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Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 26 March 2015 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
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
Alison Knowles	NHS England
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

26 MARCH 2015

Order of Business

1. Apologies for Absence

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

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

4. Update on the Joint Health and Wellbeing Strategy: Outcomes 4 and 5 (Pages 5 - 40)
Report of the Co-Chairs of the Board concerning Outcomes 4 and 5 of the Joint Health and Wellbeing Strategy

- Outcome 4: People get the help and support that they need and feel is right for them
- Outcome 5: The health and wellbeing system is innovative, affordable and provides good value for money

5. Health, Disability and Employment in Sheffield (Pages 41 - 44)
Report of the Head of Health Improvement, Sheffield City Council

6. Update on the Joint Health and Wellbeing Strategy Work Programmes (Pages 45 - 52)
Report of the Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group and the Director of Commissioning, Sheffield City Council

7. Children and Young People's Emotional Wellbeing and Mental Health (Pages 53 - 66)
Report of the Executive Director, Children, Young People and Families, Sheffield City Council, concerning the response and progress update from the Health and Wellbeing Board to its Emotional Wellbeing and Mental Health Engagement Event with Chilypep, Sheffield Futures and Young Healthwatch in November 2014.

8. **Health and Wellbeing Plans for Sheffield in 2015/16: Sheffield City Council and NHS Sheffield Clinical Commissioning Group** (Pages 67 - 76)

Report of the Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group and the Director of Commissioning, Sheffield City Council.

9. **Director of Public Health Annual Report 2014** (Pages 77 - 98)

Report of the Director of Public Health

10. **Air Quality and Health in Sheffield** (Pages 99 - 114)

Report of the Director of Public Health

11. **Minutes of the Previous Meeting** (Pages 115 - 128)

To approve the minutes of the meeting of the Board held on 11 December 2014.

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

Further advice can be obtained from Gillian Duckworth, 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: 26 March 2015

Subject: Update on the Joint Health and Wellbeing Strategy: Outcome 4: People get the help and support that they need and feel is right for them Outcome 5: The health and wellbeing system is innovative, affordable and provides good value for money

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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. Outcomes 4 and 5 of the Strategy focus on the health and social care system's working and performance. This report sets out what has happened under each action over the past year and any issues and opportunities.

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:
  - The greater inclusion of children and young people's issues and mental health in future reports.
  - How affordability and value for money are tested and covered on the Health and Wellbeing Board's agendas and in the Strategy.
  - The alignment of the Joint Health and Wellbeing Strategy with the Integrated Commissioning Programme.
- Support the ongoing programme of needs assessment.
- Request another update on this outcome in March 2016.

Background Papers:

- Work of the Sheffield Safeguarding Boards – appended to this paper.
- Sheffield Joint Health and Wellbeing Strategy 2013-18 – https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/joint-health-and-wellbeing-strategy.html.

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

Outcome 4 – People get the help and support they need and feel is right for them

and

Outcome 5 – The health and wellbeing system is innovative, affordable and provides good value for money

March 2015

1. What are these outcomes about?

Outcome 4 is about how people of all ages should experience services in Sheffield. This is about Sheffield's health and wellbeing system working better based on the needs of people in the city. It is important to focus not only on outcomes for people, but to consider people's knowledge of, access to, and experience of services. Currently, these are not all accurately measured but are important and must be given greater emphasis.

Outcome 5 is about how Sheffield's commissioners and service providers will deliver services. As with outcome 4, it is our intention to make the changes to the way the health and wellbeing system works in Sheffield over the next 5 years to make the system sustainable and affordable in the long-term. The City's population is rising as a result of an increasing birth rate, inward migration and people living longer. Over the next 10 to 20 years there will be an increase in the number of older people in Sheffield alongside increasing numbers of children and working age adults with disabilities and complex needs. We know that this population change is likely to place a significant and increasing demand on health, social care, children's and housing resources.

2. How are we performing? – Indicators for outcomes 4 and 5

Section completed by Louise Brewins

In terms of position relative to the England average, ranking among the core cities and local trend over the last three years, Sheffield is experiencing worse outcomes for the majority of indicators related to how well services are being delivered and meeting need and expectations. The two main exceptions are older people still at home 91 days after transfer to rehabilitation/reablement and the rate of permanent admissions of older people to care homes. This is set within the current context of increasing pressures on A&E, emergency and primary care services.

Further information about these indicators can be found in Appendix A. Please note, the Board agreed that the indicators initially selected for Outcome 4 would also be used for Outcome 5 given that they provided a reasonable summary for the two indicators combined; would limit the total number of indicators included in the Strategy's framework to 30; and mirrored the indicators used by NHS England in its local authority improvement profile.

In addition, the indicators relating to A&E attendance rate and proportion of pregnant women receiving 13 week antenatal assessment have been temporarily dropped because it has not been possible to obtain timely enough national or meaningful comparable data for these indicators. Further work is being undertaken to identify more timely data for these indicators.

3. What do we need to know? – The evidence base for outcomes 4 and 5

Section completed by Louise Brewins

The Joint Strategic Needs Assessment identified a number of topics where more detailed analysis and research would be required to develop the evidence for prevention and early intervention, integrated working, building social capital and improving quality of experience. The following specific areas of work were highlighted:

- **Managing long term conditions**

There are a number of pieces of work being taken forward to provide evidence for achieving better outcomes for people with long term conditions and preventing unnecessary variation in and use of health and social care services. Detailed evaluations are being undertaken, for example, in relation to the care planning approach within the City and the Community Wellbeing Programme, together with a cost benefit analysis of the 'Patient Activation' model. An application to the Health Foundation for funding to test and develop innovative ideas and approaches to improve health care delivery is also under consideration.

- **Children with complex needs**

A detailed Health Needs Assessment (HNA) to understand the health and wellbeing needs of children with complex needs was completed in 2014 and is being used to inform future service planning for this group of children. The HNA covers numbers of children and young people with LDD and other complex health needs within Sheffield and predicts future trends, based upon diagnostic profile and DDA criteria; identifies both current and predicted future needs in order to inform appropriate planning and delivery of services and; identifies health and wellbeing needs across the different groups of children and young people as defined within the agreed scope, and by age range within each condition.

- **Access to and use of services**

A paper is currently being prepared by the SCC Healthcare Public Health Team, as part of the core offer to the CCG, to consider the options for exploring the extent to which health services meet need in the City, and the resources that would be required to support this analytical work.

- **Experience of care services, especially GP practices.**

Utilising and understanding patient, user and carer experience was a high priority for the JSNA. However national data and related initiatives (e.g. Family and Friends Test, GP Patient Survey) need to go further in terms of their ability to deliver more granular intelligence that can be used to improve care quality at a local level. Further work locally

should therefore be undertaken to assess the use and impact of data currently available and where, with relatively modest enhancements, we could improve our understanding of people's experience of services in Sheffield.

- **Urgent and non-elective care**

The Quality Metrics and Intelligence Group of the Integrated Commissioning Programme for Sheffield is focussed on what we need to measure so we can show what is really working for people in the local care system. It includes how the programme overall will be evaluated. A further external evaluation (funded by a Transformation Challenge award) will also be commissioned to support analysis of the 'Keeping People Well' strand of the Integrated Commissioning Programme.

4. Examining outcome 4, action by action

Theme: Person-centred care and support

Sheffield people receiving excellent services which support their unique needs

Action 4.1: Continue to work with providers in the city to integrate the health, social care, education and housing support and care that is available, to establish a person centred approach to care.

Section completed by Dorne Collinson, Antony Hughes, Joe Fowler and Tim Furness

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

Consultation as part of development of the Joint Health and Wellbeing Strategy and more specifically on integration, has shown general support for the view that services should be more joined up and people not handed over from one professional to another wherever that can be avoided. The CCG and Sheffield City Council have agreed plans for integrated commissioning of a range of services:

Older people and those most at risk of needing hospital care

We have agreed to establish a pooled budget of around £250m for 2015/16, which will establish a shared responsibility to meet needs and commission services in the following areas:

- **Keeping People Well in their Community** – primary care, social care and non-clinical interventions to support people identified as at risk of needing hospital or social care to stay independent, safe and well
- **Active Support and Recovery** – non-hospital clinical and social care services that provide short term interventions that help people maintain or regain their independence and wellbeing - preventing or reducing the use of acute health and care services (including intermediate care and community nursing)
- **Independent Living Solutions** – recommissioning of community equipment services as a genuinely integrated and user focussed service
- **Long Term / High Support** – integration of assessment, care management, and funding streams for people that need significant levels of care and support over a sustained period of time. This includes NHS CHC and SCC funding of residential care.
- **Non-elective (non-surgical) hospital admissions** – because our plans will reduce expenditure mainly in this area, this funding is included to release money, and to share risk.
- We expect to expand the pooled budget in time to include relevant children's service areas, mental health and learning disabilities, and possibly drug and alcohol services.

Integration of commissioning functions and budgets enables us to specify and contract for services that meet health and social care needs together. This will lead to changes to many

health and care services, and we are working with providers of health and social care in Sheffield to support the development of provider partnerships that will support integration and the delivery of more person-centred services. We are building on our current productive partnership with our providers ("Right First Time"), supporting stronger provider alliances so that providers can being together their considerable expertise to design and deliver a truly integrated health and care service for the people of Sheffield.

Children and young people

The Sheffield Children's Joint Commissioning group (CJCG) leads the work to ensure integrated health, social care and education support for children and families. The group includes key representation from Sheffield Clinical Commissioning Group, Sheffield City Council Children and Families Portfolio and Public Health England. There is a work programme which currently is focusing on delivering a joint commissioning approach to the following areas:

- Emotional Wellbeing and Mental Health.
- Early Years (A Great Start in Life).
- Supporting Children with Complex Health Needs.
- Sexual Health Services for adults and young people.
- Vulnerable Children and Young People – including Looked After Children.

The focus of the group is to ensure that service provision is jointly integrated, commissioned and redesigned where necessary. An example of joint commissioning activity currently overseen by the CJCG includes the redesign and review of the Healthy Child Programme 5-19 years in Special Schools.

Specifically partners are engaged in ensuring a person/child centred approach to improve health and wellbeing. The CJCG collectively works to address the needs of vulnerable groups including Looked After Children and Care Leavers.

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

The Health and Wellbeing Board sponsors the development of integrated commissioning and provides strategic direction and oversight for the work of the two commissioning organisations. The Health and Wellbeing Board should continue to request further updates in the future on progress with both the children's and adults' joint commissioning agendas.

Action 4.2: Commit to implementing the statutory requirements of the Children and Families Act supporting the integration of planning for children with complex needs and disabilities.

Section completed by Tony Tweedy

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

The Children and Families Act 2014 has a focus on improving outcomes for children and young people with special educational needs and/or disabilities (SEND). It extends the Special Educational Needs (SEN) system from birth to 25, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met.

Key changes include:

- Replacing statements with a new birth- to-25 education, health and care (EHC) plan.
- Producing an accessible Local Offer of all services.
- Offering families personal budgets.
- Improving cooperation between all the services that support children and their families, particularly requiring local authorities and health authorities to work together (and specifically Clinical Commissioning Groups requirement to comply with health service requirements in EHC plans).

Progress so far:

- Local offer website delivered ahead of plan.
- Six step pathway guide for families for Education, Health and Care (EHC) plans.
- High level pathway process.
- EHC plan template.
- New schools EHC referral process and guidance.
- Personal budgets position statement and service delivery arrangements.
- Conversion plan for SEN statements to EHCs.
- Joint commissioning position statement.
- Communication and engagement plan.
- Resource pack for schools and SENCOs.
- Independent supporters, Independent Mediation and disagreement resolution.
- Multi -agency 0–25 team to co- work on complex cases and develop joined up ways of working.

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

Our challenges are to implement and next stage of the legislation. With this comes an opportunity for increased joint working across services to improve outcomes for children, young people and their families.

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

- Ensure that all Health and Wellbeing services which encompass the 0–25 age range are fully engaged with the legislative changes.
- Commit to representation at the appropriate level to planning, decision making and resource allocation meetings particular around the needs of complex cases.
- Agree to the data sharing requirements to enable a comprehensive and robust commissioning framework.
- Agree to the co-location of the appropriate representation from Children's Commissioning services into the 0–25 team to develop connectivity and consolidate the effective ways of working established through the creation of the 0–25 *Scratch* team.

To note: the Children and Families Act also brings in the following changes:

- Adoption and Contact: the Act will now allow children and grandchildren including descendants, spouses or adoptive relatives to apply to an intermediary agency for help tracing relatives of the adopted person. It brings into force new duties that enable children to be placed earlier with prospective adopters who are already approved foster parents and changes the weight given to consideration of ethnicity, religious persuasion, racial origin and cultural and linguistic background in matching children to perspective adopters. The Act also increases the support given to families who adopt and brings in the concept of 'Staying Put', clarifying the circumstances in which CYPF will support a former fostering arrangement beyond a young person's 18th birthday.
- Family Justice: the Act reduces the time limits on care proceedings to 26 weeks and brings into force new rules on the use of expert witness evidence. The Act also introduces Child Arrangements Orders which replace Residence and Contact Orders.
- Childcare Reforms: the Act introduces a new mechanism for the registration of childminders via childminder agencies and repeals the Section 11 Duty to prepare, at least every three years, an assessment of the sufficiency of the provision of childcare in their area but duty to secure where practicable sufficient childcare remains.

Action 4.3: Ensure the experience of transition from child to adult services supports and promotes health and wellbeing.

Section completed by Kevin Clifford, Sue Fiennes, Tony Tweedy and Moira Wilson

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

The transition point between children's and adult services for those with complex SEND has been recognised as the most stressful and confusing period in the lives of families and carers. It is acknowledged as an extremely difficult phase for both parents/carers, children and young people. Thresholds for the movement between age determined services and for funding eligibility vary across education, health and social care. Services are complex to navigate.

- The recent parent carers forum State of Sheffield report declared that Transition from child to adult services was slammed as a 'drawn-out, faceless and fragmented process punctuated by long delays'.
- The Sheffield Complex Child Health Needs Assessment 2014 provides insight into the changing nature of and Special Educational Needs and Disability in the city. This will help to inform the longer term model which may include prevention activity as well as assessment of need support.
- Both the Children and Families Act 2014 and the Care Act 2014 place new responsibilities on children and adult social care to improve the transition to adulthood for young people with ongoing care and support needs. Adults and Children's services have been involved in working groups to develop improved pathways and this work will continue throughout the coming year.
- The recent assessment of Child Sexual Exploitation arrangements and practice highlighted the need to improve access and provision for ongoing support for young people in relation to counselling and mental health needs. In addition, the recent CDOP report on suicides in Sheffield gives cause for concern.

In order to deliver on our vision to *smooth the progression* of young people with Special Educational Needs (SEND) into adulthood we must bring together all the transition elements into a coherent and cohesive single service. Within the last year there has been some progress, specifically within the area of CAHMS, where the transfer of provision of most secondary care for 16/17 year olds from the Sheffield Health and Social Care Trust to Sheffield Children's Hospital is currently being piloted.

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

It is clear that the complexities of young people's needs in transition are not fully understood, and that despite efforts, the understanding of mental capacity legislation, working across clinical boundaries and the focus on the young person is not robust. Unfortunately, we have also had some examples of less than ideal transitions, including a case which is currently subject to a case review by the Children's Safeguarding Board.

The main challenges facing the transition to adulthood are:

- Different eligibility thresholds and funding between Children's and Adult services, both in health and social care.
- A range of transition points across different legislation – 16, 18, 19 and 25 years – which can create barriers between services and/or eligibility rules.
- Fragmented commissioning within the NHS, with some inadequate communication between the CCG and NHS England at key points in the young people's journey.
- Poor communication and handover between both services and commissioners of services.
- Ensuring involvement with adult services at an earlier stage in planning for a young person's future beyond school and further education.
- Managing expectations during a period of ongoing local authority budget reductions and changes in welfare reform.
- Developing a more consistent approach to promoting independence and personalisation so that young people and their families experience a better outcome and are fully involved in planning across social care, health and education or life-long learning.
- Capacity and conflicting priorities, meaning transition planning does not always begin early enough.

The Children and Families Act and the Care Act provides us with the legislative driver and an opportunity to move quickly to address these issues. Education, social care and health services must commit to the creation of the single service.

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

- The Health and Wellbeing Board should refresh and strengthen its commit to high quality transition to adulthood for Sheffield Young People to include:
    - Redesigning the customer pathway in line with the Children and Families Act and the Care Act.
    - Redesign of processes to remove duplication and make them efficient.
    - Joining Safeguarding Boards in making transitions a key objective within its business plan, so that mental health outcomes are improved for young people in Sheffield.
- The Board should also support a cultural and systemic change which will potentially include:
    - Changes to roles and responsibilities.
    - Maximisation of use of ICT to enable efficient practice and robust data for performance monitoring and to support joint commissioning.
    - Understanding usage of and cost of SEND provision and developing a financial model which includes pooled budgets.
    - Alignment with the Better Care Fund and Care Act programmes.
    - The consolidation of the key health functions impacting on transitions.

Action 4.4: Work with GP practices to improve the ways people can access their services.

