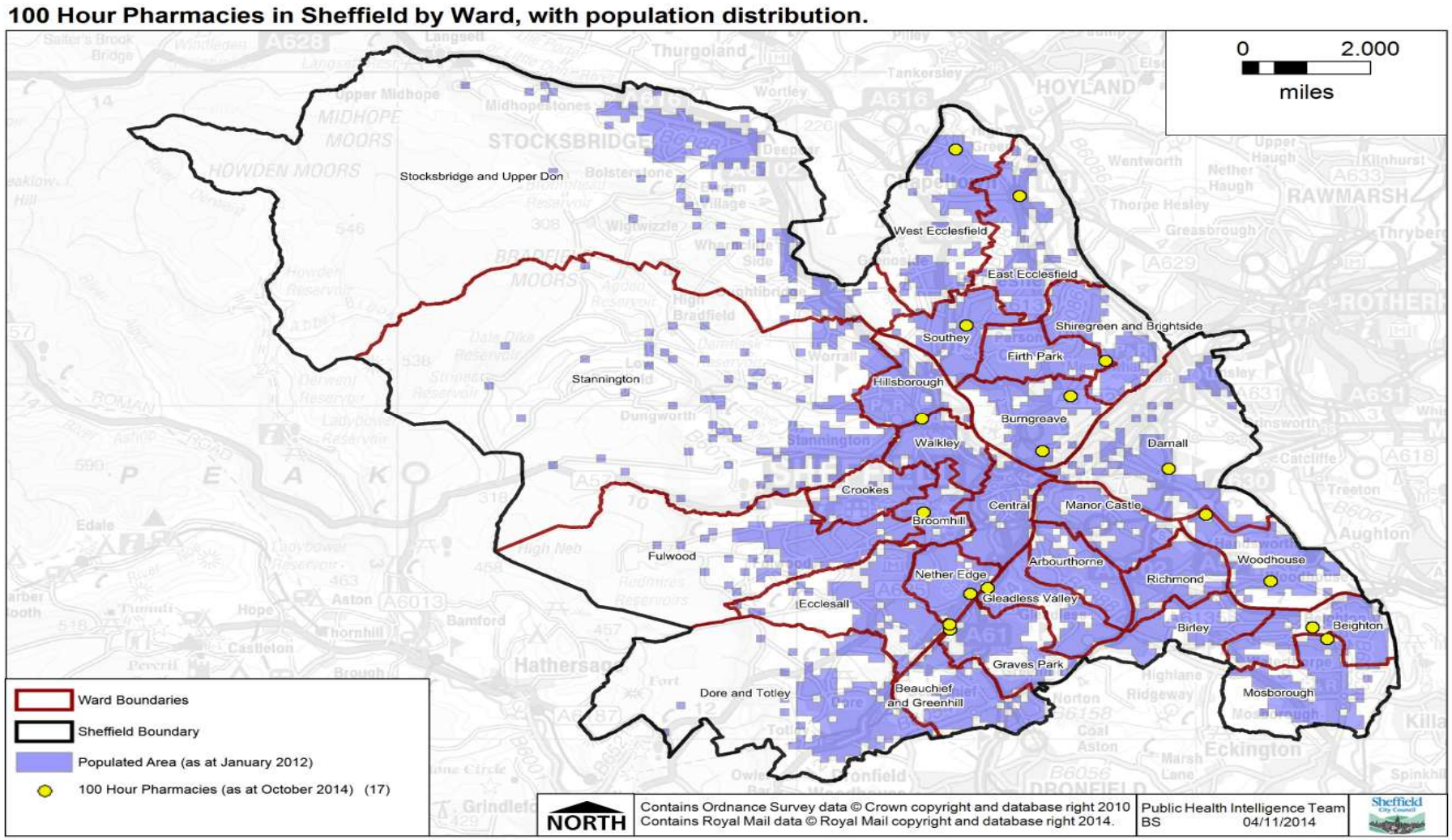
The Sheffield Clinical Commissioning Group (CCG) currently commissions three pharmacies (one in Stocksbridge and Upper Don ward and two in the Central ward) to provide an extended hours service covering bank holidays and Sundays. The CCG is currently reviewing this service however and this is likely to result in the procurement of new arrangements. Further details will be added to the PNA when these become available in 2015.

There are seventeen 100-hour pharmacies in Sheffield who generally open around 7.00am and close between 10.00pm and Midnight. These pharmacies add considerably to the out of hours pharmaceutical provision within the City. Many of these pharmacies are located within supermarkets or retail areas. The map in Figure 12 shows the locations of the 100-hour pharmacies in Sheffield.

Members of the public may also obtain emergency prescriptions and/or medication when their GP is closed by contacting the GP Collaborative (out of hours service). Prescriptions may also be obtained by attendance at the GP led walk-in centre based on Broad Lane in the City Centre (8.00am to 10.00pm, 7 days a week, 365 days a year). Medicines legislation also allows pharmacists to issue emergency supplies to patients under certain circumstances. Healthcare professionals have emergency access to medications (e.g. urgent controlled drugs) outside normal opening hours (i.e. overnight, weekends and public holidays) through the GP Collaborative. The service has access to an on-call pharmacist provided by the Sheffield Teaching Hospitals Foundation Trust and on average this is used approximately 2-3 times a month.

Community pharmacy's traditional role in supporting people to self-care for minor illnesses is an important way in which to manage demand for other NHS services, especially general practices, visits to A&E, and supporting people using the NHS 111 service. The commissioning of the Minor Ailments Service for example, allows pharmacies to provide care to those who might otherwise visit the GP or A&E; providing a network of pharmacies across Sheffield and which effectively act as healthcare walk-in centres where people live, work and shop.

Figure 12: Map of 100-hour pharmacies in Sheffield



5.2 Pharmaceutical services in Sheffield

The Community Pharmacy Contractual Framework is made up of the following service types.

5.2.1 Essential services

These services are set out in schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. All pharmacy contractors in Sheffield provide the full range of essential services which are:

- Dispensing medicines and actions associated with dispensing
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted medicines
- Public Health (promotion of healthy lifestyles)
- Signposting
- Support for self-care
- Clinical governance

5.2.2 Advanced services

Any contractor may choose to provide Advanced Services. In so doing there are requirements which need to be met in relation to the pharmacist, standard of premises or notification to NHS England. The majority of Sheffield's pharmacies (99) provide a Medicines Use Reviews service (MURs)[7] and 34 provide a New Medicines Service (NMS)[8].

5.2.3 Enhanced and locally commissioned services

Only those contractors directly commissioned by NHS England can provide enhanced services. In view of the change in the commissioner landscape however, pharmacy contractors may now also provide services commissioned by local authorities and Clinical Commissioning Groups (CCGs). Although these locally commissioned services are not enhanced services, they mirror the services that could be (and in other parts of the Country are) commissioned by NHS England and are therefore included within the list of pharmaceutical services in order to provide a full picture of current provision in the City. For Sheffield, these services include (commissioning organisation is shown in brackets):

- Seasonal influenza vaccination (NHS England)
- Anti-coagulation monitoring (SCCG)
- Advice to care homes (SCCG)

[7] MURs involve pharmacists undertaking structured reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. The process is designed to establish a picture of the patient's use of their medicines, understand their therapy and identify any problems they may be experiencing and potential solutions.

[8] The NMS provides support for people with long term conditions newly prescribed a medicine, to help them improve adherence and thus lead to better health outcomes.

- Extended opening hours (SCCG)
- Minor ailments scheme (SCCG)
- Not dispensed scheme (reducing waste) (SCCG)
- Carpal tunnel splints (SCCG)
- Assured availability of palliative care drugs (SCCG)
- Needle and syringe exchange (SCC)
- Chlamydia screening (SCC)
- Stop smoking service (SCC)
- Nicotine Replacement Therapy (NRT) voucher dispensing (SCC)
- Champix dispensing under patient group direction (SCC)
- Supervised administration of methadone and buprenorphine (SCC)
- Emergency hormonal contraception under patient group direction (SCC)

Figure 13 sets out provision of these services across Sheffield's 28 wards. In summary this analysis demonstrates that key locally commissioned services such as the minor ailments scheme, not dispensed scheme, stop smoking related dispensing, seasonal influenza vaccination and supervised administration are provided by the majority of community pharmacies in Sheffield.