Section completed by Katrina Cleary

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

- GP practices have been encouraged to look at how, within the current workforce constrains, access might be improved, and many have put in place such initiatives as phone triage, increased access to allied health professionals and nurse practitioners, and the ability for patients to book appointments/order prescriptions on line.
- The Care Planning Approach is now in its second year of implementation and encourages practices to focus on proactively managing the needs of those in the practice who without such an approach would most likely end up accessing urgent care.
- Via System Resilience funding, further resource has been allocated to general practices to enable extra appointments to be put in place by the end of March 2015.
- The emerging GP Provider Board has developed a Prime Minister's Challenge Fund (PMCF) bid which aims to increase on an ongoing basis the availability of GP appointments, provide a more seamless transition between in- and out-of hours services and promote technological advances to support access and self-care more effectively.
- The Children's Health and Wellbeing Board is working with primary care to ensure that families are supported to ensure that they are registered with a GP. There is also a specific focus to ensure 'early booking' for pregnant women so that individuals receive support and services as soon as possible once pregnancy is confirmed.

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

- Workforce pressures pose a challenge. More experienced clinicians (GPs and Nurses) are taking retirement. Recruitment to key clinical posts is proving difficult, particularly in some of the more deprived areas in particular. At the same time practices are starting to feel the impact of the national policy imperative to equalise the finances available to practices for the delivery of core primary care services.
- The PMCF bid provides a significant opportunity to put in place locally-based and consistent levels of access to primary care in a way which includes health and social care providers across the whole system. If the bid is not successful we will have to consider across the whole system how much of the bid's ambition (albeit toned down) might be realised within existing resources.

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

- The Integrated Commissioning Programme is integral to enabling primary care to offer increased access.
- Recognising the workforce and financial pressures facing General Practice it would be helpful if the whole system encouraged Sheffield patients to manage their own health as far as possible and to use services (including primary care) responsibly, promoting the use of appropriate alternatives (community pharmacy, NHS Choices, 111 etc).

Action 4.5: Ensure equality of access to services.

Section completed by Tim Furness and Adele Robinson

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

NHS Sheffield CCG

Ensuring equality of access to services is one of the key elements of addressing health inequalities. There is evidence that some sections of the population of Sheffield do not access health services in the same way as the general population, as described in the CCG's publication of equality monitoring information. Collection of demographic information to enable us to fully understand how people access services is weak in some areas, and improvement in that is a priority. To supplement our understanding of equality issues provided by data the NHS runs an Equalities Engagement Group, where CCG and Foundation Trust representatives meet representatives of people with each of the protected characteristics set out in equality legislation to understand and address issues with access to service that they experience.

The CCG has an equality action plan, with five key objectives:

1. Ensuring equality is core commissioning business
2. Improve the range of activity information we have about patients in protected groups and how this is being used
3. Improve our understanding of patient experience of services, re E&D, and act upon instances of potential discrimination
4. Developing strong and consistent leadership on equality issues
5. Improving access to services i.e. contracting

Progress on the actions is reported to the CCG Governing Body on a six monthly basis. Consideration of equality issues, including health inequalities, is now embedded in our approach to managing our programmes of work.

A paper has recently been approved by the SCC Health and Wellbeing Strategic Outcomes Board and NHSS CCG CET which outlines actions to improve access to services, reduce inequalities in access and promote health literacy. Actions are outlined to reduce inequalities in the demand on and supply of services; they include immediate actions, further investigation of the issues and how to measure impact.

Sheffield City Council

Ensuring the Council's services are fair and accessible and customer experiences are positive is one of our Equality and Fairness Objectives 2014-18 as outlined in the Annual Equality reports 2013/14 and 2014/15. The objectives are overseen by the Strategic Equality and Inclusion Board and reported on the Annual Equality Report.

In the past year in line with the objectives on accessible services and advancing health and wellbeing we have updated our monitoring form and Adult Social Care customers are now asked about their sexual orientation alongside other equality monitoring questions. To help supplement our monitoring we have updated and expanded our suite of Community

Knowledge Profiles These profiles now cover a range of the different communities of identity in Sheffield including Lesbian Gay Bisexual and Transgender (LGBT), disability, women, lone parents, carers, as well as Black and Minority Ethnic (BME) communities. The profiles help inform services that we both provide or commission, though supporting a better understanding of our diverse customers.

Another way we have tried to understand issues identified by different communities is through the newly developed a city-wide Equality Hub Network to strengthen the voice and influence of communities of identity (COIs) in Sheffield. These are specifically identified as a protected characteristic within the Equality Act 2010. We chose to focus on people with protected characteristics, because we know that these particular groups face additional barriers and therefore have difficulties accessing services and engagement routes. The Network enables the Council engage with these COIs to help shape policy and services in the city. The aim is to provide more effective and efficient routes for people to have a say on the issues that affect them and influence the decisions that are made.

We are also working collaboratively and in partnership with non for profit organisations Disabled Go, Disability Sheffield and CredAbility to support the ambitions of Sheffield to become an accessible and fairer city for all. The partnership is supporting the development and delivery of a new city access guide in 2015. The new city wide access guide is an empowering tool that enables people to make informed choices about the services they want to access.

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

The main challenges are inconsistent monitoring across protected characteristics. Without reliable consistent data it is difficult to ensure that services are fair and accessible. To this end a task and finish group of the Strategic Equality and Inclusion Board has recently been set up to look at this issue and suggest priority improvements to be made across the Council's services. In addition, the new Equality Hub Network that we have developed is providing an opportunity for groups to come together to identify and discuss relevant issues.

There is an opportunity to include health venues as part of future Accessible Sheffield access guide.

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

The Health and Wellbeing Board can continue to support the objectives of the Fairness Commission and its Health Inequalities Action Plan. The Health and Wellbeing Board are requested to support actions to improve access as it will require a system-level response.

In addition, the Board can work with the new Equality Hub Network and support the work of the Accessible Sheffield Project.

Action 4.6: Commit to reducing waiting times to at least national standards/averages for health and social care.

Section completed by Dorne Collinson, Tim Furness, Idris Griffiths and Moira Wilson

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

There are a set of national waiting time targets that the CCG is committed to ensuring its providers achieve.[1] As at December 2014, 12 of the 17 NHS Constitution core rights and pledges were being successfully delivered, with challenges in achieving the pledge for 95% of patients to be treated and discharged within 4 hours in A&E and the pledge for at least 90% of patients to start treatment within 18 weeks of referral by a GP. With respect to cancer waiting times our local providers continue to meet all the relevant standards.

Adult social care assessment times have reduced significantly over the last 2 years from an average of 90 days in 2012/13 to 31 days in quarter 3 14/15. Although there is no national target, Sheffield has set an internal target of 28 days and we are now very close to achieving this. Further performance information relating to Adult Social care can be found within the 2014 Local Account. Adult social care will continue to benchmark Sheffield's performance against the national Adult Social Care Outcomes Framework (ASCOF) and regional or core city comparators.

Children's Social Care are committed to ensuring the right level of support to families is provided at the right time. The deliverable outcomes are to provide services that are timely, high quality and responsive to need. Recent increases in demand for both services have however created pressure in being able to allocate all work for more in depth work after cases after been subject to initial screening. Local procedures (based upon statutory guidance) determine that a decision should be taken by Social Care in respect of what action is required within 24 hours of receipt of the referral. As an authority we are compliant with this requirement. Following this decision, the local authority then has up to 45 days to complete an assessment. Performance shows that we are only achieving this in 70% of cases. A number of actions have been put in place to improve this performance, these include:

- Developing community hubs
- Streamlining social care referrals and allocation
- Realignment of Social Care staffing
- 'Back to Basics' Training for all front-line staff

Children's social care is currently experiencing pressures in respect of the allocation of lower priority cases within our Early Intervention and Prevention Service. All of these cases have been subject to initial screening and priority work has continued to be allocated. These delays have been created by a combination of increases in demand and difficulties in recruiting to vacant positions.

[1] These are set out in the CCG's monthly quality and outcomes report to its Governing Body each month, available here.

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

- The CCG and local authority continually review the achievement of the standards and where there are challenges, as above, we work with providers to address problems and ensure compliance. This includes the enforcement of contractual action, including requirement for remedial action plans and penalties for failure to achieve standards, and targeted investment, for example the use of System Resilience funding to increase capacity at the busiest times of the year.
- The 2015/16 planning guidance includes new waiting time and access standards for mental health care, as part of the NHS's commitment to achieving parity of esteem for mental health. These cover waiting time for treatment for first episodes of psychosis (i.e. early intervention services), and for IAPT, together with expectations about availability of liaison psychiatry and implementation of the Crisis Care Concordat.
- Achievement of NHS waiting time standards is continually challenging, mainly due to increasing demand for services, as demonstrated in the national issues on A&E waiting times before Christmas, which affected Sheffield. Simply increasing activity levels in contracts to achieve targets is neither affordable not practical for providers and this challenge is a key driver for our plans to redesign services.
- Pressures in children's social care mean that the early help mechanism is not as effective as we would help in a minority of cases. We are consequently undertaking an analysis of the recruitment and retention strategy and some immediate plans have been put in place to recruit temporary staff to fill staffing gaps. Longer-term, thresholds of intervention into targeted services will be reviewed as part of the redesign of prevention and early intervention services, bringing clarity about the universal offer and consequently reducing cases from escalating within the system.

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

- Health and Wellbeing Board members should continue to receive relevant performance management information to review progress against agreed targets.
- The Board could continue to recognise the challenge of maintaining and improving access to services in the context of the difficult financial position and support the redesign of service delivery necessary to achieve this.

Action 4.7: Commit to: providing care closer to home; keeping hospital and short term care as effective as possible; and providing rehabilitation to help people stay independent for as long as possible.

Section completed by Joe Fowler and Tim Furness

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

- Our integrated commissioning plans set out our commitment to providing care closer to home. In particular, the Keeping People Well in Their Communities strand of the integrated commissioning programme sets out a clear aim to provide more care and support to people closer to home. It consists of:
    - Working in partnership with primary care and local communities to identify people at risk of declining wellbeing.
    - Frontline workers reaching out to people at risk.
    - People being supported to do or get things that help them achieve their goals and reduce the risk of declining wellbeing / increased use of formal health and care services.
- This includes better provision of information to help people to stay well, promoting the availability of community resources activities to maintain physical and mental health, commissioning a "sort and support" local services that helps people find the information they need and connects them to community and statutory services to resolve problems and "life navigators" to provide more intensive support for people at the highest risk, care planning with GPs and other health services to help people manage their health conditions, and integrated local services.
- The Active Support and Recovery workstream of the integrated commissioning programme will lead to an integrated service that brings together health and social care services in patients' homes, providing, where possible, an alternative to hospital care and supporting people to get home and retain their independence after a hospital stay.
- The Community Wellbeing Programme contributes to this work by empowering local people in the poorest areas to improve their health and wellbeing.
- For children and young people there is a commitment across Sheffield City Council and NHS Sheffield CCG to ensure that children and young people are cared for in Sheffield and that the number of 'out of city' placements are reduced.

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

Elements of this have already been implemented. Using funding obtained through the Government's Transformation Challenge Award the approach of Keeping People Well will be fully tested in around half of the city's communities, where the existing community assets and relationship between local services and voluntary organisations is the strongest.

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

Continue to support the integrated commissioning programme.

Theme: Self-help

Clear availability of information and support about health and wellbeing so that Sheffield people are able to help themselves

Action 4.8: Encourage an integrated 'Sheffield offer' on the help, care and support available to people so that they can access guidance, advice, signposting, advocacy and self-assessment tools themselves.

Section filled out by Dorne Collinson, Joe Fowler, Tim Furness and Phil Reid

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

Information and advice is fundamental to enabling people, carers and families to take control of, and make well-informed choices about, their care and support and how they fund it. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support.

Sheffield's health and care economy is typical in that it has a fragmented offer on information and advice – with a bewildering array of leaflets, posters, and web-based material. In the last 12 months the Government has issued Guidance about the duties contained within the Care Act for Local Authorities about the delivery of a City-wide information and advice service. In addition, as part of the 0-25 SEND reforms the city was charged with creating a single website for information for parents, cares and young people. Identifying gaps in provision and services will help inform joint commissioning strategies. The information required by the Care Act can sit on the same IT platform as the 0 – 25 local offer thus maximising resources and presenting a comprehensive view of services.

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

It is both a challenge and an opportunity to create maintain an information and advice service for people in Sheffield. The service must cover the needs of all our population, not just those who are in receipt of local authority funded care or support. The service will address prevention of care and support needs, finances, health, housing, employment, what to do in cases of abuse or neglect of an adult and other areas where required. The duty extends beyond the direct provision of information and advice to ensuring the coherence, sufficiency and availability of information and advice across Sheffield and facilitating access to it.

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

The Health and Wellbeing Board can ensure that it participates in the Advice & Information Work stream established to oversee the delivery of the practical and strategic advice and information for the City.

Action 4.9: Commit to working with partners on a model of active citizenship that promotes health literacy and supports people to look after themselves as well as possible.

Section completed by Chris Nield

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

Citizenship that promotes health literacy is more than being able to read leaflets and make appointments. It is about being able to decide whether information is relevant and how it can be used to improve health and the ability communicate health needs. People from the most deprived areas have low expectations about health services and low aspirations about their own health. This can lead to poor access to services and reluctance to make demands on services regarding their own needs.

Research shows that community-based peer support is likely to improve health literacy, and in the last year significant progress has been made in the development of community programmes. For example:

- The Community Wellbeing Programme empowers local people in the poorest areas to improve their health and wellbeing by developing social capital and building on community assets. The new contract focuses on building social capital asset based community development.
- A new Evaluation Framework is being developed by Sheffield and Sheffield Hallam University. It is anticipated that a new commissioning strategy will be developed as part of the wider work around the Integrated Health and Social Care Strategy.
- Health trainers support people to improve their health and wellbeing by increasing confidence and skills. They take referrals from GP Practices.
- Health Champions and Practice Champions are mainly recruited from disadvantaged communities and draw on their own knowledge and life experience to undertake community interventions to improve health, wellbeing and social connectedness.
- The Sheffield Executive Board has led an initiative to develop resilient communities. A task and finish group gathered evidence from a range of agencies working with communities. A Fuzzy Framework for building community resilience was developed and SEB members will be asked to consider how they could support the work.

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

- There are opportunities to integrate this work with GP Personal Centred Care.
- The resilience work led by the Strategic Executive Board is to be developed in localities.
- A community development strategy is currently being developed.

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

The Health and Wellbeing Board and its members can continue to recognise the value of a health literacy and empowerment approach to self-management of health and long term conditions. It is also important to recognise the value of a neighbourhood approach when developing citizenship, resilience and health literacy.

Theme: Engagement and Participation

Patients and service users involved in decisions and their opinions valued

Action 4.10: Require both commissioners and providers to have effective engagement processes in place that take what service users think into account in all decisions.

Section completed by Dorne Collinson, Tim Furness, Kate Register and Maggie Campbell

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

- The CCG has strengthened its engagement with patients and public over the last year and has increased its capacity to do this. Primarily this has been through the establishment of the CCG "Involve Me" network – a means of people registering their interest in being informed about, and contributing to, the CCG's work.
- The CCG has also run specific engagement exercises on development of plans for musculoskeletal services and the development of a strategy for mental health in the city, and have tested our commissioning plans with the public. Some of this work has been carried out in partnership with Healthwatch Sheffield who will continue to assist the CCG with data collection and contract monitoring of musculoskeletal services going forward.
- NHS providers have strong mechanisms to gain patient views and understand service users' experience. The CCG is working with the Foundation Trusts to align our engagement work and wherever possible to speak with one voice in communicating with the public. We will be running a joint engagement exercise to discuss our views about how healthcare should be delivered in the future.
- Sheffield City Council has a range of regular involvement mechanisms for users of adult social care and their carers. These provide a rich, ongoing source of customer perspective and an opportunity to coproduce plans, specifications and agree priorities together. The involvement work has been reviewed and evaluated, and some proposed changes are being consulted on. In addition to regular routine involvement, throughout the year emphasis has been placed on increasing contact with those who are seldom heard, and specific consultations have been run during the year, such as on the Learning Disability Commissioning Strategy.
- Right First Time involvement has seen the continuation of a citizens' reference group. This has increased in membership and representatives have joined the board and project groups of Right First Time. In addition specific consultations under Right first Time have included consultation with those with a Serious Mental Illness around their physical health needs, patient feedback from the new Care Planning approach.
- The voice and influence of Children, Young People and families is a priority. In conjunction with Young Healthwatch (part of Healthwatch Sheffield) and CHILYPEP, the Young Commissioners pilot has been developed. These young people have then worked alongside commissioning staff within the NHS and Local Authority to commission 4 new local services. In addition, the Sheffield Children's Health and Wellbeing Partnership Board and the Sheffield Children's Joint Commissioning Group both have recognised work streams focusing upon engagement and participation.

- Healthwatch Sheffield is developing an ‘assurance mechanism’ where Healthwatch Sheffield could advise about and/or offer external assurance to support in-house engagement work.

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

- One challenge is to continue to work closely with the different teams who run engagement to ensure joint working and that resources are best used, including running engagement exercises jointly wherever appropriate. An opportunity therefore is that increasingly the health and care system will work as one on public communication and engagement, and that therefore duplication is avoided and information already gathered is used effectively.
- It is a continued priority and challenge to reach those citizens (including vulnerable children and young people) whose views are seldom heard, particularly those who do not have access to online information. Priorities for the coming year include those living in Care Homes, Looked After Children and Young People, children and young people experiencing mental health issues, adult self-funders and members of Black and Minority Ethnic groups. Healthwatch Sheffield was set up to support the Health and Wellbeing Board in fulfilling the priority to engage with those hard to reach.

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

- Continue its own engagement work, continuing particularly to seek the views of children, young people and families, and to work with Healthwatch Sheffield in doing so.
- Work with Healthwatch Sheffield’s growing ‘network of networks’ to continue reach those who are seldom heard.

Action 4.11: Use patient/service user experience as a significant measure of quality.

Section completed by Dorne Collinson, Tim Furness and Kate Register

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

The Health and Wellbeing Board's partners puts patient and service user experience very high on their quality agenda reports and have a number of measures of experience including:

- Provider-generated Patient Experience data. In addition, there is an annual Department of Health Survey for users and carers of adult social care services.
- Friends and Family Test (FFT) implementation in A&E, in-patient care and Maternity at STH. FFT is now being role out to other services over 2015/16, including primary and community care.
- Work with Healthwatch Sheffield to encourage people to share their experiences of services.
- Utilising online patient experience via Patient Opinion, Care Opinion and NHS Choices. The CCG is working with Patient Opinion to develop further new and innovative ways of collecting and collating experiences of services to help assess the quality they provide.
- Including service users to help inform how our services are commissioned in future.
- The Right First Time involvement project developed and consulted on a set of patient satisfaction measures.
- Adult Social Care in the Council has a Service Improvement Forum with a quality assurance brief for services to older people and disabled adults. There is a proposal to develop a similar Service Improvement Forum for adults with a learning disability.
- The Children and Families Service in the Council have embedded service user feedback into much of their routine casework activity. In addition to routine activity, they also incorporate service user consultations into key service reviews.

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

The challenges are many and varied in collecting and interpreting good patient experience information. This can only be achieved by using a variety of means to collect experiences and collate this with the other intelligence we have around servicesAs a result high quality robust patient experience information can be very labour intensive to collect. In addition, due to the varied range of services delivered it is difficult to capture views across all activity whilst still ensuring that the wishes and feelings of the most vulnerable and hard to reach groups are appropriately represented.

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

The Health and Wellbeing Board can help by ensuring the patient/service user is encouraged and seen as essential to the city's decision making processes and by continuing to raise the profile and value of patient or user experiences of our services.

6. Examining outcome 5, action by action

Theme: Joint commissioning and whole-system transformation

Sheffield people at the centre of the Sheffield health and wellbeing system, underpinned by strong working relationships between commissioners with a clear methodology for joint working and pooled budgets underpinned by an innovative and affordable health and wellbeing system fit for the twenty-first century

Action 5.1: Build on existing joint working to establish a clear joint commissioning methodology, including the consideration of pooled budgets in areas such as the health and social care budget for older people with long term conditions and children with complex needs. The joint commissioning methodology will include a commitment to the co-production of strategic plans to ensure services are delivered in the most effective way for the benefit of all.

Please see the report under action 4.1, which covers this action too.

Action 5.2: Address city-wide causes of high hospital use by promoting innovative ideas and models for whole system change. This will include working with providers to find the best way to redesign systems upstream, and engagement to build awareness of appropriate access to services.

Section completed by Joe Fowler and Tim Furness

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

Sheffield, in common with the national picture, continues to have increasing levels of demand for hospital services, particularly urgent care (both for adults and children and young people), as was seen in the high demand for A&E services in December 2014 and the impact that had on waiting times and on the consequent demand for inpatient care and rehabilitation services.

The health and social care system is addressing this through the Integrated Commissioning Programme and the Right First Time Partnership. Through Right First Time the NHS and social care in Sheffield has reduced the average length of stay in hospital, primarily by developing and investing in services to enable people to be discharged from hospital more quickly, including expanded rehabilitation services and greater availability of intermediate care beds out of hospital. We have also been able to reduce the growth in ambulatory care sensitive admissions (those considered most avoidable) compared to total urgent admissions. The Integrated Commissioning Programme will build on these successes to establish services that reduce demand for hospital care by supporting people to keep well at home and providing alternatives to hospital care in response to health crises. In addition, the CCG is instigating a review of urgent care services in the city to ensure that when people do need hospital care, those services are as efficient and high quality as possible.

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

We need to make much more progress to achieve our stated aim of reducing urgent care admissions by 20% over the next five years. This is the key impact, in service terms, of the Integrated Commissioning Programme. Through the Keeping People Well in Their Communities work we aim to help people avoid health crises and manage crises better, so that, where it is best for that person, they can stay at home and be treated there. This work includes and further develops the established Community Wellbeing Programme. Through the Active Support and Recovery work, we will be commissioning out of hospital services differently so that there is increased support to provide alternatives to hospital admission and to support a quick discharge from hospital where a period of hospital care is needed.

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

Continue to support the Integrated Commissioning Programme.

Theme: Prevention and early intervention

A preventative system that seeks to help and identify people before they are really sick, enabling Sheffield people to stay health and well for longer

Action 5.3: Establish more preventative and targeted approaches to the provision of health and social care by extending the application of population risk profiling (predicted risk of future health crisis) to enable a closer alignment between services and people's needs. This should inform the development of integrated care and reablement services to help people stay at home, be healthy for longer and avoid hospital and long-term care.

Section completed by Lorraine Jubb

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

Sheffield Clinical Commissioning Group has identified that 40%-60% of "ambulatory care sensitive" hospital admissions are avoidable. Within this target cohort there are about 12,000 avoidable admissions per year – costing more than £20m every year. Admission and discharge to hospital is also in itself an expensive process with significant knock on costs over and above this headline figure.

The risk stratification tool (Combined Predictive Model – CPM) used by health to determine the risk of hospital admission was the basis for targeted preventative work undertaken in Lowedges, Batemoor and Jordanthorpe and subsequently by Community Support Workers in other areas. These pilots demonstrated small but significant net reductions in the number of people requiring formal social care and considerable success in reducing the number of A&E attendances by those with a history of four or more attendances in the previous year.

Significant consultation with stakeholders has taken place to both develop and promote the Keeping People Well outcomes framework. A key element of this has been to explain the importance of risk stratification in targeting resources and shifting to more proactive systems and processes based on the needs of people rather than organisations.

This approach has also led to the development of a Winter Planning protocol for ensuring those identified as vulnerable with no formal or family support receive a wellbeing call at times of severe weather to make sure they have sufficient food and medication to prevent the need for them to venture out and risk falling etc. Essential supplies are delivered by a bank of over 150 volunteers who are predominantly council employees.

The CPM is also used in Care Planning by GPs to target patients over the age of 75 for holistic health and wellbeing interventions.

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

Challenges are:

- Obtaining and sharing reliable baseline data across health and social care remains a challenge, without this effective evaluation will be difficult.
- Significant consultation with stakeholders has taken place to both develop and promote the Keeping People Well outcomes framework. A key element of this has been to explain the importance of risk stratification in targeting resources and shifting to more proactive systems and processes based on the needs of people rather than organisations. The majority of systems and processes across health and social care are reactive rather than proactive.
- Work still needs to be done to develop the awareness and understanding of targeting resources and services at particular cohorts of people. It is seen by some as "case finding" rather than a proactive attempt to prevent or delay people from needing formal care and support. Some feel it could put additional strain on an already over stretched health and social care system; however, analysis of the use of health and social care by those targeted does not reflect this perception; in fact the opposite is true.
- Investing in preventative interventions where the benefit might not be realised for several years is a challenge. Reliable quantitative evidence is hard to come by both locally and nationally and could hinder progress.
- Effective use of risk stratification varies dramatically in GP practices and some have reported difficulty in getting updated information.

Opportunities are:

- The links and dependencies between re-ablement and prevention present us with an opportunity to develop a more proactive approach with people coming out of services as well as preventing or delaying people entering.
- Funding from the TCA presents us with an opportunity to measure the impact of preventative approaches over the next year as we scale up the approach.
- Currently the CPM is based solely on health data, we have an opportunity to develop the model to include social risk factors that we know can impact severely on an individual's ability to cope, for example bereavement, caring responsibilities and loneliness and isolation.
- The Housing Plus model currently being piloted by Sheffield Council Housing presents an opportunity to target tenancy support at vulnerable people thereby acknowledging the role they can play in reducing the need for formal social care services and improving the quality of life of tenants.
- Work is underway to identify those children, young people and families who could be vulnerable and 'at risk'. One tool developed identifies those children at risk of becoming NEET those 'not in employment, education or training'.

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

The Health and Wellbeing Board have a big role to play in promoting proactive approaches like risk stratification to ensure resources are targeted efficiently and effectively and by supporting the shift in culture to embrace proactivity.

Action 5.4: Make best use of available and emerging technology to support early and local intervention.

Section completed by Dorne Collinson and Tim Ellis

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

Our world has been radically transformed by digital technology – smart phones, tablets, and web-enabled services have transformed the way we communicate and how many of us go about our daily lives. Technology and IT can provide the capability to help health and care providers provide better access to care, better communicate with the users of our services, improve the experience of care, and enhance teamwork and efficiency.

In order to make best use of technologies we need to keep abreast of the latest developments and also to understand the barriers to adopting these innovations. The Health and Wellbeing Board facilitated an event with industry to build an understanding of how we can engage with them to capitalise on the great expertise housed within the city council, NHS, universities and research centres so that they can create innovative digital products that align with our needs.

In addition the Right First Time and Integrated Commissioning Programme have been investigating how new technologies can help achieve their ambitions for integrated care closer to home. This has included examining how we can improve access to services, share information across organisations, enable collaboration, use digital information to improve services and automate routine tasks. Consideration has also been given to how services users can be more involved in their care, whether this is by monitoring their own health, booking appointments online or finding relevant information on services online.

Aligned with these programmes many of the main health and care commissioners and providers in the region have been refreshing their overarching digital strategies to reflect the need for greater integration across providers and the need to enable a connected mobile workforce. Sheffield Teaching Hospitals have announced the procurement of an electronic patient record system that will deliver on their objective of transforming services through technology over the next 5 years. STH has also invested in a technology that enables people to monitor their own health at home using their own mobile phone to communicate with healthcare staff. Sheffield City Council has also reviewed how it contracts for informatics and ensures it is getting the best from its suppliers.

Social media and the use of new technology is an important theme in the development of services for children and young people. The Children's Health and Wellbeing Partnership Board is exploring ways to improve service delivery through the use of new technology. This is particularly important for priority issues such as improving children and young people's emotional wellbeing and mental health. There is recognition that providers have to engage more innovatively and safely with children and young people through web based technology and provide up to date service information via text and email.

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

A key risk of introducing technology is that those with lower levels of digital literacy will be left behind. Some of this can be mitigated by making sure the technologies are designed with users and are intuitive to use. We must also ensure that we put in appropriate training and support to enable people to get the most out of new technologies and recognise that digital inequality has several dimensions including equipment, autonomy of use, skill, social support, and the purposes for which the technology is employed. Some people will not want to interact digitally even if they have the capability. There are a number of national and local initiatives around digital participation that we can access.

There are challenges with adopting emerging technologies because the evidence base for their effectiveness is often weak. The close links developed with the Academic Health Science Network (AHSN), Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and Devices for Dignity (D4D) in the region, together with detailed analysis of opportunities by Public Health colleagues, help minimise these risks but it has to be expected that not all innovations will be successful. To that end the way in which new technologies can be tested safely and rapidly is being explored in the region.

Another key challenge is that individual organisations may well have well developed digital strategies but together they do not support our vision for how seamless services should be provided by organisations working in close partnership. From April 2016 CCGs and Local Authorities will have to produce a digital roadmap that highlights how all the plans coordinate to deliver benefit. This should ensure that we have a coordinated regional approach to digitising our processes and information and that any risks arising from mismatches in timing or functionality can be mitigated.

A final challenge relates to the sharing and access of patient identifiable information. Organisations need to work closely together to minimise risk and to improve data sharing.

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

- The development of a city wide digital strategy that embraces the intentions of all the providers of health and care in the region should be encouraged. The Board should ensure that the digital strategy supports its wider aims and is kept up to date.
- The Board and its members need to address digital literacy in the recipients of digital services. A coordinated effort to identify needs and find solutions for them will help to ensure that people are not left behind as more services become available digitally.
- The relationship with the Yorkshire and Humber AHSN, CLAHRC and D4D should strengthen.
- The way in which the innovations that encourage integration and cooperation can be developed and tested without negative impact upon core business needs to be explored. The concept of Sheffield as an innovation hub or test bed for new innovations, as outlined in the NHS 5 Year Forward View, should be considered. The ambition would be that innovators from the UK and internationally would be attracted, and pay, to have their proposed discovery or innovation deployed and tested in these sites.
- The Health and Wellbeing Board has a role in ensuring that all the commissioners and providers in the region continue to seek out and deploy technologies to improve our care in a safe and secure manner.

Theme: Health and wellbeing workforce

Frontline workers aware of health and wellbeing needs and able to signpost and support service users in obtaining the help they need

Action 5.5: Commission a basic training programme for all frontline workers that raises the profile of public health, mental health and safeguarding issues and ensures an understanding of services and tools available to make 'Every Contact Count'.

Section completed by Victoria Horsefield and Chris Nield

1. What are the needs identified under this action and what progress has been made in the past year to meet these needs?

To enable the Council and its partner organisations to maximize opportunities of day to day contact with service users, there is a need to build the competence, confidence and commitment of front-line staff and their managers. There is also the opportunity to influence Providers to ensure public health considerations inform their practice and opportunities for positive health and wellbeing interventions are maximized. 'Making Every Contact Count' (MECC) encourages conversations about health and wellbeing including consideration of social needs which influence health.

In the last year this work has:

- Put together a multi-disciplinary, cross-organisation and cross-departmental project team to deliver this project.
- Looked at what is needed to transform the Council in to a public health organization.
- Public Health have recruited two experienced training and development consultants. One post funded through Sheffield Teaching Hospital's Charitable Trust, will work in partnership with ScHARR to carry out a four year piece of work implementing the MECC model in identified teams within SCC. The second post, also working on MECC delivery, has a wider remit to address the development of Public Health competence, working across Portfolios within SCC, to support the MECC work.
- Developed and action plan and it is anticipated the first training cohort will be trained in summer.

Sheffield Safeguarding Children Board (SSCB) has an established multi-agency training programme that includes opportunities for frontline workers and their managers to increase their knowledge, understanding and skills in relation to a number of these issues. The SSCB Learning and Improvement framework is informed by practice reviews and audits conducted by the SSCB to ensure it is able to respond quickly and efficiently to emerging issues and themes. The Sheffield Safeguarding Adults Strategic Partnership ensures that training and development on safeguarding issues is made available for staff across the multiagency partnership.

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

- Releasing front-line staff for MECC training will be a challenge. The SSCB training programme has been revised to take into account a changing workforce with shorter, focused but more intensive training opportunities being offered.
- The funded MECC project will support a concentrated evaluation to assist in developing a robust programme with lasting impact that can be rolled out across the Council and to wider partner organisations in the city.
- The Care Act 2014 puts safeguarding adults on a statutory footing for the first time from 1 April 2015. A state of readiness review has been undertaken which confirms that Sheffield is ready to undertake the new duties under the Act and the opportunities for raising the profile of adult safeguarding are welcomed

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

- Continue to support organisational engagement and development that will assist the MECC programme. We can all Make Every Contact Count so encouraging colleagues across the board to embrace this as a tool for addressing health inequalities will assist in the rollout and recognition of this programme.
- Work alongside existing training delivery programmes to ensure consistent messages are being delivered to the workforce and to use every training opportunity to give these key messages.

Action 5.6: Commit to working with VCF organisations to find the best way of meeting people's needs locally and ensuring we benefit from the added value VCF organisations can bring.

Section completed by Alexandra Shilkoff

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

Statutory sector partners and Voluntary, Community and Faith (VCF) colleagues have formed the 'Thriving VCF Leadership Group'. The purpose of this group is to:

- Develop a culture which values the skills, experience, capability and capacity of the sector, and recognises the sector's contribution as a key element of Sheffield's success.
- Champion a strong approach to co-design and co-production and empower citizens and communities to be part of designing solutions for the future.
- Encourage and promote communication and consultation between the private, public and Sector to be widespread, strong and robust.
- Advise a range of boards, including the Health and Wellbeing Board, on the development of strategy and action plans that would strengthen and promote the role and successes of the sector in the city.
- Act as custodians of the Sheffield Compact - an agreement between public sector organisations and third sector organisations that aims to strengthen working relationships between the two sectors.
- Oversee the allocation of any budget or resources that further the purposes of the Leadership Group.

In 2014/15 the Thriving VCF Leadership Group have worked with partners to arrange three events in the city to look collectively at how to best to address the issues of Health & Social Care Community Prevention (Keeping People Well in their Community), Welfare Reform and Community Cohesion.

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

There is an opportunity, with the move to more outcomes based commissioning, to generate more innovative and locally responsive ways of working to meet local needs. VCF organisations have an opportunity to deliver services or partner with other organisations to make the best use of resources and expertise. However, funding uncertainty within the sector is a significant challenge for stability and to maintain the capacity.

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

- Listen to the latest thinking from the sector on city wide and local delivery matters.
- Solicit feedback and innovative ideas from the sector on all aspects of the Board's work.
- Review commissioning and contracting practices to ensure that VCF organisations are given the best chance to shine, able to plan more than one year ahead, and that the 'Sheffield £' is maximised.

Action 5.7: Continue to seek greater efficiency from providers, without putting service users' safety or experience at risk.