Other locally commissioned services, such as emergency hormonal contraception and needle exchange, whilst provided by fewer pharmacies, are aligned to areas of relevant need e.g. in relation to areas of deprivation and areas within or very close to the City Centre. In addition, the Sheffield CCG is planning to build upon the current voluntary arrangements by which 18 pharmacies (mainly 100 hour pharmacies) stock the most commonly required palliative care drugs, assuring availability at all times of opening. This will be explored in the wider context of pharmaceutical support to palliative care services.

This leaves a small number of services that currently only a handful of pharmacies are providing. The Anti-Coagulation Monitoring service is commissioned as part of a wider model of cardiovascular provision for Sheffield. This model is currently under review and anti-coagulation monitoring requirements may therefore change as a result. A new 'Advice to Care Homes' service has also only recently been commissioned and may increase in the future. The carpal tunnel splint service is commissioned from one pharmacy only and will not be increased from this level.

5.2.4 Patient satisfaction

All pharmacies are required to conduct and publish an annual community pharmacy patient questionnaire (formerly referred to as the Patient Satisfaction Questionnaire). The questionnaire allows patients to provide valuable feedback to community pharmacies on the services they provide. Strengths and areas for improvement are identified and actively pursued by the pharmacy. Overall patient satisfaction with pharmacies in Sheffield is good with typical areas for improvement covering waiting times and comfort and convenience of waiting areas.

Healthwatch Sheffield[9] also conducts a 'Have Your Say' survey which allows people to feedback on different aspects of health and social care services. In relation to pharmacy

[9] www.healthwatchsheffield.co.uk

provision within the City, the most recent survey results (January to June 2014) show high levels of satisfaction with obtaining the help, advice and treatment required across the range of pharmacies, geographical areas and population groups of Sheffield. The main area for improvement is again concerned with waiting times.

In addition the NHS Choices website[10] provides patients with the opportunity to comment on and rate almost any NHS service, including pharmacies. Virtually all of the comments posted about pharmacies in Sheffield are positive with a key feature being the range and quality of advice, support and reassurance offered '*above and beyond what you'd expect from a chemist'*[11]. Other comments include knowing where to park and an instance of weekday afternoon closing.

5.2.5 The changing face of pharmacy

It is important to note the ways in which pharmacy and its role within the community has changed since the last PNA was produced. Two areas where change is profound are the increased use of technology and the focus on medicines optimisation.

In the case of the former, the Electronic Prescription Service in Sheffield is becoming mainstream (when compared to other areas) with GPs sending prescriptions electronically to their patients' nominated pharmacies. Within the pharmacy, increasing levels of automation are helping to keep pace with the demands of dispensing and some organisations are taking this further with 'hub and spoke' type operations where large centres can service the needs of local pharmacies. This type of approach, if successfully implemented, can release pharmacists to spend more of their time engaged in patient focussed clinical roles.

Another role is supporting medicines optimisation, which is the term now increasingly used to describe the ways in which patients can be helped to gain the greatest possible benefit from their medicines. Community pharmacists, with their unrivalled levels of patient contact, are key to the success of this concept, delivering services such as the New Medicines Service and Medicines Use Reviews. The ageing population and the increasing numbers of patients with long term conditions mean that treatment with medicines will remain a reality for millions of patients for the foreseeable future; pharmacy will need to continue to respond to this challenge.

[10] http://www.nhs.uk/Pages/HomePage.aspx

[11] The NHS Choices website was accessed on 25th July 2014 and 28th October 2014

Figure 13: Summary of enhanced and locally commissioned services by electoral ward

Enhanced and Locally Commissioned Services		GRAND TOTAL	Arbourthorne	Beauchief and Greenhill	Beighton	Birley	Broomhill	Burngreave	Central	Crookes	Darnall	Dore and Totley	East Ecclesfield	Ecclesall	Firth Park	Fulwood	Gleadless Valley	Graves Park	Hillsborough	Manor Castle	Mosborough	Nether Edge	Richmond	Shiregreen and Brightside	Southey	Stannington	Stocksbridge and Upper Don	Walkley	West Ecclesfield	Woodhouse
Commissioner	Service																													
SCCG	Extended Hours opening	3							2																		1			
SCCG	Not dispensed Scheme (reducing waste)	104	4	3	2	5	4	5	10	2	5	4	4	4	5	3	4	5	4	4	5	2		4	3		2	3	3	5
SCCG	Minor Ailments Scheme	123	4	3	5	5	6	6	12	2	5	4	4	3	5	3	5	6	5	5	5	2	1	5	4	3	3	3	4	5
SCCG	Anti-coagulant monitoring service (heart disease)	3	1			1																							1	
SCCG	Advice to care homes	10					1	1	3			1						1	1		1	1								
SCCG	Carpel Tunnel Splints	1							1																					
SCCG	Palliative Care Medicines	18			1		1	1	2		1		1	1	1		1	1	1			1			1		1		1	2
SCC	Substance Misuse Services: Supervised Administration	107	4	2	2	5	5	5	9	1	5	3	4	6	5	2	5	4	5	5	3	1	1	5	4	2	3	3	4	4
SCC	Substance Misuse Services: Needle & Syringe Exchange	22				1	1	1	5	1	1			2	1				1	3	1	1			1				1	1
SCC	Sexual health: Chlamydia Screening	7	1				1		2												2						1			
SCC	Sexual health: Emergency Hormonal contraception	38	1	1	2	2	3	2	7	2	1		2			2	3	1	1	1	2	1			1		1		1	1
SCC	Smoking: Stop Smoking Service	24	1		1	3			5		2	1			2		1	1			1			1	1	1	1		1	1
SCC	Smoking: Nicotine Relacement Therapy Voucher Dispensing	111	3	3	5	5	6	6	8	2	5	4	3	5	4	3	4	6	5	4	4	2	1	5	4	2	2	3	3	4
SCC	Smoking: Champix dispensing	63	1	2	4	3	3	3	5	2	4	3	1	1	1	1	1	2	4	1	3	1	1	4	2	1	1	3	2	3
NHSE	Seasonal influenza vaccination service	69	3		3	5	3	3	6	2	2	2	2	4	3	2	4	3	3	2	3			3	3		2	2	2	2
	Total Number of Pharmacies	125	4	3	5	5	6	6	12	2	5	4	4	4	5	3	5	6	5	5	5	2	1	5	4	3	4	3	4	5

Reported position as at October 2014

SCCG = Sheffield Clinical Commissioning Group; SCC = Sheffield City Council; NHSE = NHS England (South Yorkshire and Bassetlaw)

5.3 Future developments and improvements

There are a number of future developments, in relation to pharmacy services, health services and other relevant services that could impact on the need for pharmaceutical services in the future. These are considered as follows:

5.3.1 Pharmacy First

With primary care facing unprecedented demand and GP services increasingly coming under pressure it is essential that the NHS deploys, to best effect, all of the clinical resources available to it. Pharmacy is the third largest health profession and delivers care at scale seeing 1.6 million patients a day in England. This equates to around 20,000 per day in Sheffield. Valuable though this contribution is there is the potential for it be far more effectively utilised via greater integration with the other elements of primary care.

Approximately 90% of pharmacy business is derived from the NHS. Whilst the majority sits within the national contracting framework there is increasing scope for local commissioning and co-commissioning of services from pharmacy where these meet local needs. To achieve maximum benefit from the resources available from pharmacy, commissioners will need to commit to fully integrating pharmacy into NHS primary care. Integration at the front end of primary care, via a “pharmacy first” model, has the potential to make the greatest impact with respect to both urgent care and the care of patients with long term conditions.

Given that these are amongst the greatest challenges facing the NHS there is a clear rationale for commissioners to explore how to make best use of pharmacy’s contribution to higher quality primary care in the City.

The potential/enhanced role of local pharmacies

- Immediate access – convenience and longer opening hours
- Case finding – engagement with well people; opportunities for proactive interventions (e.g. alcohol screening, bowel cancer screening)
- Support for self-care, demand management, patient education
- Medicines support and optimisation – better outcomes from medicines
- Monitoring – long term condition management
- Treatment – minor ailments, ‘flu vaccinations
- Referrals – integration with care pathways (e.g. falls)

5.3.2 Public health role of pharmacies

Pharmacy has a key and expanding role to play in supporting public health outcomes through provision of prevention and early intervention services and support and helping to tackle health inequalities.