Section completed by Joe Fowler, Anthony Hughes and Julia Newton

1. **What are the needs identified under this action and what progress has been made in the past year to meet these needs?**

- The CCG requires providers to achieve greater efficiency year on year through the mandatory price setting mechanisms in NHS contracts. Over the last few years this has resulted in a net reduction in price for services, with allowance for cost increases more than offset by an efficiency requirement. This net price reduction is then also used as the baseline for local price setting, with variation only being made where there is clear evidence that achieving the price reduction could compromise patient safety or the quality of care (this most often applies in agreeing prices with care homes).
- In addition to the above the CCG plans to achieve further efficiency gains through changes in the levels of activity it commissions (e.g. reducing urgent hospital admissions by improving care in community settings, developing alternatives to GP referral to hospital for non-urgent care).
- The Council has asked care providers to contribute to meeting its financial challenges over the last four years. This has resulted, in the main, in standstill or very low fee increases. Sheffield now has some of the lowest care costs in the country. The drive to deliver cost reductions has also seen the Council taking action to move care provision away from more expensive providers. This has been done on a quality first basis – ensuring that compromises are not made on the quality of care provided.
- There are still some areas of care provision where new contractual arrangements or negotiation will deliver further cost savings without compromising on service quality. These areas are mainly in learning disability services where costs are relatively high compared to other areas.
- The Council's Children, Young People and Families portfolio has worked to seek greater efficiency from providers and to ensure effective service delivery that achieves positive outcomes for children and families. Particularly there has been a focus on the monitoring and performance management of contracts to question and challenge outcomes and to instigate redesign where necessary, and to review or change contracts where required.

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

- As budget reductions continue it is becoming clear that the squeeze on costs is starting to impact on the ability of providers to deliver services to the standards required. This has been apparent in recent weeks when home care providers have struggled to cope with demand – with a direct consequential impact on the ability of the care system to support hospital patients back into the community. The slim margins in the sector mean that providers struggle to bring in additional capacity at peak times and we need to consider how we fund this additional capacity based on the very tangible savings that can be achieved by avoiding unnecessarily long hospital stays.
- We also have ambitions to deliver living wage across the care sector, which will also drive further pressure on costs.

Appendix A – Outcome indicators for outcomes 4 and 5

Indicator: Improving access to GP services

Definition: Proportion of GP Patient Survey respondents reporting a very good or fairly good experience of making an appointment.

	2011-12	2012-13	2013-14
Sheffield	75.5%	72.4%	70.4%
England	79.1%	76.3%	74.6%
Core City Rank (1 is best)	6	7	7

Indicator: Avoidable admissions to hospital

Definition: Rate of emergency admissions to hospital for acute conditions that should not usually require hospital admission. Rate per 100,000 population.

	2011-12	2012-13	2013-14
Sheffield	1288.1	1476.4	1462.1
England	1130.2	1204.3	1195.7
Core City Rank (1 is best)	3	6	6

Indicator: Delayed transfers of care from hospital

Definition: Average number of delayed transfers of care from hospital on a particular day taken over the year divided by the size of the adult (18 years and over) population in the area and multiplied by 100,000.

	2011-12	2012-13	2013-14[1]
Sheffield	3.5	3.6	15.6
England	9.7	9.5	9.6
Core City Rank (1 is best)	1	1	6

1 The number of delayed transfers of care in Sheffield on the day of the census in 2013-14 was 69 compared to 16 in 2012-13. In August 2013 the Sheffield Teaching Hospital Foundation Trust changed how it defines delayed transfers and also started to report delays directly from its case management system. Although this is a much more accurate method of capturing information it has led to a five-fold increase in the number of delays identified. This means the figures for 2013-14 onwards are no longer comparable with previous years or other areas of the country.

Indicator: Older people still at home 91 days after discharge from hospital

Definition: Proportion of people aged 65 years and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

	2011-12	2012-13	2013-14
Sheffield	86.2%	76.8%	84.8%
England	82.7%	81.4%	82.5%
Core City Rank (1 is best)	1	4	3

Indicator: Control over daily life

Definition: Proportion of social care clients (users/carers) who say they have sufficient control over their daily life. (18 years and over)

	2011-12	2012-13	2013-14
Sheffield	76.2%	74.7%	74.2%
England	75.1%	75.9%	76.8%
Core City Rank (1 is best)	3	6	4

Indicator: Self-directed support

Definition: Number of social care clients (users/carers) receiving self-directed support as a proportion of clients receiving community based services and carers receiving carer specific services (18 years and over).

	2011-12	2012-13	2013-14
Sheffield	54.2%	69.3%	63.1%
England	43%	55.6%	61.9%
Core City Rank (1 is best)	2	2	6

Indicator: Older people admitted to care homes

Definition: Rate of council supported permanent admissions to nursing and residential care homes of people aged 65 years and over per 100,000 population.

	2011-12	2012-13	2013-14
Sheffield	443.2	796	677.5
England	695.9	708.8	650.6
Core City Rank (1 is best)	1	5	2

Appendix B – Work of the Sheffield Safeguarding Boards

Health and Wellbeing Board

Safeguarding Boards' work in Sheffield

This is a summary of key issues for both Safeguarding Boards in Sheffield which have a relationship to the Health and Wellbeing Board's Joint Health and Wellbeing Strategy.

The Child Sexual Exploitation Assessment Report for Sheffield published in December 2014 identified 44 strengths and 16 areas requiring further development. Areas requiring development/improvement included the need for clearer pathways especially therapeutic to improve access and provision for ongoing support for young people in relation to counselling and mental health needs.

The CSE strategic group has produced an action plan which will include this aspect of support. The Safeguarding Children Executive Board will oversee this action plan.

The Board recently supported a plan to extend CAMHS -Child and Adolescent Mental Health Service- up to 18 and indeed this was the first recommendation of a case review report presented to the same meeting.

The case review concerned a young man whose transition from children to adult services broke down. It is clear that the complexities of young peoples' needs in transition are not fully understood and that despite efforts, the understanding of mental capacity legislation, working across clinical boundaries and the focus on the young person is not robust.

Both safeguarding boards will have transition improvement in their business plans for 2015-16 and will work with the Health and Well Being Board transition programme to ensure improved arrangements and mental health outcomes.

In addition, the recent Sheffield Child Death Overview Panel (CDOP) report on suicides, which reported on the death by suicide of 6 young people since CDOP processes commenced in 2008 gives cause for concern. As this assurance responsibility is part of the children safeguarding board agenda and relevant to wellbeing in Sheffield it is important to highlight the factors found in the study which affect the wellbeing of some vulnerable young people and can inform the work with young people in transition to adult services.

The Safeguarding Adults Board, now a statutory Board as part of the Care Act 2014 has assurance responsibility for the significantly increased Deprivation of Liberty Standards activity following a High Court Ruling.

The supervisory body for this is the local authority affecting people lacking capacity who are in health and care settings and supported accommodation as well as at home.

If there are restrictions which need authorisation then the person's best interests must be assessed and the supervisory body must be assured that they are necessary to keep people safe.

This is part of considerations of health and wellbeing and given the increased volume there is an assurance responsibility in relation to the risks being managed given the workload. This is being exercised but nationally as well as locally there are challenges which affect vulnerable people who lack capacity.

Sue Fiennes

Independent Chair Safeguarding Children and Adults Boards Sheffield

March 2015

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of: Chris Shaw, Head of Health Improvement, Sheffield City Council

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Date: 26 March 2015

Subject: Health, Disability and Employment in Sheffield

Author of Report: Chris Shaw, 0114 273 5015

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. It has five work programmes, one of which focusses on Health, Disability and Employment. This paper aims to briefly summarise the key issues for the Health and Wellbeing Board in seeking to improve the employment opportunities for people with health and disability barriers to employment and reduce the impact of poor health on employment across the City. It will be supported by a presentation at the meeting.

Recommendations: Health and Wellbeing Board members are invited to support the work in this area (see section 5 of this report for specific recommendations).

Background Papers:

- Baseline report looking at Health, Disability and Employment issues in Sheffield – https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/work-programmes/health-dis-employ.html.
- Sheffield Joint Health and Wellbeing Strategy 2013-18 – https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/joint-health-and-wellbeing-strategy.html.
- *A presentation will be given at the meeting alongside this paper. This will be published online after the meeting.*

Health Disability and Employment in Sheffield: Discussion Paper for the Health and Wellbeing Board Thursday 26 March 2015

1. Background to the report

One of the Health and Wellbeing Board's Work Programmes is the issue of Health, Disability and Employment. Good work is good for health, the evidence for this, and the strategic context and existing performance was presented in the baseline report on health, disability and employment which was previously presented to the Board.

This report will briefly summarise the key issues for the Health and Wellbeing Board in seeking to improve the employment opportunities for people with health and disability barriers to employment and reduce the impact of poor health on employment across the City. The majority of the paper will focus on the "off work (long and short term)" cohort.

2. A summary of progress so far

In work and at work cohort

- Commissioned SOHAS to deliver Public Health England's Workplace Wellbeing Award, encouraging businesses to consider workforce wellbeing and offering connections to various avenues of support from Move More to Mindful Employer. The target is 200 employers within 2 years.
- Worked with Macmillan to develop Vocational Rehab for people recovering from and living with cancer.

In work but off work

- Working with National Fit for Work Service delivered by Maximus (who also won the Work Capability Assessment contract vacated by ATOS), currently being piloted in Sheffield by Health Management Ltd.

Off Work (long and short term)

- Commissioned jointly with Jobcentre Plus the "Works Well" project which seeks to provide employment opportunities for 200 people with health and disability barriers to employment. This is being delivered by SOAR, ZEST and Manor and Castle Development Trust.
- Conducted 'audit' of existing service provision across the Council and NHS against best evidence criteria.
- Working with Public Sector Transformation Network to develop a single referral pathway into employment for the cohort.

3. What we have learned

- Sheffield Performance against a range of health and care outcome measures is variable, but in the main slightly below average.
- The things we do collectively to support the cohort into employment are not joined up and there are duplication and gaps. Outcomes are not adequately measured. It has evolved rather than been constructed.
- Culturally (nationally) our health and care systems do not view employment as a productive health outcome.
- Our welfare system has inadequate contact with health provision.
- The national employment system has not delivered for the cohort.
- The level of increase in demand for opportunity has to be balanced with an increase in supply – and brokerage/ support for employers is probably our weakest area both within existing provision and as a gap between.
- Too much of the provision focusses on preparation for employment, when all the evidence says acquisition and retention are more important (Place *then* Train).
- We do not have enough provision for below 16 hrs per week, job carved opportunities or enough supported internships.
- School and FE leavers from the cohort are not prepared for nor helped to operate in the world of work.
- We also need to prepare for the ageing workforce and the implications of this (no work done here yet).
- Not addressing the issue has significant health and social care implications now and in the future.

4. What we must balance

In terms of action, it is important to maintain a balance between:

1. Quick wins (increase/ improve commissioning activity and coordination) *and* longer term 'system' change to reduce system and culture barriers to improving outcomes. (The Devolution and Public Services Transformation Network agendas are key here.)
2. Supply of opportunity *and* demand for opportunity.

We also need to be mindful that both Outcomes Framework measures (employment gap for those with a learning disability and those in contact with secondary mental health services) are comparatively small cohorts (100s) whereas those on Employment Support Allowance due to a health condition or disability are much greater (20,000+). We need to be mindful of hitting the target but missing the point.

5. How the Health and Wellbeing Board can support the work

- GPs to refer into the Well To Do Pilot (ESA referral).
- Put 'weight' behind 'Workplace Wellbeing/Good Employer' award; for example, a joint endorsement with Chamber of Commerce or Local Enterprise Partnership?
- Actively participate in Local Enterprise Partnership Social Inclusion and Equalities Advisory Board and seek to influence investment regarding support funding (ESIF) for employment of those with health conditions or disabilities.

- Set target for the partners in terms of increasing employment outcomes (upper quartile by 2016?).
- Actively participate in PSTN group to develop the devolution ask back to Government in terms of health and disability related employment provision.
- Arrange further discussion by Health and Wellbeing Board representatives to develop the city's approach – possibly develop a SCC/CCG shared/integrated Commissioning Strategy for Supported Employment to steer related commissioning intentions over next 3-4 years.
- Encourage (big?) employers to lead by example.

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

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Date: 26 March 2015

Subject: Update on the Joint Health and Wellbeing Strategy's Work Programmes

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Author of Report: A Good Start in Life: Bethan Plant

Building Mental Wellbeing and Emotional Resilience: Janet Southworth

Food and Physical Activity: Jess Wilson and Dawn Lockley

Summary:

The Joint Health and Wellbeing Strategy has five work programmes which cover some cross-cutting themes of the Strategy. This paper provides a short update on three of the five work programmes: A Good Start in Life, Building Mental Wellbeing and Emotional Resilience, and Food and Physical Activity. The remaining two work programmes are covered elsewhere: Health, Disability and Employment is the subject of a wider discussion at the March 2015 Board meeting, while Supporting People At or Closer to Home is covered by the Board's work to integrate health and social care, about which it receives regular updates.

Recommendations: Health and Wellbeing Board members are invited to:

- Support the progress made with each work programme.
- Request another update on the work programmes in March 2016 if not before.

Background Paper: Sheffield Joint Health and Wellbeing Strategy 2013-18 – https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/joint-health-and-wellbeing-strategy.html.

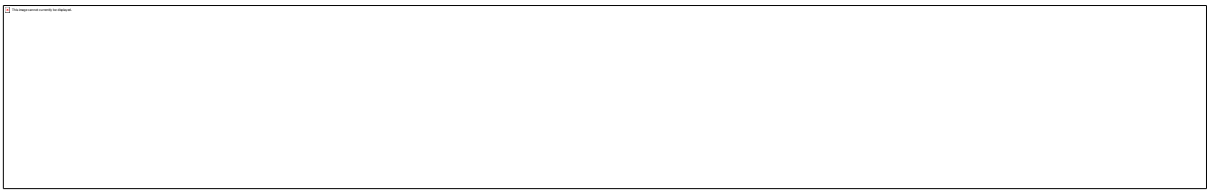
A Good Start in Life Work Programme

Update for the Health and Wellbeing Board March 2015

- The Best Start Early Years' Strategy consultation began week commencing 16 March for a 4 week period. The draft document has already been changed and amended following contributions from managers and practitioners across a range of organisations including health, and children and families. It has also been presented at various boards, to primary heads and to elected members. Feedback is now being sought from a wider audience. Cabinet sign off of the final document is expected April 2015.
- The strategy sets out 6 priority areas to achieve a progressive programme of universal and targeted interventions from pregnancy to end of Foundation Stage. It includes an Integrated Performance Outcomes Framework which identifies key indicators for measuring progress and impact on early years' provision. This framework provides a means for delivery partners to agree joint accountability and identify where whole system approaches could achieve greater service improvement.
- A delivery and governance structure is set out in the Best Start strategy describing partnership arrangements and how these will be used to influence and shape commissioning and delivery in line with strategic objectives.
- The Best Start Delivery Board has been established to support implementation of the 6 priority areas, and its role is to recommend on key decisions, advise on progress, highlight risks and issues and influence other strategies. It will be accountable for a range of workstreams including: Children's Centres development, joint health early years 2 year assessment, quality improvement across the PVI sector and free early learning. The Delivery Board will be responsible for providing regular progress updates to the Children's Health and Wellbeing Board.
- The redesign of SCC early years' services is progressing well with opportunities being identified at community level to integrate practice across settings and professions. The delivery model uses evidence based approaches designed to target resources in the most deprived areas and on the most vulnerable families.
- Since October 2014 meetings have been taking place with CCG, SCC, maternity and health visiting services colleagues to explore ways to improve integrated low level perinatal mental health services in Sheffield. A detailed care pathway is being developed (due to be completed June 2015), for treating mild to moderate mental ill-health which focuses on community based assessment, referral and support arrangements. The pathway will be uploaded onto the GP portal and made accessible to other professionals and early years' practitioners as a point of reference. A service user friendly version of the pathway is also being planned to improve understanding and awareness of the range of support available and how this can be accessed. Other developments proposed include:
    - Discussions with IAPT about improving perinatal mental health support
    - Improving the menu of self help and community interventions available through Children's Centres and Best Start teams to reduce isolation, improve confidence and self-esteem, and develop parenting skills including play, attachment and bonding.

Building Mental Wellbeing and Emotional Resilience Work Programme

Update for the Health and Wellbeing Board March 2015



1. Introduction

A working group was established in August 2014 to co-ordinate a plan for the delivery of a programme of work to help achieve the aims of the work programme 2. In terms of governance this group operates as a sub-group of the Mental Health Partnership Board and reports on progress there also.

2. The working group

The working group is led by Chris Nield, Consultant in Public Health within Communities SCC; it is supported by Janet Southworth, Health Improvement Principal. The membership of the group is still being developed; so far we have representation from the CCG – Partnerships, Commissioning and GP lead, from the City Council - member lead for Mental Health, CYPF Public Health, Mental Health Commissioning and Safer and Sustainable Communities, from the Voluntary Sector.

3. Progress and next steps

The group has now met 3 times, and is close to agreement on a draft plan. The remit is challenging, as often ideas drift towards the agenda of treating illness, or early intervention, we aim to keep a focus on a primary preventative and holistic approach.

Emotional wellbeing is influenced by an extremely broad range of factors, and this programme does not attempt to capture all of the possible related actions. The task would be impossible. We will focus on continuing support for some actions currently underway, and some development priorities that are achievable. We want to keep growing and developing the plan.

The plan has benefitted from the previous work to develop an emotional wellbeing strategy. (in line with a forthcoming framework for mental health and wellbeing from Public Health England). The plan is grouped around key themes.

1. Wellbeing for All (universal approaches) - Mental Health and Wellbeing Literacy.
2. Improving equality (targeted interventions) and Empowering Communities.
3. Children and Young people - linked to the work of the Children's Health and WB Board.
4. Working Life and Employment - Link to work programme on Health, Disability and Employment.

5. Suicide Prevention – local city wide group to be developed.

Most of the key actions for this work programme will be developed around themes 1 and 2, but important linkages and key opportunities to support work led by other groups under the other themes are also noted. A key theme of 5 Ways to Wellbeing (GIVE; BE ACTIVE; KEEP LEARNING; TAKE NOTICE; CONNECT), an evidence based approach to improving individual wellbeing, runs throughout.