Sheffield City Council (SCC) is currently developing its commissioning model for public health funded community programmes, set within the broader strategic context of keeping people well. A key element of this model is the development of the Community Wellbeing Programme which is designed to promote health and wellbeing in those communities in Sheffield where it is worst. We want to develop partnerships with primary care providers, including pharmacies, to develop services that fit the needs of the local area, are trusted and more likely to be taken up by those who need them most. Overall, the approach is designed to develop social capital or 'community assets' that help people to maintain and improve their health and wellbeing.

One such area ripe for further development is Healthy Living Pharmacies. Healthy Living Pharmacies aim to improve the health and wellbeing of the local area and help to reduce health inequalities by delivering, through community pharmacies, a broad range of public health services including a stop smoking service, brief alcohol interventions, weight loss, treatment of minor ailments, contraception and sexual health and targeted medicine use reviews to meet local health needs. One of the key distinctions of a Healthy Living Pharmacy is having a trained Healthy Living Champion who engages proactively with the population served, using every interaction as an opportunity to promote health and 'make every contact count'.[12] Evaluation of pathfinders has demonstrated that the Healthy Living Pharmacy model is capable of making a significant contribution to improving health and wellbeing in the area[13].

There are many other opportunities for pharmacies to play a greater role in promoting health and wellbeing where it is poorest and we want to develop this in the context of our community wellbeing programme. Key areas of the City will be those where the level of deprivation is greatest and details of deprivation score by electoral ward are given in Appendix B.

The potential/enhanced role of local pharmacies

- 25 pharmacies have already embraced the Healthy Living Pharmacy approach in Sheffield, covering 17/28 wards. Although we would encourage the presence of a Healthy Living Pharmacy in all of our wards we are keen to see further developments in the following three wards of Burngreave, Shiregreen and Brightside and Richmond.
- Provision of a range of health promoting services and advice including, for example, Health Checks, screening, immunisation and vaccination, weight management, Best Start in Life (e.g. oral health, Healthy Start Vitamins) and provision of Mental Health First Aid[14]

[12] More information on Healthy Living Pharmacies is available from http://www.npa.co.uk/business-management/service-development-opportunities/healthy-living-pharmacy/

[13] Royal Pharmaceutical Society (2013) Evaluation of the Healthy Living Pharmacy Pathfinder Work Programme 2011-2012. Available from www.psnc.org.uk

[14] Mental Health First Aid is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health problem see http://mhfaengland.org/ for

5.3.3 Other developments

Over the next 10 years it is anticipated that a number of new houses and apartments will be built across the City. Two thirds of these dwellings are likely to be apartments, including for students. Over half of the dwellings, assuming all progress according to plan, will be focussed primarily in the Central ward (which includes the City Centre) and, to a lesser extent, the Manor Castle ward. Given the current pharmaceutical provision in these wards, the type of housing to be built, the proposed timescale and pace of development, and assuming all sites go ahead as planned, it is concluded that existing pharmaceutical provision within these areas is likely to be sufficient to meet need/demand.

In relation to other related health and social care developments (such as primary care health centres or nursing homes) applications for such developments are dealt with on a case by case basis. Where a proposed development is likely to introduce more than 100 new residents or more than 10 beds into the area, the Clinical Commissioning Group is consulted by the Council as part of its overall consideration of implications for the local support infrastructure; this would therefore include potential implications for pharmaceutical provision. As and when this arises, the Health and Wellbeing Board will issue a statement supplementary to this PNA where relevant and proportionate.

more details. Contact bob.levesley@sheffield.gov.uk to find out about courses in Sheffield and how to apply.

6 Conclusions

The key element of a pharmaceutical needs assessment is the requirement to assess the extent to which the demography of the local population and its pharmaceutical health and wellbeing needs align with service provision. Information has been collected about pharmaceutical provision within and outside Sheffield and this has been mapped to demographic information and the health needs of our 28 electoral wards. A table setting this information out in detail is included as Appendix B. In addition, details of current service provision and future developments have been considered.

In summary, our analysis of this information shows that:

- Sheffield is well-served by its pharmacies and dispensing doctors with good coverage and choice across the different areas of the City and good availability and access arrangements, including out of hours.

- Patient satisfaction with the facilities and services provided by pharmacies in Sheffield is generally good with areas for improvement identified and taken forward.

- There are no gaps in current provision.

- There are good links with other NHS services within the City both in relation to primary care (especially GP practices) and acute hospital services. Nevertheless, it is recognised that there is potential to develop this much further, particularly in the context of developing integrated primary care services.

- In terms of health needs, Sheffield's pharmacies are already contributing extensively to raising awareness and understanding of health risks, promoting healthy lifestyles, providing advice and signposting/ referral to treatment and providing services, often in more accessible and acceptable settings.

- Demographic and cost pressures from patients with long-term conditions is only likely to increase in the coming years and pharmacy's continued role in helping to meet this need is acknowledged. Further development of the public health role of pharmacy and commissioning of relevant services could therefore secure additional improvement in health.

- Known future other developments are unlikely to generate a significant level of need/demand for additional pharmaceutical provision over the lifetime of this PNA (2015-18).

7 Appendix A: Consultation Report

7.1 The consultation process

A consultation on the first full draft of the PNA took place for a period of 60 days from 1st August to 30th September 2014, in line with the 2013 Regulations. A short online questionnaire was prepared for this purpose and stakeholders were contacted by email and letter inviting comment. The letter included a link to the questionnaire and the PNA document was included as an attachment. Printed versions of both the questionnaire and the PNA were made available on request. Weekly reminders were sent to pharmacies via the Sheffield LPC e-newsletter throughout the consultation period.

7.2 Responders

The table in Figure 14 sets out the stakeholders consulted and who responded.

Figure 14: Stakeholder responses

Stakeholder	Number Responded
Sheffield Local Pharmaceutical Committee	1
Healthwatch Sheffield	1
Sheffield Local Medical Committee	1
Community Pharmacies	13
Dispensing practices	1
Sheffield Teaching Hospitals NHS Foundation Trust	1
Sheffield Children's Hospital NHS Foundation Trust	0
Sheffield Health and Social Care NHS Foundation Trust	0
Barnsley Health and Wellbeing Board	0
Rotherham Health and Wellbeing Board	0
Derbyshire Health and Wellbeing Board	0
NHS England (South Yorkshire & Bassetlaw)	0

Three of the community pharmacy responses were from Pharmacy Groups. A response was also received from NHS Sheffield Clinical Commissioning Group and two further responses were unidentified. As NHS England (South Yorkshire and Bassetlaw) participated as a member of the PNA Steering Group (providing data, supporting analysis and commenting on drafts), a formal response to consultation was not required (although details were sent). In total 21 responses were received.

7.3 Summary of responses

The following tables summarise the responses received to each of the six consultation questions, alongside the action taken by the PNA Steering Group.

Question 1: Do you agree with our assessment that current pharmaceutical service provision meets the needs of the Sheffield population? 15 responses agreed; 2 responses disagreed; 4 responses missing.

Q1b If no, please explain.

Comment	Response
Figure 14 shows number of branches in each ward that offer Enhanced/Locally Commissioned Services. However, we cannot draw conclusions that every ward is sufficiently served with services based on this information. We cannot say if there are gaps in particular wards. This means that we are unable to prove that offering a particular service would be an improvement.	Information on the health and wellbeing of wards was provided via a web-link in the document. It would have been impractical to include this information as part of the document as it represents almost 200 pages. Figure 14 (re-numbered Figure 13) is just a summary. More detail is given in Appendix B.
Further consideration should be given to the provision of pharmaceutical services to NHS Sheffield patients, by providers outside the boundary of Sheffield.	The PNAs of Rotherham, Barnsley and Derbyshire take these considerations into account.
Whilst the PNA recognises that there are no dispensing appliance contractors in Sheffield, needs may be met by agency type schemes where Sheffield patients accesses DAC through their local community pharmacy. Acknowledgement should be extended to community pharmacies that choose to dispense appliances, either directly or via agency schemes. Greater information should be available to the public.	It is acknowledged that pharmacies outside of Sheffield, which may be used by Sheffield residents, can include dispensing of appliances. This will be investigated further by SCCG to determine the extent to which relevant information is made available to patients using these services.
No pharmaceutical cover at late night until early morning by a pharmacy	People may access late night/early morning pharmaceutical advice via the GP out of hours service.
Attercliffe is a highly deprived area and there is no access to pharmaceutical services for at least a mile away.	Attercliffe is a low density residential area < 1,000 residents. Residential areas are concentrated in two areas; one is around Spital Hill and there are two pharmacies less than 1 mile away. The second is close to Staniforth Road and there are three pharmacies within a mile of this area.

Question 2: Do you agree with our assessment of the ways in which pharmacies could make a greater contribution to improving the health of Sheffield people? 18 responses agreed; 1 response disagreed; 2 responses missing.

Q2b If no, please explain.

Comment	Response
Section 5.3.1 states that a potential enhanced role of local pharmacies would be to have immediate access – convenience and longer opening hours, however the PNA does not state which branches this refers to.	This section refers to pharmacies in general so it applies to all pharmacies.
Section 5.3.2 states that there are 26 Healthy Living Pharmacies in Sheffield, but the PNA does not state which branches these are and which wards they are in.	Appendix B shows which wards the Healthy Living Pharmacies are in. This information has been updated since publication of the consultation draft and now identifies 25 Healthy Living Pharmacies. The SCCG maintains the detail of this provision.
Allow us to increase services such as weight loss and stop smoking.	Currently the SCC commissions weight loss services from voluntary sector providers as part of broader programmes to promote social capital and community development within wards and neighbourhoods. However the need to offer a range of provision, in conjunction with other relevant public health services, particularly for deprived communities, is identified in the PNA and this could therefore include weight management services. Stop smoking services and related prescribing (including Champix) are already commissioned from the majority of pharmacies.
Stop smoking service currently is too time consuming and under-funded.	Comments concerning the Stop Smoking Service have been raised with SCC commissioners as part of on-going development of the Tobacco Control Programme for the City.

Question 3: Do you agree with our assessment that there are acceptable levels of 'out of hours' pharmaceutical provision in Sheffield? 14 responses agreed; 6 responses disagreed; 1 response missing.

Q3b If no please explain

Comment	Response
Section 5.1.3 states that 'most of Sheffield's pharmacies open between 8.30am & 9.00am Monday to Friday with some opening much earlier...', however, it does not state how many pharmacies open at 6am, 7am, 8am 8.30am & 9am and where they are within Sheffield.	Figure 11 shows the number of pharmacies open at these times and clearly shows there are no significant gaps in provision. Information about opening times is updated frequently and including this level of detail within the PNA would therefore become quickly out of date. The detail of opening times by individual pharmacy is held by NHS England and can be accessed from the NHS Choices website. This information was accessed to support the analysis of the PNA and the link to the NHS Choices website included in the document.
Figure 11 does not show the exact number of pharmacies open late Monday to Friday, Saturday or Sunday, or where these 'Out of Hours' pharmacies are situated (i.e. their addresses).	Figure 11 shows number of pharmacies open at these times and Figure 12 shows locations of the 100 hours pharmacies. Appendix B provides details of 100 and 40 hour pharmacies, extended hours pharmacies and number opening on Saturdays and Sundays by ward. The detail of opening times by individual pharmacy is held by NHS England and can be accessed from the NHS Choices website. This information was accessed to support the analysis of the PNA and the link to the NHS Choices website included in the document.
Recently a pilot service involving NHS 111 referred emergency supplies, was commissioned using non-recurrent winter resilience funds. The PNA should consider capturing this service and the associated need.	The SCCG is currently exploring expanding this service to eligible pharmacies, subject to appropriate market infrastructure, linked to winter resilience arrangements and resources.
The out of hours service in the Stocksbridge area is inadequate.	People may access late night/early morning pharmaceutical advice via the GP out of hours service.
Figure 13 is inaccurate, there is a 100 hour pharmacy in the Darnall ward	Information has been updated; now shows the 100 hour pharmacy in Darnall (NB this is now re-numbered as Figure 12)
Currently 2 pharmacies are paid to provide extended cover, named in PNA as Lloyds and Wicker, they are NOT really providing extended cover at all as there are pharmacies which are open longer and earlier providing better coverage, so why are these pharmacies being paid?	The SCCG currently commissions 3 pharmacies to provide the extended hours (bank holiday) service in Sheffield. SCCG is currently reviewing this service however and this is likely to result in the procurement of new arrangements. Further details will be added to the PNA when these become available in 2015.

100 hour pharmacies don't have to open on bank holidays, but that is not enough to pay approx 35k to each of these pharmacies, it will be better to pay 100 hour pharmacies to open on these days and cheaper for the NHS. (by the way all the supermarket, city centre and Meadowhall pharmacies are open on bank holidays except Xmas day).	There are 17, 100 hour pharmacies in Sheffield and 3 pharmacies who provide the extended hours (bank holiday) service. In relation to the latter, SCCG is currently reviewing this service and this is likely to result in the procurement of new arrangements. Further details will be added to the PNA when these become available in 2015.
Sheffield NHS should fund a 24 hour pharmacy in Sheffield to provide full pharmaceutical coverage.	There is insufficient demand in Sheffield for this type of provision.
Currently there are approx 11 pharmacies providing 100hrs a week pharmaceutical cover. Giving 2 pharmacies a contract to stay open on bank holidays is totally unnecessary as other care providers are open on the bank holidays and open for longer. They are strategically placed within the city to provide good coverage. This money could be better utilised in minor ailment funding or other services	There are 17, 100 hour pharmacies in Sheffield. In addition, SCCG currently commissions 3 pharmacies to provide the extended hours (bank holiday) service in Sheffield. SCCG is currently reviewing this service and this is likely to result in the procurement of new arrangements. Further details will be added to the PNA when these become available in 2015
The pharmacies getting paid to stay open on bank holidays is totally outrages (sic). How someone has made this decision when there are 12 100hr pharmacies in Sheffield I do not know. They are all strategically placed within the city for even coverage. The funding should be divided - 4 pharmacies each given £500 for 8 hours opened. That £2000 per day cost to NHS x 9 days = £18000. Saving of £42k.	There are 17, 100 hour pharmacies in Sheffield and 3 pharmacies who provide the extended hours (bank holiday) service. In relation to the latter, SCCG is currently reviewing this service and this is likely to result in the procurement of new arrangements. Further details will be added to the PNA when these become available in 2015.
Early morning provision and Sunday provision is very poor. Especially in areas like Attercliffe.	People may access pharmaceutical advice via the GP out of hours service as well as other services located in nearby areas. See response about Attercliffe under Question 1.
Section 5.1.5 states that there are only two pharmacies in the Central ward commissioned to provide extended hours service, when there is a pharmacy in Stocksbridge also commissioned to offer this service. This pharmacy is, however, included in Appendix B.	The SCCG currently commissions 3 pharmacies to provide the extended hours (bank holiday) service in Sheffield; two are based in the Central ward and 1 is based in the Stocksbridge and Upper Don ward. This information is reported in section 5.1.5 of the PNA.