4. Work underway - some examples

- Developing the public health role of front line workers, including their understanding of the 5 Ways to Wellbeing.
- Delivery and growth of Mental Health First Aid training - a collaboration between SCC, SHSC, Hallam University and Voluntary Sector.
- Relaunch and promotion of Mental Health Information service and web site.
- Develop links with the Community Learning Sector to normalise learning about emotional wellbeing.

5. Support from the Board; the 'narrative' around emotional wellbeing

Improved mental wellbeing is associated with better physical and mental health, reduced inequalities, improved social relationships and healthier lifestyles. It can help people achieve their potential, realise ambitions, cope with adversity, work productively and contribute to their community and society.

The foundations of mental wellbeing develop in early childhood, and multiple social, psychological, health, material and situational factors determine a person's mental health and wellbeing at any point in time. Risk, vulnerability and protective factors all impact on mental wellbeing, but they are not the whole picture, we can all act to improve our mental wellbeing too - hence the 5 Ways to Wellbeing. There is strong evidence that investment in the protection and promotion of mental wellbeing improves quality of life, life expectancy, educational achievement, productivity and economic outcomes, and reduces violence, antisocial behaviour and crime.

An important element of this programme is this 'narrative' around emotional and mental wellbeing**. Support from the Board in promoting the importance of this upstream approach alongside the key aim to 'get it right' for children, at both a strategic and operational level, is essential.**

Emotional wellbeing is a valuable resource for individuals, communities and the City as a whole. Its strategic significance needs to be better understood. **The Board is asked to adopt and promote this narrative.**

Food and Physical Activity Work Programme

Update for the Health and Wellbeing Board March 2015

1. Food

The Sheffield Food Strategy was approved by cabinet in June 2014 and year one of the implementation plan is almost complete. The implementation plan for 2015/16 is currently under review. Progress in 14/15 included:

- Short term financial support has been identified for a number of schemes to alleviate food poverty.
- Considerable work has taken place to increase Free School Meal uptake within the 125 schools in the SCC catering contract.
- All Infant and Primary schools with infant departments are now providing universal free school meals to KS 1 pupils from September 2014 and each school is now being assessed to ensure they are able to manage this increase in meals.
- Community development work around food and eating well has begun in 4 neighbourhoods - Arbourthorne, Acres Hill, New Parsons Cross and Gleadless Valley. Local people and stakeholders have been consulted and local partners are now developing locally owned food plans.
- Classes to teach cooking skills have been delivered across the city and have targeted groups and areas who are least likely to access a healthy diet.
- The Start Well Sheffield Early Years' Healthy weight Service began in October 2014 working with early years settings to achieve the Healthy Early Years Award, providing new tools and training for professionals that work with families and providing the Health Exercise and Nutrition for the Really Young programme to parents and carers across Sheffield.
- Environmental Health are about to commence an initiative testing elements of the "Takeaways Toolkit" with a number of fast food businesses.

Many partner and community organisations are also engaged in supporting all aspects of the Food Strategy. Here are a few examples:

- WRAP have launched a Love Food Hate Waste campaign in Sheffield.
- A number of local organisations (Heeley City Farm, Sage Greenfingers, ShipShape, Regather to name but a few) are involved in work that promotes local food, food growing and community engagement.
- The student union led 'Sheffield on a Plate' project has engaged many student volunteers in their work which included delivering a 'Big Stew' event to raise awareness of healthy eating, food waste, and food poverty.

2. Physical Activity

Progress has been made in implementing some areas of the Move More Plan. However, more financial resources are required if we are to fully realise the ambition within the Plan.

Empowered Communities:

- The Community Advisory Panel is working on the developing the Move More ambassador programme.
- The Move More network continues to grow and currently consists of approximately 200 well-connected people.
- An online survey is being designed to evaluate the impact of the initial wave of Asset Based Community Development (ABCD) training to identify if it has changed practice and identify the support people need to be able to implement ABCD work.
- £10,000 has been allocated by SCC and is governed by the Move More Community Advisory panel to fund community projects enabling them to lift the barriers to physical activity. Funds are being distributed in pots of £300. The funding panel have currently received 25 applications to date.

Active Environments:

- A Get Sheffield Cycling group has been established which will drive forward cycling opportunities and communication about what is available
- The first anniversary of Tour de France will see a weekend of cycling activity including a school event on Friday 3rd July; Jenkin Hill Climb for local people and professional cyclists on Saturday 4th July; Sky Ride mass participation event on closed Sheffield roads on Sunday 5th July.
- Work is progressing on 20 mph zones and further work is planned to implement the restriction in additional areas of Sheffield
- Work is progressing within Sheffield City Council to develop a Playing Out Strategy for the city.
- A “routes to physical activity” section has been created for the Move More website (linked in in with SCC website) under the banner of Active Travel that covers walking, running and cycling maps, apps, trackers, planners and challenges. This was launched on the 30th January 2015.

Active People and Families:

- 108 JC Decaux Boards displayed Move More and cycling messages for 2 weeks in February. The capital programmes at Concord, Graves and North Active are progressing well.

Physical Activity as Medicine:

- The building work at Concord has now been completed (this is part of the National Centre for Sport and Exercise Medicine (NCSEM) programme). There is a strong mix of clinical activity planned.
- Discussions have also begun regarding research programmes that will operate from Concord and we already have agreements in place for a Prostate Cancer Trial and are exploring Exercise and Stroke currently.
- Graves and North Active have been given the go ahead from City Council planning and build contractors are in place. Both venues are due to open in the Spring of 2016.

Active Schools and Active Pupils:

- SHU have opened up Woodbourne Road athletics stadium and are exploring the feasibility of attracting schools and community groups to use the facilities with the added incentive of innovative technology.
- 36 satellite clubs currently planned or active across Sheffield, working primarily (but not exclusively) with 11 to 18 year olds.
- Aspiration to have a club on every secondary school and college site by 2016.

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Jayne Ludlam, Executive Director, Children, Young People and Families, Sheffield City Council
Date:	26 March 2015
Subject:	Response and progress update from the Health and Wellbeing Board to its Emotional Wellbeing and Mental Health Engagement Event with Chilypep, Sheffield Futures and Young Healthwatch in November 2014 *Including CAMHS Scrutiny response and update on progress*
Author of Report:	Bethan Plant, 0114 293 0133

Summary:

This paper provides a brief account of progress to date and a response to how those issues identified by the young people who facilitated the emotional wellbeing and mental health engagement event in November are being addressed.

This outline is to be approved by the Board and shared with the organisations and young people who led and participated in the engagement event.

In addition appended to the paper is an update for the Board on progress on actions and service redesign following recommendations made via the CAMHS scrutiny process.

Recommendations:

- Agreement from the Board to agenda a further review on progress and implementation during early summer 2015.
- To note actions and service redesign being taken forward as an outcome of the CAMHS Scrutiny process.

Response and progress update from the Health and Wellbeing Board to its Emotional Wellbeing and Mental Health Engagement Event with Chilypep, Sheffield Futures and Young Healthwatch in November 2014

1.0 SUMMARY

Health and Wellbeing Board members were impressed with the commitment, honesty and passion shown by the young people who facilitated the Emotional Wellbeing and Mental Health (EWBMH) engagement event in November 2014. The accounts and experiences which the young people shared emphasised the need for the Health and Wellbeing Board to continue to prioritise Emotional Wellbeing and Mental Health so as to ensure improved outcomes and experiences for those young people using mental health services. A one-page summary from the event was published on the Board's website.[1]

2.0 ACCOUNT OF PROGRESS TO DATE

This gives a brief account of progress to date and a response to how those issues identified by the young people are being addressed. As a result of the issues the young people raised a new Emotional Health and Wellbeing Executive Group has been established. This group will be jointly chaired by Sheffield City Council and NHS Sheffield CCG to provide a partnership focus to all actions that will impact on the delivery of EWBMH. The Executive Group will oversee the delivery and implementation of a new EWBMH Action Plan which is addressing the following priorities:

Positive mental health and resilience including early intervention and prevention

- The young people consistently identified the gap in addressing EWBMH in school & youth settings and supporting children and young people to develop resilience in schools. There was acknowledgement that there continues to be a strong focus on attainment and achievement in school settings and in some cases a loss of the wider pastoral support to address emotional wellbeing and mental health needs. As a result a commitment is given through the delivery of high quality Personal and Social Health Education (PSHE) to support schools to deliver a robust EWBMH offer. The EWBMH school toolkit will be refreshed and new lesson plans and resources developed ready for implementation in September 2015. Through the Citywide Learning Body schools will be asked to consistently deliver EWBMH input through the PSHE curriculum and using the new toolkit and material provided.
- Young people commented that they 'want someone to help', someone who they can turn to for information and support with low level mental health issues (e.g. family breakdown, exam pressure etc.) A new primary mental health intervention will be piloted and further tested in 3 families of schools using a school based 'hub' model. This is to expand and build on the pilot delivered at Park Academy in 2014 and will help all partners including Sheffield City Council, NHS Sheffield Clinical Commissioning Group

[1] See https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/events/engagementevent.html.

and schools to make the right decisions about investments for young people's services in the future. The new service is currently being mobilised and will be operational from April 2015. The providers Interchange and Family Action will deliver the Emotional Health & Wellbeing Service through Community Youth Teams and schools offering counselling, signposting and a whole school approach to support settings to provide help, advocate for young people and improve their resilience and emotional wellbeing.

- The evaluation and outcomes of the service offered across the three families of schools will contribute towards the development of a business case focusing on improving accessibility, pathways and the potential redesign of EWBMH provision. This business case will be presented to the Children's Trust Executive Board (CTEB) in the future.

Young People Approaching Adulthood

- The new Executive Group will include a work stream focusing specifically on provision for 16-18 year olds. Its focus will be to ensure appropriate support for young people already engaged in specialist services, the development of a clear Pathway and 'step down' for those young people transitioning out of specialist provision. The current extension of CAMHS from 16 to 18 years will be evaluated to review the delivery model and experiences of young people aged 16+ using CAMHS services.

Development of community based support (Tier 3.5)

- Working with NHS Sheffield CCG the development of community based support as an alternative to hospital care is being explored so as to offer improved local community mental health services. This is in response to recognising that inpatient provision isn't always most appropriate or necessarily best tailored to young people's needs.

Services for Vulnerable C&YP

- In most instances the best place for children and young people experiencing severe mental health problems is to remain in Sheffield and close to home. The priority is to support the needs of vulnerable children and young people (particularly Children in Care) and reduce the number of children and young people who are placed out of city for their care.

Engagement and Participation

- The Board engagement event highlighted how powerful and important the views of children, young people and families are. The Executive Group is committed to hearing the voice of children and young people through using existing engagement structures. The engagement work led by the executive group will look to implement a new EWBMH local campaign. This will provide positive stories from young people and be used in schools and youth settings to reduce stigma, dispel myths and improve communication regarding EWBMH. This group will also continue to ensure the role of the 'Young Commissioners' in the development of EWBMH service provision. The young commissioners played an essential role in the recent commissioning of the EWBMH Service (described earlier) having active involvement in the procurement process, interviewing potential providers, informing the service model and selecting Interchange and Family Action as our preferred providers.

The Health and Wellbeing Board is committed to continue to prioritise EWMB. The young people involved in the engagement event from Chilypep, Sheffield Futures and Young Healthwatch are invited to ask for regular updates, get involved or challenge progress.

3.0 RECOMMENDATIONS

- Agreement from the Board to agenda a further review on progress and implementation during early summer 2015.
- To note actions and service redesign being taken forward as an outcome of the CAMHS Scrutiny process.

Health & Wellbeing Board – Thursday 26th March 2015 - CAMHS Scrutiny Update

A sub group of the Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee convened a Child and Adolescent Mental Health Working Group to review emotional wellbeing and mental health provision. This group developed a number of service principles which required Sheffield Clinical Commissioning Group (CCG), Sheffield Children's NHS Foundation Trust and Sheffield City Council to work together to redesign and implement service changes in order to improve the provision of emotional wellbeing and mental health services for children, young people and families.

The following template provides an update on progress against the service principles identified. The newly established Emotional Wellbeing and Mental Health Executive Group has oversight of implementation of the Scrutiny Board recommendations and reports back progress.

	10 Principles for the Service recommended via Scrutiny	Update on Progress
➢	**The Pathway**	
1	**Communication** - is key at all stages of the process, this includes information on waiting times/ interim support /outcomes and reasons for case closure.	There is potential to develop an e-portal site which would host information on emotional wellbeing, as well as have links to training & development This will include referrals forms, exemplar referral forms, checklists to guide people's decision regarding what to do next and how to access provision. It would also host self-help guides to support step down from specialist care. The local authority and partner agencies has included the CAMHS provision in the local offer for children and young people with special educational needs, this is the place where information about provision is available, the local offer has been coproduced with families. The Specialist NHS CAMH Service agree it would be useful to include waiting time information in their acknowledgment letter to families and are instigating this change. Specialist NHS CAMHS offer access to their consultation line for accepted referrals as well as routinely offering information about self-help and other resources where appropriate. For specialist NHS CAMHS, cases are closed with agreement and understanding of the family. The referrer is always informed about the outcome of a case and the reason for closing the case. The Emotional Wellbeing and Mental Health pilot at Sheffield Park Academy last year included a pilot CAMHS step up and step down element i.e. support whilst on waiting list and following discharge (involving Primary Mental Health Worker in development of this). This is in response to the Emotional Wellbeing service* consultation held in OCT 2013.
2	**Clear information** – should be produced to outline the services available and the referral routes. This needs to be accessible to both those making referrals and those who access services (see point 10 co-production).	Specialist NHS CAMHS have a referral document for referrers and professionals. All specialist CAMHS teams have team leaflets but we agree that these should be more accessible to families. New leaflets are currently being produced with service users and which will be available this year - in written form and also on the Sheffield Children's website.

3	**Family assessment and confidentiality-** where possible, a family assessment should be offered to ensure a more holistic approach (this is not always possible as some young people will request confidentiality). There also needs to be a clear route for parents to pass on information confidentially throughout the process	The Specialist NHS CAMHS normal procedure is for a family based assessment with opportunity – as appropriate – for the young person or/and parents to be seen separately. In most cases, especially where the young person is older there will be a separate meeting for the young person. Specialist CAMHS provide parents/carers with information before they engage with the service and parents /carers are often offered their own appointment for a confidential meeting.
4	**Role of the GP**– GP referral notes should be transferred onto the Assessor and should be fully used as part of the assessment process. Communication channels between the GP and the Assessor should remain open.	Sheffield is one of 10 sites in England chosen for a GP Champion project**,** funded by the Department of Health and run by the Association for Young People's Health, Youth Access and RCGP. The 3 year project aims to bridge the gap between GPs and the voluntary youth sector and to "implement an innovative model for transforming the way public health services are delivered to young people, thereby improving their health outcomes". The Sheffield project, led by Interchange/Right Here working in partnership with Pitsmoor Medical Centre, focuses upon emotional wellbeing and mental health of young people. In Specialist CAMHS, referral information is always available and is used for the initial assessment. No referral can proceed without this but it is also extremely important that the professional undertaking the initial assessment hears the family's concerns in their own words. It will, however, be helpful to ensure that families understand this.
5	**Transitions** - there needs to be early preparation for those transitioning out of a service and clarity in terms of next steps.	There is an agreement that transition arrangements need to improve and following Scrutiny this issue will be looked at in more detail and reported back in the future. This is a national problem and Sheffield's specialist NHS CAMHS agree that this is an area of need and difficulty in Sheffield which, although good for a small number, needs to improve. CAMHS and the adult mental health service have been working to improve transitions and a number of events have been held or will be held this year, including contributions from service users.
6	**Services for those aged 16-25** - there should be a specially commissioned young	NHSS Clinical Commissioning Group, NHS CAMHS and Sheffield City Council are committed to working with their partners in adult mental health to achieve better transition and improve services. Some services within CAMHS are already provided up to age 18 for specific groups of children.

	adult's service for those aged 16-25, consideration should be given to having this as a community based service.	The CAMHS service has now been extended and is mobilised up to 18 years. This provision is being evaluated and impacts/outcomes monitored.
7	**Single point of referral** - there should be a single point of referral and standardised referral documentation, this process should assess the person and determine which pathway they go onto.	There has to be an acknowledgement that for certain groups of vulnerable children there is a necessity to have different referral process as some young people do not present to services in the traditional way (e.g. via Youth Offending Service, children with disabilities). There is a single point of referral with a single referral document for specialist NHS CAMHS which is co-ordinated with the CAMHS element of the MAST service. This is available electronically for all GP's and provides a simple, straightforward referral and service pathway. Confidentiality is a key issue for families who, quite rightly do not want their confidential details widely distributed without their consent. This applies to both Multi Agency Support Teams (MAST) and Specialist NHS referrals. Unfortunately, not all referrers are using the standard document which means that for confidentiality reasons some referrals which might benefit from the simple pathway we have devised cannot be processed as simply as we would like. Work is underway to address this and to ensure consistency in how referrals are completed. Given the volumes involved (as well as the confidentiality issues), it is not practical to have one access point for specialist NHS CAMHS and MAST. (MAST receives a very large number of non-mental health referrals and most referrals to Specialist CAMHS are entirely appropriate).
8	**Improving Access to Psychological Therapies (IAPT)** - consideration should be given to developing an IAPT service for young people.	CYP-IAPT (Improving Access to Psychological Therapy) for Young People is now available although it should be noted that CYP-IAPT is a different concept in comparison with IAPT for adults, which is a separate service. Sheffield is part of the national CYP-IAPT programme whose approach is to change or transform the way that CAMHS works – to ensure that we use the best possible evidence in our therapies and involve service users and carers.
➢ **Raising awareness amongst young people, effective signposting and involvement**		
9	**Role of Schools** - The role of Schools	There are important measures to improve access to emotional wellbeing and mental health support

	needs to be increased to improve communication with young people and aid an early intervention / prevention approach. Schools need to consistently promote the services that are available i.e. through the School email services / intranet, and should have staff with the knowledge/skills to make referrals.	through schools. An Emotional Wellbeing and Mental Health school pilot was completed in 2014 to help test and define a model for Emotional Wellbeing provision and staff support in school. The pilot was offered to schools and through a selection process focusing on need and those schools best placed to undertake the pilot one secondary school selected. The pilot was delivered by Family Action (Targeted Mental Health in Schools) and Interchange Sheffield CIC at Sheffield Park Academy. This pilot has informed future services to support children and young people's emotional wellbeing and mental health. To further test the model funding has been identified to expand the pilot to 3 families of schools during 2015. It will be externally evaluated and its impact on referrals to specialist services analysed. There is a Personal Social Health Education Review underway which includes an emphasis on EWBM. There has also been a You're Welcome* inspection of CAMHS completed to identify appropriateness of young person friendly service. *You're Welcome are national standards to benchmark service delivery. It is implemented through young people 'inspecting' provision and service managers self-validating the views and outcomes of the service against national indicators/standards. The feedback from the young people is used to improve service provision and comparisons are made with the views of staff and service managers.
10	**Co-production** - young people who access the service and their carers need to be involved designing the service, including producing communication materials and performance monitoring criteria.	Work is currently happening in SCC with support of clinical and VCF partners to define a good practice model for involving young people in planning, commissioning and delivery of services – using the new Emotional Wellbeing Service and other service provision as a working example. Specialist NHS CAMHS agree that there are many benefits of participation for service users, for parents and carers and for the organisation. This approach is very much part of the service's ambitions – we have used feedback surveys and focus groups extensively over the years as well as involving service users and carers in recruitment. This approach is also integral to the CYP-IAPT programme and we will be further developing our co-production with service users and families. We will also be continuing our work with STAMP and other service user and parent/carer groups, for example, in our project to produce new leaflets.

	Other Areas for Further Discussion	
11	**Weighting of funding for the services across the 4 tiers** - funding is currently more heavily weighted towards tier 4, does this clearly reflect need in the City? And does it support the early intervention / prevention approach that is required?	Consideration is being given to how the Public Health Grant can support early intervention and prevention alongside existing activities such as MAST (Multi-agency support teams). Work is currently being undertaken to define an early intervention and prevention model for CYP EWB& MH in school as outlined in point 9. This is being informed by a Health Needs Assessment, stakeholder consultation, pilot programmes and good practice examples. The Health Needs Assessment has been completed and has included collecting all appropriate data to determine the needs and changes in emotional well being and mental health for young people across the city. It has looked at prevalence, risk factors and the evidence base for interventions which are effective. This information will influence any future service redesign and changes in provision. Interventions at Tier 4 reflect high cost of intervention and demand for service. Further information is required and potentially further analysis to better understand this issue. CCG will take findings of review and consider response. NHS England is the specialist commissioner for Tier 4 services so the interface between local commissioners and NHS England is important. NHS England are currently reviewing tier 4 provision due to rises in admissions. Specialist CAMHS intervention with serious mental health problems is an essential early intervention for the mental health of adults. Most adult mental health disorders can be traced to a start before age 18. Collectively, we need to ensure that children and young people with greatest need get a good, effective service which they can access readily. Sheffield Children's NHS CAMHS provide both the local specialist community service as well as the in-patient ('Tier 4') service.
12	**Understanding and co-ordination -** There appears to be a lack of understanding and co-ordination between the full range of services available i.e. mainstream, voluntary and community sector and those	Providers collectively agree that as an outcome of Scrutiny this is an area for further consideration and future work. SCC corporate training provides training to Residential workers on Emotional wellbeing for Looked after children.

	commissioned separately e.g. by Community Youth Teams – can you tell us what's being done to address this?	Community Youth Teams (CYTs). CYTs provide support to vulnerable young people and may identify young people with emotional wellbeing and mental health difficulties. The referral pathway and access to Primary Mental Health workers, particularly for CYT's is to be considered and clarified and where relevant further training offered. A number of services are currently being redesigned including the development of the Integrated Sexual Health Services (ISHS) and the Sheffield School Nursing Service. As part of the service design process clear thought will be given to ensure appropriate pathways are developed and an EWMH early intervention/prevention pathway is available so as organisations both statutory and voluntary are clear how to refer and signpost children and young people to access support. Within specialist NHS CAMHS there is a high level of co-ordination across teams and with in-patient care. The main agencies and services concerned with children's mental health, GP's, specialist CAMHS and the Sheffield City Council's MAST teams have also achieved a much better level of understanding and co-ordination by working together. This is being carried forward as part of the CYP-IAPT programme - although it is acknowledged there is still more to do. This level of co-ordination is more difficult with schools which are all separate entities. (There are very many more schools in Sheffield than there are specialist NHS CAMHS staff). Where services are separately funded and established this can lead to poor co-ordination or confusion – particularly where these projects have a mental health aspect which is not built into the provision in the planning stage. For specialist CAMHS, co-ordination can be a crucial part of what we do, especially for looked after children, children in need, children in trouble with the law, and those with severe learning disabilities. These referrals will start with a meeting designed to aid understanding and co-ordination'. Specialist CAMHS also provides extensive training for agencies across the city to help them understand mental health problems, specialist CAMHS and how to access these and co-ordinate their contribution including with other mental health services, including MAST. Over 200 staff across all agencies including the voluntary sector attended this training last year A range of more specialist training is also offered across agencies, for professionals and, for example with adoptive and foster carers. Over 300 staff including 68 foster-carers attended CAMHS training last year. Specialist training has also included infant mental health and theraplay.

13	**Ryegate –** can you give clarification in terms of the pathway for Ryegate patients to CAMHS?	Commissioners are starting to look at Pathways. NHS England is the lead specialist commissioner and this organisation has a key interface with Ryegate. Local commissioners are only at present working to a draft specification for children with complex problems to work to from NHS England and are awaiting further national guidance regarding improving pathways for families. This will help inform further work at Ryegate. Ryegate and CAMHS do address different patient groups with Ryegate specialising in developmental and neuro-disability problems, including children with severe disabilities and autistic spectrum disorders. A small number of Ryegate patients may have additional, serious mental health needs which require referral to CAMHS. These will often have severe learning disabilities and a serious mental health disorder or very challenging behaviour. Where a referral to CAMHS involves developmental problems or severe learning disabilities it may be re-directed to Ryegate or to a community Paediatrician but this is uncommon as most referrers are aware of this. However, these pathways can be better defined and streamlined and the Service intends to examine this.
14	**Performance monitoring –** the current framework was criticised for focusing on process and not outcomes - does this need revising?	Sheffield Clinical Commissioning Group as the commissioners of specialist NHS CAMHS pay keen attention to the performance of the service. This relies on a full range of performance information including both key process and outcome information such as how referrals are handled, how long people wait to access the service and how long they spend in it. The commissioners have also built into the service specification a requirement to use outcome monitoring and there is a move to commission for outcomes more. However, this is a complex area with the 'outcomes' being very different depending on the 'problem', (for example, depression, autistic spectrum disorder, psychosis etc.) or the patient (their age, looked after child status, whether the service user is the young person or parent/carer etc.). The national CAMHS Outcomes Research Consortium (CORC) of which Sheffield has been a member from the outset in 2004 has focussed on ensuring that outcome monitoring is a feature of services and is used to improve them. However, outcome measures are difficult to monitor and to identify outcomes which can be effectively measured, CORC caution against simplistic approaches and league tables,

		recommending that the outcome monitoring comes from a variety of sources. Nonetheless, Sheffield specialist NHS CAMHS and MAST use outcomes extensively to inform service provision and improvement. A major plank of the CYP-IAPT initiative of which Sheffield is a participant includes a requirement to use outcome measures. Sheffield is unique in being a partnership between the NHS specialist service and the Local Authority – both of whom use outcome measures already. The draft standards which Sheffield is contributing to, suggest that 90% of service users should have contributed outcome measures and that these are actively used to support improvement in practice. Nationally there is a focus to move towards mental health commissioning for outcomes. Both commissioners and services very much agree with this approach.
15	**Emergency situations –** does consideration need to be given to how the service responds in an emergency situation?	Specialist NHS CAMHS is responsible for all mental health emergencies relating to under 16's. For all these cases the primary access route is through Sheffield Children's Hospital Accident & Emergency Department. All emergency admissions are initially triaged by the A&E team and followed up as required by specialist assessment by a dedicated rota of CAMHS specialist and consultant child & adolescent psychiatrists. Where required, children will be admitted to a hospital ward for further assessment and intervention. Where indicated, specialist mental health in-patient care is sought and provided. This service is in place 24/7 throughout the year. In 2013 165 young people under 16 years were seen for specialist mental health follow-up having presented at A&E. This represents a 100% increase over a three year period.
16	**Advocacy and support –** availability of advocacy and support for patients and carers – is there scope for a commissioned advocacy service? And if so could it be involved in the performance monitoring?	There already are a range of ways in which we ensure effective advocacy for children and young people who access services. However, there is potential for development via early intervention/primary prevention work. This is an area that will be considered further and investigated. We would need to consider evidence base and need. If there is a specific need then this will have to considered against other competing priorities. The model of advocacy is important and potentially something which could be supported by work outside of clinical providers.
17	**Waiting Times –**	The NHS CAMHS service has worked with Sheffield CCG to introduce a new service model and re-organise the Service in order to impact on waiting times and to improve efficiency. This work has successfully reduced the waiting times.

		However, despite the efficiency gains made, referrals have continued to increase in number. Whilst we are looking at ways to address the parity of esteem issues, this is likely to represent a slow move of resources over time in order not to destabilise other services and to also ensure that this is done where investment in mental health improves outcomes overall. The use of outcome measures aims to improve effectiveness which will allow better use of resources, and by having bimonthly performance meeting that have both clinical and managerial input, we are in a position to identify and find solutions to significant problems that might arise in addition to informing how the service develops. At the time that the Scrutiny Committee launched its report some two years ago, the waiting lists for specialist NHS CAMHS were unacceptably long. This was a difficult time for CAMHS, the City and for children and parents following the impact of the economic downturn, significant cuts in specialist NHS CAMHS and the need to re-organise the Service. The Service consequently introduced a new service model and successfully reduced the waiting times with additional temporary funding from Sheffield CCG. In April 2012 there were 527 referrals waiting with an average (median wait) of 22 weeks. In April 2013 this had been reduced to just 102 referrals waiting with a median wait of only 5 weeks. However, although specialist CAMHS completed 11% more appointments since April 2013 (despite having lost the temporary staff), referrals have risen by 34% in the same period and the number waiting at December 2013 has risen to 212 waiting for 10 weeks as a median average. Specialist CAMHS continues to work closely with commissioners, GPs and the MAST teams but both services are under increasing pressure. Families who have been referred to specialist NHS CAMHS and, having been accepted, are waiting for a service are offered support through a consultation phone line and self-help advice if appropriate. Families are also asked to contact the service if their circumstances change which will also lead to re-prioritising if appropriate.

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:	26th March 2015
Subject:	Health and Wellbeing Plans for Sheffield in 2015/16: Plans from Sheffield City Council and NHS Sheffield Clinical Commissioning Group
Author of Report:	Louisa Willoughby, 0114 205 7143

Summary:

Sheffield's Health and Wellbeing Board exists to bring together the many elements of the health and wellbeing system in Sheffield and provide a joint strategy and structure for making decisions that benefit the health and wellbeing of Sheffield people. The Board is built on positive and fruitful relationships and partnership between the organisations that commission health and wellbeing services across the city. This paper presents the commissioning plans for the partners for consideration by the Health and Wellbeing Board.

Questions for the Health and Wellbeing Board:

- Does the Health and Wellbeing Board support the priorities proposed by the commissioning organisations?
- Are there areas for greater joint working between the organisations on the Health and Wellbeing Board (and others) in 2015/16?
- What role is there for Healthwatch Sheffield over the coming year in assisting with the implementation of these plans?

Recommendations for the Health and Wellbeing Board:

- That the Board supports and endorses the commissioning plans set out in this document.
- That Board members and the Board's organisations commit to working together in an integrated way over the coming year.

HEALTH AND WELLBEING PLANS FOR SHEFFIELD IN 2015/16: PLANS FROM SHEFFIELD CITY COUNCIL AND NHS SHEFFIELD CLINICAL COMMISSIONING GROUP

1.0 SUMMARY

Sheffield's Health and Wellbeing Board exists to bring together the many elements of the health and wellbeing system in Sheffield and provide a joint strategy and structure for making decisions that benefit the health and wellbeing of Sheffield people. The Board is built on positive and fruitful relationships and partnership between the organisations that commission health and wellbeing services across the city. This paper presents the commissioning plans for the partners for consideration by the Health and Wellbeing Board.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

The Health and Wellbeing Board's Joint Health and Wellbeing Strategy recognises that good health and wellbeing is a matter for every service area, and that people are healthy and well not just because of the health and social care they receive, but also because of the nature of the housing, environment, communities, amenities, activities and economy surrounding them. The Board's Strategy focuses therefore not just on specific interventions to improve health and social care, but also on the 'wider determinants' of health. This means that the Health and Wellbeing Board aims for *all* Sheffield people to be *positively* affected by its plans to improve health and wellbeing in Sheffield.

Of course, the Health and Wellbeing Board cannot prevent all sickness and ill health, but this paper sets out plans to best support and maintain Sheffield peoples' health and wellbeing in 2015/16. The plans of the organisations which make up the Health and Wellbeing Board also have a preventative focus, working to delay people's need for long term help, care and support.

In creating its Joint Health and Wellbeing Strategy, the Health and Wellbeing Board was careful to engage closely with Sheffield people and service users, providers and members of the public. The Board can be confident that its Strategy, and therefore its plans, reflect the needs and concerns of Sheffield people. Services will work together with Sheffield people to design and deliver services which best meet the needs of an individual.

3.0 A REVIEW OF THE HEALTH AND WELLBEING BOARD IN 2014/15

2014/15 was an effective year for the Health and Wellbeing Board in which:

- The Board's work on the integration of health and social care continued with the submission of a £250m Better Care Fund and the establishment of a programme of integrated commissioning.
- The Board oversaw the performance of its Joint Health and Wellbeing Strategy through quarterly updates, and received updates from each of the Strategy's work programmes

with a particular focus on Health, Disability and Employment. The Board also made sure the city was prepared to meet the requirements of the Care Act and the Children and Families Act.

- The Board approved the Pharmaceutical Needs Assessment, a Mental Health Strategy, and the Health Inequalities Action Plan.
- Behind the scenes, the Board agreed a protocol for working with the city's safeguarding boards, discussed the tricky issue of progression from child to adult services, and considered key issues facing primary care.
- The Board held popular engagement events with Sheffield people and providers, covering health inequalities, mental health, children and young people's mental and emotional health and wellbeing, healthcare technology business, and health and wellbeing system challenges. The Board also continued to communicate about its work through regular enewsletters and publishing meeting papers and presentations.

4.0 THE HEALTH AND WELLBEING BOARD'S SPECIFIC PRIORITIES FOR 2015/16

The Health and Wellbeing Board's priorities are covered by five themes:

1. Integrating health and social care.
2. Tackling health inequalities.
3. Monitoring the Joint Health and Wellbeing Strategy.
4. Overseeing the plans of the organisations on the Board.
5. Influencing and involving others.

These priorities are all long term, ongoing commitments and it is proposed that the Health and Wellbeing Board confirms that these remain its priorities for 2015/16.

4.1 Integrating health and social care

The Health and Wellbeing Board receives regular updates on the establishment of integrated commissioning arrangements between Sheffield City Council and NHS Sheffield CCG. A pooled budget of around £250m will be established on 1 April 2015, to enable a single commissioning approach to developing integrated services in the following areas:

- Keeping People Well in their Communities.
- Active Support and Recovery.
- Independent Living Solutions.
- Long Term High Cost Support.

This budget will include most of the City Council's expenditure on adult social care and most of the CCG's expenditure on urgent care for adults. The areas of work listed above

are intended to integrate services, improve patient experience, and achieve the necessary cost reductions so that expenditure remains within the reducing budget for care.

4.2 Tackling health inequalities

The third outcome of the Health and Wellbeing Board's Joint Health and Wellbeing Strategy is focussed on tackling health inequalities. Health inequalities are a matter of life and death. Although there are many different ways in which health inequalities can be measured, the best overall indicator is the slope index of inequality of life expectancy which indicates a life expectancy gap of just over 9 years for men and just under 7 years for women (2011-13 data).

Tackling health inequalities continues to be an area of focus for the Board. An update will be presented to the Board at their public meeting in June 2015.

4.3 Monitoring the Joint Health and Wellbeing Strategy

Sheffield's Health and Wellbeing Board formally agreed in September 2013 a Joint Health and Wellbeing Strategy. This was based on the evidence of the Joint Strategic Needs Assessment. Both documents were agreed following extensive consultation with Sheffield people and professionals.

The Board takes seriously its role to monitor the Strategy's progress and ensure action is taking place in each of the areas outlined in the Strategy. Over 2015/16, the Health and Wellbeing Board will monitor:

- The Joint Health and Wellbeing Strategy's *five outcomes and indicators of progress*. Each outcome will be considered over the course of the year, along with updates focussing on the *evidence base* for the Joint Health and Wellbeing Strategy (the Joint Strategic Needs Assessment).
- The Joint Health and Wellbeing Strategy's *five work programmes*. These will be considered in March 2015 and March 2016.