Question 4a: Are there any additional pharmaceutical services that should be provided in Sheffield? 13 responses agreed 8 responses disagreed

Q4b If yes please give details

Comment	Response
Medicines Optimisation – strengthen and expand services particularly in relation to people with long term conditions and older people.	SCCG is currently examining potential to take this forward and our PNA supports this.
Out of Hours – supply of medicines in all pharmacies; dedicated centre on a Sunday.	There are 17, 100 hour pharmacies in Sheffield and 3 pharmacies who provide the extended hours (bank holiday) service in Sheffield. In relation to the latter, SCCG is currently reviewing this service and this is likely to result in the procurement of new arrangements. Further details will be added to the PNA when these become available in 2015.
Emergency contraceptive service - expand to include those who would not normally pay for NHS prescriptions but preferably to all women who need the service promptly	The service is targeted towards 14-17 year olds in response to the need to reduce teenage conceptions. Although the rate is reducing there is still more to do and this will need to remain the focus of the service for the foreseeable future.
Health checks – provided by pharmacies	The current commissioning model is based on GP practice provision. However the need to offer a range of provision, in conjunction with other relevant public health services, particularly for deprived communities is identified in the PNA and this could therefore include Health Checks.
Healthy Start Vitamins – distributed by pharmacies	As a standalone service this in unlikely to be viable. However the need to offer a range of provision linked to a best start in life, in conjunction with other relevant public health services, particularly for deprived communities is identified in the PNA and this could therefore include Healthy Start vitamins.
Weight management service – provided by pharmacies	The current commissioning model is based on voluntary and community sector provision. However the need to offer a range of provision, in conjunction with other relevant public health services, particularly for deprived communities, is identified in the PNA and this could therefore include weight management services.
Diagnosis and management of hypertension - provided by pharmacies	SCCG is currently examining potential to take this forward.
Stop Smoking Service – should be simpler to run and better funded.	Comments have been raised with SCC commissioners as part of on-going development of the Tobacco Control Programme for the City.

Question 5: Was the process used to produce the PNA appropriate? 20 responses agreed; 1 response disagreed

Q5b If no please explain

Comment	Response
Sheffield Health & Wellbeing Board did not issue a Pre Consultation Pharmacy survey for pharmacies to complete so we cannot be sure that the pharmacy information (contact details, opening hours, services offered) is 100% accurate.	All our information was obtained from NHS England (South Yorkshire and Bassetlaw). Pharmacies are contractually obliged to provide this information (accurately) to NHS England. NHS England is responsible for maintaining and updating the information. The information was correct at the time the initial assessment was undertaken (June 2014) and updated following the consultation, in October 2014. Details are also available via the NHS Choices website and a link to this website is provided in the PNA.

Question 6: Any other comments

Comment	Response
The draft PNA does not give details of each pharmacy within Sheffield, i.e. address, opening times and services provided, which makes it difficult to check that all the information is accurate.	Our information was obtained from NHS England (South Yorkshire and Bassetlaw). Pharmacies are contractually obliged to provide this information (accurately) to NHS England. NHS England is responsible for maintaining and updating the information. The information was correct at the time the initial assessment was undertaken (June 2014) and updated in October 2014. Details are also available on NHS Choices and a link to this website is provided in the PNA.
Figure 14 – Summary of Enhanced & Locally Commissioned Services by Electoral Ward – Services are detailed as number of branches offering the service within each ward, however there is no information given as to which pharmacies offer which services.	This table is a summary and more detail is provided in Appendix B. Please note the table has been re-numbered as Figure 13.
A number of non-NHS commissioned services have been identified in the PNA. These services contribute to meeting pharmaceutical needs for people with long term conditions (e.g. compliance aids and Medication Administration Record Schemes). Other medication management solutions currently offer practical support for navigating the NHS repeat prescription service such as prescription collection and delivery services. These interventions often allow people to stay in their own home longer and therefore support the conclusion to consider formalising an NHS Service.	We agree; we are keen to see these and other, similar services developed further although it should be noted that we would not necessarily commission such services.
As a dispensing practice we would like to have special permission to dispense to the elderly in sheltered housing opposite the surgery. Access to the village chemist is almost impossible for most of them.	Such changes may be made providing relevant conditions are met (as set out in part 8 of regulation 48 [*arrangements for the provision of pharmaceutical services by doctors: applications by patients*] of the National Health Service Pharmaceutical and Local Pharmaceutical Services Regulations 2013). In summary, the relevant GP would need to make an application, on behalf of the individual patients who have requested this change, to NHS England (South Yorkshire and Bassetlaw) for approval.
The number of pharmacies offering the NMS seems low. Is it possible to encourage more to offer the service?	We are keen to see this number increase over the coming years.
Improvements in communication between GPs and pharmacies, summary care records	We agree; this is why we included the progress being made with implementation of the electronic prescription service in Sheffield. We are also participating in a national pilot of the summary care record (due to report in 2015-16)

8 Appendix B: Summary Table of Pharmacy Services by Ward

Pharmacy HNA Ward Summary Quilt

Version 2.0 October 2014

Areas are shown in order of deprivation; highest at the top least at the bottom.

Some columns are coloured by Quintile of values from Highest (Red), Middle (Yellow) to Lowest (Green). Please note that for some indicators the highest values do not necessarily represent a worse outcome.

Other columns are coloured light (least) to dark (most) blue to illustrate provider numbers.

Ward code	Ward Name	Deprivation score (1):	All Cause <75 Mortality Rate (2)	Population (3)				Total no. GP Surgeries (5)	Pharmacies Provision (6)					Advanced Services (6)		Enhanced and Locally Commissoned Services (6)																		No. Healthy Living Pharmacies
											Number of pharmacies providing:			Number of pharmacies providing:		Number of pharmacies providing:								Substance Misuse		Sexual Health		Smoking						
				Total Registered Population (Jan 2012)	No. Aged Under 5	No. Aged 75+	% BME (4)		Total no. Pharmacies (6)	Population per pharmacy (7)	Maximum Open on a Saturday	Maximum Open on a Sunday	100 hr pharmacies	New Medicines Service	Medicines Usage Review	Extended Hours	Not Dispensed Scheme	Seasonal Influenza Vaccination	Minor Ailments Scheme	Anticoagulant Monitoring Service	Advice to care homes	Palliative Care Drugs	Carpal tunnel splints	Needle & Syringe Exchange	Supervised Administration	Chlamydia Screening	Emergency Hormonal contraception	Stop Smoking Service	Nitotine Replacement Therapy	Champix (Stop Smoking)	
E05001056	Manor Castle	53.9	500.1	21,524	1,464	1,180	26.6	5	5	4,305	1			1	5		4	2	5					3	5	1	1		4	1	1
E05001051	Firth Park	52.5	514.6	22,189	1,822	1,597	25.4	7	5	4,438	5	1	1	1	3		5	3	5			1		1	5			2	4	1	1
E05001044	Burngreave	46.8	529.9	30,097	2,745	1,822	61.9	6	6	5,016	5	2	2		3		5	3	6		1	1		1	5		2	0	6	3	
E05001039	Arbourthorne	46.8	469.6	19,368	1,263	1,576	17.1	4	4	4,842	2			1	2		4	3	4	1					4	1	1	1	3	1	1
E05001061	Southey	46.0	452.8	19,956	1,384	1,409	7.4	5	4	4,989	3	1	1		4		3	3	4			1		1	4		1	1	4	2	1
E05001060	Shiregreen and Brightside	41.2	507.0	22,106	1,732	1,193	18.6	4	5	4,421	2			2	4		4	3	5						5			1	5	4	
E05001047	Darnall	41.1	454.2	25,332	2,159	1,571	48.5	6	5	5,066	3	2	1	1	4		5	2	5			1		1	5		1	2	5	4	2
E05001053	Gleadless Valley	36.6	432.4	21,005	1,398	1,523	19.1	6	5	4,201	5	1	1	1	4		4	4	5			1			5		3	1	4	1	1
E05001059	Richmond	33.0	442.1	17,965	1,068	1,662	7.3	5	1	17,965	1				1				1						1				1	1	
E05001040	Beauchief and Greenhill	31.4	403.7	18,932	1,186	1,984	9.1	6	3	6,311	3				1		3		3						2		1		3	2	1
E05001045	Central	31.3	409.1	34,885	1,225	646	46.3	10	12	2,907	9	5		4	12	2	10	6	12		3	2	1	5	9	2	7	5	8	5	3
E05001066	Woodhouse	27.8	444.9	17,862	906	1,925	7.6	2	5	3,572	5	2	2	1	3		5	2	5			2		1	4		1	1	4	3	1
E05001064	Walkley	27.5	431.1	22,791	1,152	1,249	30.2	3	3	7,597	2	1		3	3		3	2	3						3				3	3	
E05001042	Birley	25.5	344.7	17,171	904	1,761	4.7	2	5	3,434	3				5		5	5	5	1				1	5		2	3	5	3	3
E05001057	Mosborough	21.1	287.5	17,823	971	1,351	5.3	3	5	3,565	5	3	1	1	4		5	3	5		1			1	3	2	2	1	4	3	
E05001055	Hillsborough	19.8	328.9	19,243	1,116	1,376	8.2	4	5	3,849	2	1	1	2	4		4	3	5		1	1		1	5		1		5	4	
E05001049	East Ecclesfield	19.6	327.3	18,669	883	1,672	4.0	3	4	4,667	4	2	1	1	3		4	2	4			1			4		2		3	1	2
E05001065	West Ecclesfield	18.8	328.1	18,496	918	1,737	3.9	3	4	4,624	3	1	1	2	3		3	2	4	1		1		1	4		1	1	3	2	2
E05001041	Beighton	18.0	353.9	17,549	894	1,263	5.5	4	5	3,510	1	1	1	2	3		2	3	5			1			2		2	1	5	4	2
E05001063	Stocksbridge and Upper Don	17.8	340.0	19,285	993	1,655	3.2	3	4	4,821	3	1		3	4	1	2	2	3			1			3	1	1	1	2	1	1
E05001062	Stannington	15.6	275.9	18,721	900	1,869	5.3	4	3	6,240	1			3	3				3						2			1	2	1	
E05001058	Nether Edge	15.6	286.3	19,548	1,117	1,137	29.9	2	2	9,774	1		1		2		2		2		1	1		1	1		1		2	1	
E05001043	Broomhill	13.9	362.3	16,444	377	780	19.0	3	6	2,741	4	2	1		5		4	3	6		1	1		1	5		3		6	3	
E05001054	Graves Park	13.6	292.3	17,454	939	1,664	8.2	2	6	2,909	5	1	1	3	4		5	3	6		1	1			4		1	1	6	2	
E05001046	Crookes	8.0	236.2	17,655	807	1,371	14.2	2	2	8,828	2				2		2	2	2					1	1		2		2	2	1
E05001048	Dore and Totley	7.4	259.8	17,074	776	2,126	7.8	3	4	4,269	3				4		4	2	4		1				3			1	4	3	1
E05001052	Fulwood	5.4	207.5	19,449	650	1,466	14.7	2	3	6,483	3			1	2		3	2	3						2		2		3	1	1
E05001050	Ecclesall	4.8	214.9	19,841	1,107	1,641	11.8	5	4	4,960	4	1	1	1	2		4	4	3			1		2	6				5	1	
Sheffield		27.1	373.1	568,434	32,856	42,206	19.2	114	125	4,547	90	28	17	34	99	3	104	69	123	3	10	18	1	22	107	7	38	24	111	63	25

Notes

(1) IMD2010, May 2012 Calculations. LSOA level IMD scores have been attributed to Wards based on the proportion of the Ward population resident within each LSOA.
(2) 2008-2012,Directly Age Standardised Rate per 100,000 using 2013 Euro standard population
(3) Data Source: Sheffield Registered Population, January 2012. Public Health Register (persons registered with GP practices).
(4) Data Source: 2011 Census. BME refers to Non-White British (ethnic groups other than 'White British').
(5) Branch and Main surgeries counted separately. As at June 2014.
(6) Pharmacies Provision, Advanced Services, Enhanced and Locally Commissioned Services as at October 2014 unless specified elsewhere.
(7) Note Richmond ward: Even though the population per pharmacy is high, none of the population of Richmond ward is more than 1 mile from a phamacy as there are several just over the boundary of the ward.

Public Health Intelligence Team, Sheffield City Council

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Councillor Julie Dore and Dr Tim Moorhead
Date:	11 December 2014
Subject:	Briefing on Preparedness for Winter and the Ebola Virus
Author of Report:	Louisa Willoughby *and others as specified in the report*, 0114 205 7143

Summary:

This paper provides a short update to the Health and Wellbeing Board on the Preparedness for Winter and the Ebola Virus.

Recommendations:

That the Health and Wellbeing Board receives the report and thanks those, especially volunteers, who will support the frail and unwell over the winter period.

Briefing on the Preparedness for Winter

Completed by Steve Ashmore, NHS Sheffield CCG and Lorraine Mitchell, Sheffield City Council

Overview

This briefing summarises the arrangements made by the NHS and Social Care in Sheffield to ensure services are able to respond to the anticipated increased patient need and continue to achieve national standards.

Healthcare

NHS Sheffield CCG has £3.77m funding available to support preparedness for winter over 2014/15. This national resilience funding provides the local economy with welcome additional resources to target admissions avoidance and streamline admission processes, profiling work across the week and days, to enable the better management of patient flow, including at weekends and peak holiday periods, so that patient need is met and national standards, including the four hour maximum wait in A&E, are met.

Our plan ensures the resilience of the existing system working with our large provider partners. However we are also supporting a number of innovative projects with a more diverse range of providers. These schemes will pilot and test small, often community based, projects that should keep people well in the community and reduce flows to GPs and Hospital care developing or not. The programme represents a balance of investment across the health and social care system. Initiatives are complementary to ensure 'flow' through the system.

Since this process was completed further additional funds have been allocated to Sheffield Teaching and Sheffield Children's Hospitals by NHS England. This funding is specifically focused on achieving the 4-hour Accident and Emergency Target. It is possible that there may be some further additional funding for Mental Health Services but we have not yet been informed of any final decision.

Surge Planning Group

It is important that all organisations across the health care system are sighted on each other's winter plans and that we understand the interdependencies across the system. To facilitate this the Surge Planning Group, a sub-group of the System Resilience Group, chaired by the Sheffield CCG Medical Director, Dr Zak McMurray, has been established. This group, and the use of resources described above, will ensure that the health and social care system in Sheffield is as well prepared as possible for the impact of winter on the health of our population.

Social Care

- There is a joint plan between Sheffield City Council, Sheffield Teaching Hospitals Primary and Community Services [PCS], Sheffield Health and Social Care Trust and Continuing Health Care [CHC] that can be activated in a business continuity incident to ensure that the organisations work together to support existing service users and other vulnerable people. This is called the Local Area Continuity Team [LACT]. Some new staff have been recruited to support potential need over the winter.

- All care homes have individual contingency plans in the event of an enforced emergency closure or evacuation. In the event of a home closing under such circumstances the 'serious incident process' would be implemented and all sections would be involved in facilitating appropriate care.

- New developments on prevention and early intervention are being introduced such as Community Support Workers who liaise with GPs to identify vulnerable people within the community and to refer them to support if needed.

- Community Support Workers will be managing a network of volunteers to support frail and vulnerable older people (identified through their work) who have no access to formal or family support. If we have heavy snow or prolonged periods of severe weather, people on our at risk register are contacted to find out if they have enough food, medication and that their heating is working and on. Where this is not the case a named volunteer is dispatched to take whatever is required.

- The Drugs and Alcohol Coordination Team in Sheffield City Council requires all commissioned providers to have up to date business continuity plans which as a minimum should cover severe weather events. They work closely with pharmacies to ensure service can be provided through alternative routes should business as usual be affected by winter weather, sickness etc. A robust communication strategy is established within plans and all agreements are signed off by the Head of Medicines Management, NHS.

- Clear guidance is available to the general public on a range of websites as to preventative measures to take during winter months. Further information is made available to advise the public should there be sustained activity which affects day to day living and services available. This includes links to information from the Department of Health and the NHS.

Briefing on the Ebola Virus

Completed by Ruth Granger, Health Protection Manager, Public Health, Sheffield City Council

The current situation

There is currently an outbreak of Ebola Virus Disease in West Africa. Three countries are chiefly affected: Guinea, Liberia, and Sierra Leone. There have also been a small number of cases in healthcare workers who have treated Ebola patients in the USA and Spain.

Ebola is a rare but serious viral infection. People in the UK are at low risk of Ebola, as the virus is only transmitted by direct contact with the blood or bodily fluids of an infected person, showing symptoms of the disease. There have been no cases of Ebola virus disease being contracted in the UK.

It remains unlikely but not impossible that people infected in Guinea, Liberia or Sierra Leone could arrive in the UK. These countries have exit screening at airports to ensure that individuals who are unwell do not board flights. The UK has also introduced entry screening for people arriving from these three countries. However, as the time between infection and symptoms first appearing can be up to 21 days, it is possible that individuals returning from affected countries could develop symptoms up to three weeks after arrival.