4.4 Testing the plans of the organisations on the Board fit the Joint Health and Wellbeing Strategy

The Health and Wellbeing Board has a role to play in commenting on and influencing the different plans of the Board's key partners. Joint working is particularly imperative in times of financial constraints, as it enables efficiencies to be made and services to be more targeted at people who need them. It is undoubtedly the case that all partners on the Board are under severe financial constraints. While the cuts to local authorities are well known and sustained over a number of years, NHS Sheffield Clinical Commissioning Group is also getting less money than expected.

Health and Wellbeing Board partners have been involving one another in developing their plans for 2015/16. Over the coming year, Board members will assist one another in delivering the plans to ensure they meet the Joint Health and Wellbeing Strategy's aims and objectives. With that in mind, the plans of the main organisations on the Board are set out in brief below:

- **Sheffield City Council**'s plans are based on the outcomes set out in the Council's Corporate Plan and the principles of the Fairness Commission. The Council carried out a 'budget conversation' with Sheffield people and partners before approving its budget in early March.

- **NHS Sheffield Clinical Commissioning Group** is continuing with the two-year commissioning plans agreed in 2014. However, new work for 2015/16 includes agreeing a new Respiratory Strategy, work on the Mental Health Crisis Care Concordat, a review of Urgent Care leading to a new Urgent Care Strategy, and further work with partners on supporting children with Special Educational Needs and Disabilities.

4.5 Influencing and involving others

As the strategic lead for health and wellbeing in Sheffield, the Health and Wellbeing Board has a role to play in influencing partners and engaging with members of the public. It will do this through events and communications. The Board sends out a monthly e-newsletter which around 1,700 people receive and which publicises information about meetings, events and consultations, enabling individuals and organisations to get involved, be informed, and attend meetings and events. Other tools are used to ensure that the Board's work is communicated across the city.[1] A yearly update to the Board summarises this work.

5.0 QUESTIONS FOR THE BOARD

- Does the Health and Wellbeing Board support the priorities proposed by the commissioning organisations?

- Are there areas for greater joint working between the organisations on the Health and Wellbeing Board (and others) in 2015/16?

- What role is there for Healthwatch Sheffield over the coming year in assisting with the implementation of these plans?

6.0 RECOMMENDATIONS FOR THE BOARD

- That the Board supports and endorses the commissioning plans set out in this document.

- That Board members and the Board's organisations commit to working together in an integrated way over the coming year.

[1] More information: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board.html.

Appendix A: **NHS Sheffield Clinical Commissioning Group's priorities for 2015/16**

1. Strategic aims and objectives

- To improve patient experience and access to care.
- To improve the quality and equality of healthcare in Sheffield.
- To work with Sheffield City Council to continue to reduce health inequalities in Sheffield.
- To ensure there is a sustainable, affordable healthcare system in Sheffield.

2. Ambitions for the next five years

- All those who are identified to have emerging risk of admission through risk stratification are offered a care plan, agreed between them and their clinicians (possibly 15,000 people).
- By establishing integrated primary care and community based health and social care services, care planning, and holistic long term conditions management to support people living independently at home, reduce emergency admissions by up to 20% Emergency Department attendances by up to 40%.
- Minimise repeated trips to the GP and hospital for specialist diagnosis and monitoring of health problems, replacing them with community and home based services that make best use of technology, and keep people at the centre of their care.
- Reduce the gap in life expectancy for people with mental health problems and learning disabilities.
- Put in place support and services that will help all children have the best possible start in life.

3. Big projects

- With the City Council, through integrated commissioning :
    - Extend care planning.
    - Test the "Keeping People Well in Their Communities" model proposed in our integrated commissioning plans.
    - Specify and procure improved intermediate care services.
    - Establish an integrated approach to long term health and social care.
- Working with NHS England:
    - Jointly commission primary care services.

- Be actively involved in and supporting NHSE commissioning of specialised services.

- CCG specific priorities:
  - Improving community nursing services.
  - Mobilisation of the outcomes based contract for musculoskeletal services.
  - Contributing to delivery of Sheffield Health Inequalities plan.
  - Transforming outpatient services.
  - Redesigning urgent care services.
  - And supporting primary care providers to establish a collective approach to care provision, and to working with other providers.

4. Likely new major projects

- Respiratory Strategy.
- Mental Health Crisis Care Concordat.
- Review of Urgent Care – leading to Urgent Care Strategy.
- Improvements to Elective Care.
- Implementation of Special Educational Needs reforms.

Appendix B: **Sheffield City Council's priorities for 2015/16**

Strategic aims and objectives

- Adhering to the principles of the Fairness Commission.
- Being ambitious for Sheffield.
- Working with partners to achieve the best for Sheffield – changing not cutting services.

The Council's priorities for 2015/16 include:

1. Health and social care

- Ongoing work with the Clinical Commissioning Group to commission services together.
- Continuing to review and reassess people's care packages.
- Changing and reclassifying registered care homes.
- Retendering services to providers to increase efficiency and effectiveness.
- Develop the Adult Placements approach as an alternative to long-term care placements.
- Review short breaks and respite services for children with a disability.

2. Public health

- The ring fenced public health grant remains unchanged in 2015/16 at £30.7M. The majority of public health programmes and public health grant expenditure (>£28M worth) will continue unchanged in 2015/16, though some are due for re-tender.
- However, some cuts have been made to public health budgets in order to make money available for vulnerable programmes previously funded by mainstream Council General Fund, as a result of the overall reduction in Council revenue. This includes a reduction in the tobacco control budget of £550K, and the sexual health budget of £266K, as well as reduction in specialist public health staffing (-£247K), disinvestment in the tier 3 weight management contract (-£137K), dedicated food and cooking skills projects (-£170K), mental health promotion (-£64K) and promotion of physical activity (-£36K). This has allowed for additional public health grant investment in early years work (£500K). Other possible uses of the resource released are still under discussion.

3. Wider determinants of health (the things the Council spends money on which impact people's health and wellbeing)

- Smarter working between housing and parks and open spaces.
- Working with partners to improve income and savings from sports and arts.

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Dr Jeremy Wight, Director of Public Health
Date:	26th March 2015
Subject:	Director of Public Health Annual Report 2014: Air Quality and Health in Sheffield
Author of Report:	Various as stated in papers

Summary:

Directors of Public Health have a statutory duty to produce an annual report on the health of the local population. The 2014 report focuses on what the World Health Organisation has described as the greatest threat to public health and the defining issue of the 21st century – the impact of climate change on health, principally through increased greenhouse gas emissions. The report firstly describes the scale of the challenge and then draws attention to actions that can be taken to mitigate, or adapt to, the impact of climate change, which as well as reducing greenhouse gas emissions, also benefit health.

The report makes a number of recommendations about improving the health of the Sheffield population by addressing issues that affect climate change. These recommendations are directed towards particular organisations or groups. There are three in particular that are addressed to the Health and Wellbeing Board (see below).

The Health and Wellbeing Board has previously requested information about the impact of poor air quality on health in Sheffield, and steps being taken to address that. Promoting 'active travel' is recommended in the DPH Annual Report as this will improve health (through increased levels of physical activity), reduce carbon emissions and improve air quality. The accompanying paper summarises what is known about air quality in Sheffield, the Council's Air Quality Action Plan (AQAP), and makes recommendations.

Recommendations for the Health and Wellbeing Board:

- That the Board receives the Director of Public Health's annual report for 2014.

- The Health and Wellbeing Board, and Sheffield's NHS Foundation Trusts, should adopt an explicit sustainability policy aimed at ensuring that Sheffield meets its carbon reduction obligations by 2020. This should be underpinned by the adoption of a sustainability manifesto for the health and social care system in the City.
- The Health and Wellbeing Board should give urgent consideration to the ways in which the implications for carbon emissions of different approaches to the delivery of health and social care in the City can be evaluated. A system of carbon accounting needs to be developed.
- The Health and Wellbeing Board should consider how to enforce and report on actions set out in the Heatwave Plan for health and social care facilities such as care homes, before next summer.
- The Health and Wellbeing Board endorses the other recommendations contained within the report, which are addressed at other organisations.

DIRECTOR OF PUBLIC HEALTH REPORT FOR SHEFFIELD 2014

Climate Change and Health

Sheffield City Council

DIRECTOR OF PUBLIC HEALTH REPORT FOR SHEFFIELD 2014

Contents

1. Introduction 4
2. How will a changing climate affect health in Sheffield? 8
   - 2.1 Direct health effects of climate change and global warming 8
   - 2.2 Indirect effects of climate change 10
   - 2.3 Social and demographic impacts of climate change 12
3. What should we be doing about it? 14
   - 3.1 Adaptation or mitigation? 14
   - 3.2 Active travel 16
   - 3.3 Reducing meat consumption 17
   - 3.4 Warmer homes 20
   - 3.5 Strengthening the local economy and increasing social capital 23
   - 3.6 Developing a low carbon health and social care economy 24
   - 3.7 Preparing for extreme weather events 26
   - 3.8 Designing healthy urban spaces and places 28
4. Recommendations 30
   - 4.1 Progress on 2013 recommendations 30
   - 4.2 Recommendations for 2014 32
5. Glossary 34

More information 36

THE BIGGEST PUBLIC HEALTH CHALLENGE.

1 Introduction

Why climate change is the biggest public health challenge of the 21st century.

Climate change is the defining public health issue of this century. In this report I hope to show you why, how it may affect Sheffield, and what we can do, and already are doing about it.

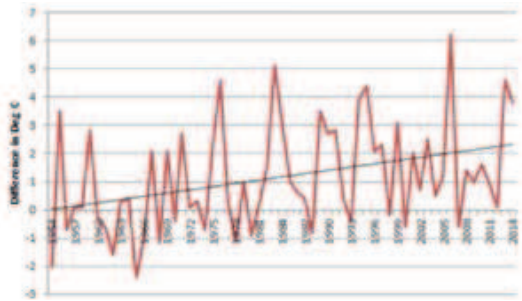
In the medium to long term, climate change is significantly more threatening to public health than any of the other problems we spend our time dealing with. Although smoking, physical inactivity, alcohol and so on are all major public health issues that we have to address, they are not universal in their impact, and they do not threaten the fundamentals of human society. We quite rightly spend a lot of time and energy seeking to ensure the Best Start for our children, and ensuring they are safe, but if we do not tackle climate change effectively, their future will be very bleak. There are however links between present public health problems and the kind of steps we have to take to tackle climate change. Many of the things we need to do to reduce greenhouse gas emissions will benefit our health in the short term, too. We describe some of those things.

Page 88

Climate change is caused by global warming, which in turn is caused by the accumulation of greenhouse gases in the atmosphere. Chief amongst these is carbon dioxide (CO_2) released by the burning of fossil fuels, but other gases also contribute. Average global temperatures have risen by about 0.5 degrees centigrade (^oC) in the last 50 years, and by 0.8^oC from pre-industrial times. Each of the last three decades has been hotter than the previous one, by about 0.2^oC. The Intergovernmental Panel on Climate Change (IPCC) says it is virtually certain that human influence has warmed the global climate system, and extremely likely that more than half of the observed increase in global temperature is related to human activity.

Global warming changes the climate in a number of different ways. As well as increasing average temperatures, it increases the frequency and severity of heatwaves. Warmer air carries more water vapour, so global warming increases rainfall, particularly in storms. Storms contain more energy and so are more intense, as well as being more frequent. In addition global warming is causing melting of the permafrost, glaciers and arctic sea ice, all of which have the effect of further increasing the warming of the planet. The sea level is rising, and the sea itself becoming more acidic. This is a real problem when fish feed so much of the world.

Figure 1: Difference in average July daily maximum temperatures from 1953, Sheffield



http://www.metoffice.gov.uk/climatechange/science/monitoring

All of these changes are happening already. What happens in future depends primarily on the trajectory of global greenhouse gas emissions, but also changes in agriculture, diet, land use, rates of economic development and population growth. The development and use of carbon capture and storage may also play a part. But first we need to recognise that because carbon dioxide is a very long lived atmospheric pollutant, we are already committed to significant further global warming based simply on the amount already in the atmosphere.

UNFORTUNATELY AT THE MOMENT GLOBAL CARBON DIOXIDE EMISSIONS ARE INCREASING.

The Intergovernmental Panel on Climate Change has described four different scenarios for different trajectories of greenhouse gas emissions up to the year 2100. The best case scenario assumes a radical reduction of emissions starting almost immediately, which leads to a slow rate of temperature increase that levels off at about 1 degree increase over current levels by the middle of this century. By contrast, in the worst case scenario, with unabated greenhouse gas emissions, average temperatures will rise by 2 degrees by the middle of the century and nearly 4 degrees by the end. A summer like that of 2003 would be a cool one.

What does all of this mean for health? This report outlines briefly how climate change can threaten the health of our population. All of the key social determinants of health – food, water, shelter, even the normal function of human society - are threatened by climate change. How bad the effects will be will depend on how much global warming happens, which in turn depends primarily on how effectively we can collectively control greenhouse gas emissions. How we do this is the most important challenge facing human civilisation.

Figure 2: The Long Range Weather Forecast for Sheffield

- Hotter, drier summers
- Milder, wetter winters
- More frequent extreme high temperatures
- Decrease in annual rainfall
- More frequent heavy downpours
- Lower summer soil moisture content
- Greater number of days when temperatures above 5°C leading to longer growing / breeding season
- Higher wind speeds during storms
- Reduced cloud cover leading to increased bright sunshine
- Cooler and wetter in the west of Sheffield.
- Higher temperatures and lower rainfall in the east of Sheffield

Sheffield Local Climate Impacts Profile (Weston Park data) and the South Yorkshire Weather Trends report (UKCP09 data)

If, globally, we achieve the rapid reduction in greenhouse gas emissions necessary for the IPCC's best case scenario, the public health consequences of climate change will still be significant, but manageable.On the other hand if we continue with business as usual, leading to a four degree centigrade increase in global temperatures, the public health consequences could well be catastrophic. The Lancet has recently warned that it would lead to a "discontinuity in the long term progression of humanity". In other words, a breakdown of society, and the loss of what humankind has built up over centuries to make life worth living.

Unfortunately at the moment global carbon dioxide emissions are increasing. Burning more than a quarter of known fossil fuel reserves would release enough CO2 to put the world on a trajectory to over 4 degrees of warming. It is therefore perhaps not surprising that the World Health Organisation (WHO) Director General Margaret Chan has stated that climate change is the greatest threat to public health and the defining issue of the 21st century. She is supported in this conclusion by both the Lancet and the British Medical Journal, which now states that the WHO should declare a public health emergency.

THERE ARE MANY THINGS WE CAN DO THAT WOULD BE BENEFICIAL TO HEALTH AND TO THE CLIMATE.

However there are signs that increasing numbers of people are recognising the dangerous position we are in, and exploring ways in which a global economy has to change. This includes the establishment of the 'Green Commission' here in Sheffield. In addition there are many things that we can do, and are already doing, that would be beneficial both to health and to the climate.

On the 16 September 1948, Aneurin Bevan, the founder of the NHS, said in a speech to the Society of Medical Officers of Health (the forerunners of Directors of Public Health) that they should be "like some watcher of the skies – for portents, not merely of epidemic disease, but of anything likely to have an adverse effect on health". Climate change is certainly one such portent.

Jeremy Wight
Director of Public Health

Acknowledgements

Reports such as this are always the result of many people's work. I am particularly grateful this year to the contributors from outside the City who have written sections. In addition to the named authors I would also like to thank Bernd Hoermann, Mark Daly, John Clephan, David Caulfield, Ed Highfield and Mark Whitworth for their help with different sections, and to Cathy Read for comments on the overall report. Particular thanks are due to John Skinner and Louise Brewins for their work in editing the text, and to the Sheffield City Council Communications Team. Final responsibility for the content rests with me.

Jeremy Wight
Director of Public Health
October 2014

BIGGEST RISKS ARE OVERHEATING AND FLOODING.

2 The impact of climate change: how will a changing climate affect health in Sheffield?

Section 2 of this report looks at how the changing climate affects peoples' health. Heatwaves, storms & floods, and extreme cold weather each have a direct impact on a population's morbidity and mortality. At the same time, climate change affects food production and water supply and thereby has an indirect impact on health, through the availability of food and water and the spread of disease. This section goes on to discuss the global impacts of climate change, showing how breakdown in local infrastructure in one part of the world has social and demographic consequences elsewhere.

2.1 Direct health effects of climate change and global warming

Stephen Morton and Angie Bone, Public Health England

The potential impacts of climate change have been well summarised by the Intergovernmental Panel on Climate Change. In the House of Commons, the Energy and Climate Change Committee concluded 'there is no reason to doubt the credibility of the science or the integrity of the scientists involved'. The UK Climate Change Risk Assessment (2012) concluded that the most significant risks to health in the UK are likely to be from increased summer temperatures and overheating in buildings, and flooding.

Heatwaves

The prolonged high temperatures in August 2003 caused 2000 excess deaths in England, with elderly people with chronic heart and lung disease being most at risk. Projections indicate that heat-related deaths may increase to 7000 per year by 2050.

Overheating in buildings is thought to be an important factor in heat-related illness and death. Purpose-built or top floor flats and terraced houses are most at risk, particularly un-insulated loft conversions in pre-1919 properties, and flats built after the 1960s. In the relatively cool summer of 2007, 21% of bedrooms were found to be overheated. Overheating in hospitals is also a significant concern, with one study suggesting that 90% of wards are prone to overheating.