In summary:

- The risk of Ebola arriving in the UK is **low**.
- Transmission of Ebola from person to person is only by direct contact with the blood or body fluids of an ill person with the disease. The virus is **not** spread by the airborne route.
- The time between infection and symptoms first appearing (incubation period) of Ebola ranges from two to 21 days.
- People arriving back in the UK having travelled from any of the **affected countries**, and who are free of symptoms, are **not infectious** and there should be **no restrictions** on their school attendance or normal activities.
- Only people with symptoms of Ebola can infect others. Symptoms include fever, diarrhoea and vomiting.

Preparedness in South Yorkshire

In line with national plans relating to Ebola a number of actions have been taking place in South Yorkshire. Three exercises have been held in October and November testing the preparedness of health services and wider partners for dealing with a case of Ebola and the wider consequences for communities.

The Royal Hallamshire Hospital Infectious Diseases department is one of the 4 High Level Isolation Centres across the country that could, if required, receive a case of Ebola. Sheffield Teaching Hospital Foundation Trust have planned extensively for this eventuality.

South Yorkshire Local Resilience Forum (LRF - the partnership group that plans and responds to emergency situations) has discussed Ebola preparedness and the Local Resilience Forum public information and media group has met to coordinate communication messages about Ebola across South Yorkshire Public Sector Organisations.

Sources of further information:

Public Health England has produced fact sheets and guidance for a wide range of settings and audiences including:

- Public Health England Ebola advice and risk assessment for educational childcare and young person's settings https://www.gov.uk/government/publications/ebola-advice-and-risk-assessment-for-educational-childcare-and-young-persons-settings last updated 17th October 2014.
- Facts and mythbusters https://www.gov.uk/government/publications/ebola-top-facts-and-mythbuster.

This briefing includes information produced by Public Health England.

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 25 September 2014

PRESENT: Councillor Julie Dore (Chair), Dr Tim Moorhead (Co-Chair), Ian Atkinson, Jackie Drayton, Pam Enderby, Mazher Iqbal, Mary Lea, Jayne Ludlam, Dr Zak McMurray, John Mothersole and Dr Jeremy Wight, Director of Public Health

In Attendance

Fiona McCaul, Programme Director, Programme for Integrated Commissioning

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Richard Armstrong, Laraine Manley and Ted Turner.

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where it was proposed to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. PUBLIC QUESTIONS

4.1 Public Question in respect of Personal Healthcare Budgets

Mike Simpkin commented that NHS England was actively encouraging the introduction of personal healthcare budgets. He therefore asked what effect did the Board think this was likely to have on health and social care services in Sheffield?

Tim Moorhead commented that the issue had been debated at the Clinical Commissioning Group. Sheffield was required to implement personal healthcare budgets as their introduction was in national legislation. There had been pilots in the City over the last 2-3 years. Success had been mixed and the use of personal budgets had not been shown to reduce service costs. There was still a lot to learn and the impact on the social care system had not yet been understood.

Councillor Julie Dore added that there was a wish to see assessments integrated as having separate assessments for health and social care did not make sense.

Councillor Mary Lea commented that personal budgets within social care had been used for a number of years. There had been issues which had arisen. It was

important to closely monitor budgets. There is evidence to suggest the system can work better if budgets were integrated. Further discussions would be held on the issue.

Pam Enderby commented that the issue had also been discussed at Healthwatch Sheffield where concern had been expressed about the changes to social care budgets. She stated that it would be useful to have some information on the Council's website as a lack of information about the changes was causing concern about the impact.

5. UPDATE ON THE JOINT HEALTH AND WELLBEING STRATEGY: OUTCOME 1 - SHEFFIELD IS A HEALTHY AND SUCCESSFUL CITY

5.1 The Co-Chairs of the Board submitted a report in relation to the Joint Health and Wellbeing Strategy. It had been agreed that each progress on each outcome would be examined one by one. Outcome 1 of the Strategy was about the wider determinants of health, including employment, housing and poverty. Board Members were invited to discuss the report in depth and pay particular attention to the Living Wage, Fuel Poverty and Worklessness.

5.2 Members of the Board made comments on the matters contained in the report summarised as follows:-

- The Council was moving towards becoming a Living Wage employer. Sheffield University had made the same commitment and the Chamber of Commerce had agreed to support the principle of the Living Wage where companies could afford it. There were concerns about viability for some companies.

- The Sheffield Executive Board was tasked with overseeing the implementation of the recommendations from the Fairness Commission. The role of this Board was to identify things where the Board felt it could make a difference.

- The health and care sector were working towards the implementation of the Living Wage by 2019. The sector was looking at minimising the impact of austerity measures putting pressure on staff.

- Within the health and care sector the introduction of the Living Wage would increase costs and reduce demand. Poverty was a driver of ill health.

- The Clinical Commissioning Group paid above the Living Wage. Sheffield Children's Hospital and the Health and Social Care Trust also paid the living wage. Sheffield Teaching Hospitals supported the Living Wage in principle and were looking into its implementation.

- The introduction of the Living Wage across the City was an ambition for the Fairness Commission but could not be considered a target. It was about winning the hearts and minds of employers and continuing to influence their decisions.

- The implication for welfare costs of the implementation of the Living Wage

should not be forgotten. This would move some of the burden onto the employer where it should be and would result in more money being available to invest in health services.

- There had recently been a Board established to look at the social and equality impact of future investments of the Local Enterprise Partnership (LEP). The Health and Wellbeing Board could help by feeding in the health and social impacts which needed to be achieved.

- When the Regional Growth Fund had been established it was understood that a lot of the economy was based around small businesses. The bid was therefore for a lot of money to be managed on a small scale. It was not just about the creation of a large number of jobs but also the importance of the type and quality of those jobs. There was no wish to create jobs which were low skilled with no prospect of progression.

- The Sheffield Executive Board would examine progress towards the creation and implementation of a city-wide fuel poverty strategy. The Council had established a Green Commission to look at how the cost of energy could be reduced.

- The Director of Public Health would investigate progress with the Warm Homes and Healthy People project and report back to the Cabinet Member for Communities and Public Health.

Resolved that the Board:

1. Accepts the Living Wage, Fuel Poverty and Worklessness as key areas of focus arising from the Fairness Commission and that progress on Outcome 1 of the Joint Health and Wellbeing Strategy will be reported to this Board and the Sheffield Executive Board;

2. Supports the ongoing programme of needs assessment and requests that a report be submitted to a future Board meeting on tackling air quality; and

3. Requests another update on this outcome in September 2015.

6. MENTAL HEALTH IN SHEFFIELD: A SNAPSHOT

6.1 Pam Enderby, Chair of Healthwatch Sheffield, submitted a report detailing the Health and Wellbeing Board's Engagement Event of the 24th July, facilitated by Healthwatch Sheffield, on Mental Health. The report contained a write up of findings, recommendations, methodology and a full set of responses.

6.2 Pam Enderby commented that the event was very successful with more than 80 people in attendance, 60% of which had been service users either at present or in the near past. Discussions were held on ten areas that had been highlighted via other routes as causing a concern in Sheffield and these were highlighted in the report.

6.3 The comments at the event were reported in full in the report. Some people who were not able to attend in person were linked into the event through the web or Twitter.

6.4 It should be possible for some of the issues raised to be addressed in the short term. It was important to ensure services were joined up.

6.5 Not many carers who attended the event. Of those who did, many had said that they often felt excluded and found it difficult to access information and support.

6.6 Members of the Board made comments on the matters contained in the report and accompanying presentation, summarised as follows:-

- More detailed analysis would be welcomed and information on how comments received could influence policy decisions in the future.

- The Local Authority did invest in care and support. It was not clear whether something different needed to be done in respect of mental health care and support. Sheffield was at the forefront of this work a number of years ago and this should be checked to see how it related to current practice.

- A report summarising the event and lessons learned should be circulated to providers and commissioners. It would be helpful to synthesise the information to establish what 'quick wins' could be achieved.

- Mental health was still seen as a 'cinderella' service and treated as such. The joining up of health and social care services should help prevent this. Work needed to be done to ensure G.Ps talked to psychiatrists and other mental health professionals.

- The ten key issues discussed at the event had been informed by evidence collected prior to the event. Not all the comments made were negative and comments were invited by those not able to attend the meeting through social media and the internet.

- The difference between the reality of the service provided and people's perception of a service should not be forgotten. People needed to feel that a service was right for them.

- Those involved needed to look at how stakeholders could be influenced to make people feel well and priority should be given to assessing how employers treated and understood mental health issues.

- Children did not always recognise where they were suffering mental health issues. The help and support needed to be in place as soon as possible and crisis treatment should be available immediately.

- A pilot was taking place between the City Council and the Clinical Commissioning Group promoting a good environment for mental health and early support and diagnosis. The outcomes of which could be reported to the

Health and Wellbeing Board.

6.7 **Resolved** that:

1. The Board notes the points of the report and will work proactively to translate people's views into action, and requests that all actions are communicated back to the people who attended this event;

2. All future engagement events should include an appropriate number of service users to ensure sufficient representation from members of the public;

3. An update on the actions contained in the event's report to be submitted to the Board within 12 months and Healthwatch Sheffield be requested to hold another engagement event (although not necessarily on the topic of mental health); and

4. The Board work with Healthwatch Sheffield to ensure that people remain involved and their views and experiences are used to help shape and improve services in the City.

7. REPORT ON HEALTH AND WELLBEING BOARD ENGAGEMENT APRIL-SEPTEMBER 2014

7.1 The Co-Chair's of the Board submitted a report providing the Board with a snapshot of its engagement from the last six months. It focused on Health and Wellbeing Board-specific engagement and therefore did not cover the engagement carried out in their own right by the organisations that were represented on the Board. It also provided some suggestions for how that engagement could be improved.

7.2 Members of the Board made comments on the matters contained in the report summarised as follows:-

- It was important to have good engagement which needed to lead to a change in services commissioned which leads to an improvement in outcomes.

- More analysis was needed of what made a difference. The next stage was to think about whether the Board could get more valuable information from people's comments at engagement events.

7.3 **Resolved** that the Board focus its engagement from October 2014-March 2015 on a range of areas specified in the report.

8. DUE NORTH: REPORT OF THE INQUIRY ON HEALTH EQUITY FOR THE NORTH

8.1 The Director of Public Health in relation to Due North: A Report of the Inquiry on Health Equity for the North. This was commissioned by Public Health England from the Centre for Local Economic Strategies (CLES) at the University of Liverpool, and written by a panel led by Professor Margaret Whitehead. The brief was to examine health inequalities in the North of England – both within the North

and between the North and the rest of the country, to 'provide fresh insight into policy and actions'.

8.2 The report made a very clear link with the need for economic development in the North and the need to invest in the development of people and places. Equally, the need for devolution and democratic renewal (to give local people more power over the conditions in which they live) was emphasised. There were recommendations for actions in the areas of tackling poverty, actions in early childhood, democratic renewal and strengthening the role of the health sector. Many, but not all of the recommendations were already being implemented in Sheffield and were included in the Health Inequalities Plan.

8.3 The Director of Public Health then gave a presentation on the report. He stated that the north of England generally did worse than the south in terms of life expectancy. However, Sheffield had one of the highest life expectancies in the North of England for those living in deprived areas.

8.4 Health inequalities were seen as a deep rooted issue and there was a concern that the gap could widen. Public Health England did not accept that the gaps were inevitable and couldn't change.

8.5 It was important to look at the causes of health inequalities which was often a result of economic drivers. The north needed to examine what agencies could do to reduce inequalities.

8.6 The report outlined a number of recommendations, some of which the Board could play a role in implementing and some where work was already in place which would assist with implementation and some where it would require close working between agencies across the north.

8.7 The report did not mention a role for NHS England. Public Health England had issued an interim response and a more detailed response was expected in Spring 2015.

8.8 The Board commented on issues arising from the report and presentation, as follows:-

- Recommendations for National Government and 'Agencies in the North' should not be considered as separate issues. In many cases complementary action is needed from both sides.

- Historical factors should be taken into consideration as it was not easy to change things in one generation.

- The City was in a good position to work together to change if the system would allow. There needed to be a lot of freedom granted to try new solutions.

- There could be a role for the Health and Wellbeing Board to play as advocates. Members could attend other Health and Wellbeing meetings across the north and Boards could collectively make representations nationally.

- The north needed to be proactive and not wait for the Government to give permission. There was a need for further learning on how to attract investment and how to co-ordinate to generate investment.

- The Sheffield City region did not do enough to promote the good work being undertaken in the region and this should be promoted on the national agenda. The key was to determine how to influence on the local as well as the national stage.

- It would be more appropriate for Public Health England to respond in time to influence the next commissioning round rather than in the Spring. It may be a different allocation was needed which took into account health inequalities.

- The proposition based approach was supported. There was a need to be bold and outline what could be done if the north and the City region had more control over resources and policy.

- Political points could be made without being party political. Whenever a new policy was announced the region should outline the impact on Sheffield regardless of party politics.

- The Health and Wellbeing Board should not just seek to influence policy matters specifically relating to health. Every decision made had an impact on the health and wellbeing of the City.

Resolved: that the Board:-

1. Requests that the Chief Executive, SCC and the Director of Public Health should discuss the report further, and in particular how best to bring it to the attention of the Sheffield Executive Board and the Local Enterprise Partnership; and

2. The Director of Public Health be requested to feed back to Public Health England the need for a more timely response to the report in line with the next commissioning round.

9. THE INTEGRATION OF HEALTH AND SOCIAL CARE

9.1 Fiona McCaul, Programme Director, Programme for Integrated Commisioning gave a presentation on the programme for integrated commissioning. She commented that she was looking at the programme as more than the pooling of budgets and more about redesigning services.

9.2 She further reported that Sheffield had made its submission to the Better Care Fund on 19th September. This may be subject to a review and if so the Board would be informed as soon as possible.

9.3 There were a number of care model options being explored and those involved

were looking at how services could be co-ordinated in a more effective way.

9.4 There were a number of workstreams in place, developing care model options and estimating their benefits prior to submitting their business cases to the Programme Board. The first meeting of the Programme Board had been held on 3rd September and a number of Health and Wellbeing Board members also sat on the Programme Board. A project structure had now been established to support ownership and decision making.

9.5 Budgets had been agreed but were subject to review as the case was developed for integration and change. Sheffield had a strong ambition to integrate health and social care in the City.

9.6 The project plan had clear dates and activities proposed. There was a need for the business case to show quantifiable evidence to say how public health in the City would be better and save money from the public purse.

9.7 Fiona would be working closely with the Director of Public Health on the outcomes framework. In respect of involvement and engagement advice would be sought from Healthwatch Sheffield. It was planned to hold a series of workshops and it was the aim to create a vision which everyone could share in.

9.8 Access to information was a key issue. Nothing could be done if the information wasn't shared. The Programme Board should not work in isolation and keep ties to other Boards in the City.

9.9 There was a need to strengthen analysis and work out the key impacts of the proposals. Relationships should be built up such as with Children's Services.

9.10 Members of the Board made comments on the issues raised by the presentation, as follows:-

- It was right and proper to integrate health and social care. However, at this stage the impact could not yet be seen. There had to be a positive difference for those who used the services.

- Success could be seen when all agencies and services were working together towards a common model. Children's services could be brought into this. There was a lot of good practice work that could be shared.

- The integration was a key reputational risk for the City and it was crucial to achieve successful outcomes.

Resolved: that the Board extends its appreciation to all those involved in the work towards integration of health and social care in the City.

10. FUNDING TRANSFER FROM NHS ENGLAND TO SOCIAL CARE

10.1 The Director of Commissioning, Sheffield City Council, submitted a report providing an update to the Board of details of the Section 256 transfer from the

NHS to fund adult social care services.

10.2 Members agreed that the date at the end of paragraph 3.5 should read 2015/16 rather than 2014/15.

10.3 **Resolved:** that the Board notes the report and approves the funding transfer.

11. BETTER CARE FUND

11. It was noted that this had been discussed earlier in the meeting under item 9 'The Integration of Health and Social Care'.

12. MINUTES OF THE PREVIOUS MEETING

12.1 The minutes of the meeting of the Board held on 26 June 2014 were approved as a correct record.

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