During heatwaves there can be considerable temperature variation, especially within urban areas. Urban heat islands are caused when natural surfaces (vegetation and soil) are replaced by built surfaces consisting of non-reflective and water resistant construction materials. This leads to higher daytime temperatures, and night time temperatures not falling. Sheffield has some protection from this because of the large amount of green space within the City boundaries.

Floods and storms

Direct deaths and injuries occur in Britain from floods and storms; mainly from drowning, or being crushed by falling trees and masonry, but the biggest health impacts are due to the disruption and distress caused by these events. During the summer storms of 2007, two people in South Yorkshire were drowned, many hundreds were rescued by boat or helicopter, and 700 people, who lived near the Ulley reservoir, were evacuated. A report on the psychological impact of the 2007 floods found that 'the prevalence of all mental health symptoms was significantly higher among individuals who reported flood water in the home'. Symptoms of psychological distress, anxiety, depression, and post-traumatic stress disorder were greater among the unemployed and elderly.

Sheffield's topography means that severe rain in the Peak District is channelled downstream into water courses constrained by over a century of building and development. Some of this burden can be mitigated by sustainable urban drainage systems.

Severe cold weather

Whilst severely cold weather is likely to become less frequent we may still experience very cold winters. Winter morbidity and mortality are predicted to remain a problem. Excess winter deaths can be expressed as the number of extra deaths that occur in the winter compared to the non-winter months, expressed as a percentage. The majority of these deaths are from cardiovascular, respiratory diseases, and dementia. The number may be exacerbated by poor air quality.

Around 30% of excess winter deaths may be attributed to living in a cold home. Fuel poverty is certainly an important

SHEFFIELD HAS A HIGHER LEVEL OF FUEL POVERTY THAN THE ENGLAND AVERAGE.

contributor to this, but other factors such as occupant attitudes, behaviour and ability to operate heating also play an important role. Sheffield has higher levels of fuel poverty (measured as the 'low income – high cost' (LIHC) indicator – the percentage of households that have high fuel costs and low incomes) than the England average, but lower levels than many other core cities (Figure 3). We have lower levels of excess winter deaths than the England average, and the lowest of all the Core Cities.

Win-win opportunities in adaptation for climate change

There are a number of strategies to reduce the direct effects of climate change that would have potentially wider public health benefits.

- The planting of more trees and shrubs in the City could be part of sustainable urban drainage systems and reduce heat island effects. They can also attract wildlife and contribute to recreational green space, thus benefitting physical and mental health.
- Schemes to improve energy efficiency can reduce fuel poverty in low income households, reduce the harmful health effects of cold homes, and also reduce the emission of greenhouse gases. Insulation is also important in protecting against heat, as long as ventilation is also considered.
- Good neighbour schemes can reduce the risks of isolated and elderly or disabled people from cold related illnesses and also improve social capital in an area. Indeed asset based community development is potentially a very useful tool for improving sustainability and tackling the risks of climate change.

Figure 3:
Three year all age excess winter death index and fuel poverty indicators

City	3 year EWDI 2009-2012 (all age)	Fuel poverty LIHC indicator (2012)
Sheffield	12.7 (9.0 -16.6)	11.3 (11.2 - 11.4)
Nottingham	15.1 (9.6 - 20.9)	18.4 (18.1 - 18.6)
Birmingham	15.6 (12.7 - 18.7)	20.1 (20.0 - 20.3)
Newcastle	15.7 (10.3 - 21.3)	13.4 (13.2 - 13.6)
Bristol	16.0 (11.3 - 20.8)	11.1 (10.9 -11.2)
Manchester	16.2 (11.7 - 20.9)	15.9 (15.7 - 16.0)
Leeds	16.5 (13.1 - 19.9)	11.6 (11.5-11.7)
Liverpool	16.8 (12.7 - 21.0)	14.4 (14.3 - 14.6)
England	16.5 (16 - 16.9)	10.4 (10.4 - 10.4)

Source: Public Health Outcomes Framework online tool http://www.phoutcomes.info/

2.2 Indirect health effects of climate change

Ruth Speare, Public Health England

Changes in temperature and an increased frequency of extreme weather events not only have immediate effects on health and infrastructure but also have indirect impact on the availability of food and water, and on the distribution of disease. The threats they pose to our health and wellbeing are potentially serious, and need to be addressed.

THERE ARE A NUMBER OF STRATEGIES TO REDUCE THE DIRECT EFFECTS OF CLIMATE CHANGE.

Food and water supply

Food security involves producing enough food globally and getting the produce to those who need it at an affordable price. Because only about half of our food is produced in this country, we are reliant on global food markets. Crop production is vulnerable to the extreme weather associated with climate change. Drier spells increase demand for irrigation, which places a strain on water supplies, so a significant shortfall in water supply for farming in the UK is predicted by the 2020s. Conversely heavy rain or floods may damage crops and cause soil erosion, leading to poorer soil quality and reduced yields. Climate change is likely to increase the spread of existing and emerging crop pests. Livestock will probably benefit from milder winters but could be harmed by hotter summers. Fish stocks will fall as a result of ocean acidification.

The UK relies heavily on overseas markets both for food for human consumption as well as animal foodstuffs, in particular soybean protein. Extreme weather events, such as drought, storms and floods elsewhere are likely to impact on food security in the UK by reducing yields and by disrupting the infrastructure needed to harvest, process and transport food.

Scarcity of food globally will drive up food prices in the UK. This is likely to particularly affect low income families, the elderly and those whose health is already poor. Costs of other commodities that are largely imported, including energy, are also likely to rise and again will place a disproportionate burden on vulnerable people.

The IPCC Working Group 2 stated that temperature increases of more than 2^{o}C are projected to lead to a decline in production of major crops, at a time of increasing global demand. There is also increased likelihood of year on year variability. Global temperature increases of more than 4^{o}C would pose large risks to food security globally and regionally.

Freshwater supplies will also be threatened, through drought, contamination of water supplies by flooding, or the drying up of melt waters when the glaciers disappear.

Water-borne disease

The risks of water-borne diseases are strongly affected by flooding and warmer temperatures. Heavy rain and water run-off can wash pathogens into water courses, or overwhelm sewerage systems, leading to contamination of water supplies. Studies of outbreaks in the UK due to water-borne diseases, for example Cryptosporidiosis and Vero cytotoxin-producing Escherichia Coli (VTEC), have shown them to be linked to heavy rainfall. Flooding may also cause rodents to be displaced from their normal habitats, and lead to a greater likelihood of disease transmission to humans. Increased incidence of Leptospirosis has been associated with episodes of flooding.

Disease causing organisms can also contaminate recreational water and people can become infected whilst swimming or taking part in water sports. Conversely periods of drought reduce the amount of water in river and lake systems available to dilute the concentration of pathogens, and this has also been shown to be associated with disease outbreaks. Warmer houses and warmer water, combined with increased use of air conditioning or other cooling equipment, is likely to cause an increase in cases of Legionnaire's disease.

Food-borne infections

Many of the infectious organisms that cause illness in humans, for example Salmonella, thrive in warm water and weather. Warmer temperatures lead to faster replication so that the threshold of numbers required to cause infection is reached more quickly.

THE WORST EFFECTS OF CLIMATE CHANGE WILL BE EXPERIENCED BY COMMUNITIES THAT ARE THE POOREST.

Warmer weather and milder winters will encourage flies and other pests to multiply, which can also affect food safety by spreading disease. Warmer, wetter weather increases the reproductive potential of rats and other rodents, leading to increased risk of disease transmission to humans.

Insect-borne disease

Other infectious diseases are caused by arthropods, such as mosquitos and ticks, carrying and transmitting disease through their bites. One such disease is Lyme disease, which is normally associated with mild flu-like symptoms but can also affect the nervous system. Around 2,000 to 3,000 cases of Lyme disease occur in the UK per year, and the number of cases is rising both here and in Europe.

There is evidence that climate change is changing the distribution of diseases, and may make the UK more suitable for the establishment of tick populations, or new arthropods, as they are carried by animals and birds from other countries. It may also allow the re-introduction of mosquito borne illness.

Ticks are found in woodlands, grassland, moorland, heathland but also some urban parks and gardens. This may be an increasing concern in Sheffield because of its proximity to the Peak District and its many green spaces. Flood alleviation schemes and adaptation measures such as the establishment of wetlands, will also alter the distribution and abundance of mosquitoes and ticks, and this may increase the incidence of associated diseases already present in the UK.

2.3 Social and demographic impacts of climate change

David McCoy, Queen Mary University London

Climate change and the related effects of greenhouse gas emissions (GHG) are truly global phenomena. It is an issue that connects and binds all peoples and all nations.

People in the UK are connected to all who suffer the effects of climate change because of our contribution to global warming, both in the past and now. The way we eat, travel, commute, relax, shop, cook, bathe and warm ourselves is generally done in a way that far exceeds our 'fair share' of the earth's capacity to absorb GHG emissions without causing catastrophic global warming.

The IPCC's second Working Group (IPPC-WG2) recent report on the current and projected impacts of climate change describes how most of the worst effects of climate change will be experienced by countries and communities that are poorest, and which have made the least contribution to global warming.

The impacts of climate change will vary across regions and will depend on many factors, including what are called 'non-climate stressors' (things that will aggravate the effects of climate change including continued deforestation, rapid population growth and war), as well as the extent to which societies are able to mitigate or adapt. Of particular note in the latest IPCC-WG2 report was its emphasis on the potential for climate change to precipitate systemic crises and wholesale social disruption, including large-scale migration as well as conflict (between countries or within countries).

Among the 'key risks' (defined as risks with potentially severe or irreversible adverse consequences, or risks for which there is limited potential to avert through adaptation or mitigation) identified by IPCC-WG2 were extreme weather events leading to breakdown of infrastructure networks and critical services such as electricity, water supply, and health and emergency services; and the breakdown of food and water systems. Some places will become uninhabitable or prone to emergencies and disasters, undermining livelihoods and

SHEFFIELD IS PROUD TO BE A CITY OF SANCTUARY THAT WELCOMES REFUGEES AND ASYLUM SEEKERS.

breaking down social solidarity. Although the future cannot be predicted with certainty, there is a sound, scientific basis for highlighting the potential of climate change to lead to significant chaos, violence and suffering. One example of the potential for climate change to do this is the link that has already been made between drought in Eastern Europe and the subsequent reduction in the Russian grain harvest in 2010. The rise in wheat and hence bread prices that followed are thought to have helped precipitate the 'Arab spring', and the subsequent political instability in the region. This in turn aggravated existing tensions and conflicts, including the armed conflict that now engulfs Syria and Iraq – a situation which will ultimately affect the security and wellbeing of people in Britain, and Sheffield.

Europe will itself experience the direct effects of climate change and global warming but it will also be affected by the effects of climate change elsewhere. Drought, extreme heat and social disruption will affect the production of basic commodities on which we all depend. New wars over scarce resources will contribute to further global warming and ecological degradation, which will affect our single and shared global weather system. War is not only harmful locally where it is occurring, but also further afield. Mass migration, including of refugees, will inevitably place greater social pressures on countries in Western Europe.

Sheffield is proud to be a City of Sanctuary that welcomes refugees and asylum seekers. It cares for the health of new arrivals to the City, which is sometimes made worse by the journeys they have endured, though it is aware that this can place a strain on our services. Climate change will cause more civil conflict and war, and more displacement of peoples and mass migration. Whether we're living in Sheffield or Shanghai, Doncaster or Dacca, we share one world.

3 What should we be doing about it?

Section 3 of this report draws attention to the actions we can take to mitigate, or adapt to, the impact of climate change. In addition to reducing greenhouse gas emissions, these actions also benefit our health. They include: promoting more active forms of travel; reducing our consumption of meat; making sure our homes are heated appropriately; and developing social capital in communities. The importance of underpinning plans to implement a sustainable carbon reduction policy and to prepare for extreme weather events is discussed. Finally, the section notes the contribution which urban design can make to improving the climate and our health.

3.1 Adaptation or mitigation?

David Pencheon, NHS Sustainable Development Unit

The first part of this report has described the damage that climate change could do to health and wellbeing if we continue business as usual. We now turn to the solutions. Five principles underpin the necessary actions.

1. The scale of the challenge is immense. Instead of wasting time deciding if we should take one action or another, we should understand how to do all of those actions we know to be effective.
2. The actions are only likely to be effective if they are based on well-coordinated collaboration between health and care sectors, Health and Wellbeing Boards, and local communities.
3. The public sector needs to set an example in how to improve the quality of services in sustainable ways by taking very visible and practical actions.
4. Many of the actions that help both adapt to and mitigate climate change also offer immediate health benefits.
5. We do not have much time left, so we should not wait for yet more evidence before we start actions now.

Adaptation must not compromise mitigation. For instance, universal air conditioning to deal with overheated homes would increase carbon emissions, and we do not need it, but we do need almost universal passive warming and cooling of our buildings. We must manage natural water supplies in a way that provides water every day, but avoids flooding and droughts. We must develop strong local communities which are good places to live and work, but are also resilient in times of stress and crisis.

The following sections of this report give examples of the actions that we must take now - where actions have additional and almost immediate benefits: “co-benefits”. Making the right choices about how we feed ourselves, and how we move about, can improve health now, and also mitigate climate change in the longer term. For instance, local government and the NHS together can actively stimulate a local food economy which creates more fulfilling jobs, produces fresh, healthy and tasty food, and strengthens local social links on which our future community resilience depends. This would make our diets more healthy and enjoyable, make tasty food more accessible and affordable, and help to prevent harmful climate change.

BUSINESS AS USUAL IS NOT AN OPTION: WE NEED TO FOCUS ON THE SOLUTIONS.

PHYSICAL INACTIVITY AND OBESITY ARE ASSOCIATED WITH A RANGE OF MEDICAL CONDITIONS.

Local government and the NHS together account for the movement of many people, goods and services. Many more services can be delivered closer to home using technology better. Active travel (walking and cycling) and public transport increases physical activity and social connections, improves physical and mental health, helps people stick to a healthy weight, and reduces harmful air pollution and greenhouse gas emissions.

The remainder of this report shows how preventing the preventable, adapting to inevitable changes that have already been set in motion, and ensuring we do not continue to make the problem worse, can all create both immediate and longer term benefits.

Every city and community, in every generation, is faced with challenges that are both life threatening and life affirming. If we want to leave a fair and healthy legacy we can be proud of, then tackling climate change and embedding sustainable development at every level and in every area of our lives is that challenge now.

Adaptation consists of managing the unavoidable. Mitigation involves avoiding the unmanageable. We must do both, we must do them together, and we must do them now.

3.2 Active travel

Dawn Lockley, Duncan McIntyre and Mark Daly, Sheffield City Council

Why is this important?

Changes to the way in which we travel can reduce greenhouse gas emissions and increase physical activity, thereby reducing the burden of ill health and early death associated with these. Consequently, both health and the climate benefit.

Our over-reliance on fossil fuelled cars and buses increases both carbon emissions and non CO_2 air pollution. Exposure to air pollution, particularly of vulnerable people, increases the risk of acute and chronic diseases such as heart attacks and strokes, lung cancer and asthma. Equally, lack of physical activity, including for many people making even the shortest of journeys by car rather than walking or cycling, contributes to the rise in obesity in the City. Physical inactivity and obesity are associated with a range of medical conditions including type 2 diabetes, heart disease, strokes, certain cancers, arthritis, and poor mental health.

Promoting active travel – walking and cycling - therefore plays an important role in responding positively to climate change and improving health.

Current position

Domestic transport currently accounts for 21% of the UK's CO_2 emissions, with more than half of this coming from the use of private cars. The total emissions from transport (measured in kilo tonnes of CO_2 ($KtCO_2$) declined in Sheffield between 2005 and 2012 (from 585.0 to 530.0 $KtCO_2$). Emissions per person due to transport use are estimated to have reduced from 1.1 to 1.0 tonnes of CO_2 during the same period. We have also seen modest reductions in mortality attributed to air pollution caused by fossil fuelled transport, but the current figure of approximately 500 deaths per year, is still unacceptably high.

In Sheffield only 55% of adults self-report achieving 150 minutes of moderate physical activity a week (the recommended level). 30% report not even achieving 30 minutes a week. If car journeys of under 2 miles were to be made on foot or by bicycle, the potential for reducing the level of disease associated with physical inactivity would be significant. Currently only 3% of the Sheffield population report using a bicycle as a means of travel.

What can we do?

People have many perceived barriers to substituting active travel for motorised transport.

WE WANT TO MAKE IT EASIER TO BE PHYSICALLY ACTIVE.

These include hilly terrain, fears about road safety, over estimation of distances, physical effort, and the requirements for showers in workplaces. There are a number of ways in which we can encourage and support people to overcome these barriers.

Sheffield's commitment to active travel was outlined in our 2010 strategy 'A vision for excellent transport in Sheffield'. This outlined how transport would contribute to a competitive low carbon economy and a better environment, create a culture where the car would not always be the first choice, and most importantly lead to a healthier population.

In addition, the recently published 'Move More' plan sets out a 5 year framework for increasing physical activity and reducing sedentary lifestyles in Sheffield. A key aim of the Plan is to support the creation of active environments which make it easier for people to build physical activity into their daily lives. For example, the Streets Ahead project provides the City with the opportunity to build new road layouts within the existing road network, creating more cycle paths on roads and, where possible, shared walking and cycling paths. Signposting walking routes, with times taken to walk to the destination, which is often overestimated, rather than distances, would encourage more people to walk.

In response to the Department of Health's 'Get Britain Cycling' report, the Economic and Environmental Wellbeing Scrutiny and Policy Development Committee conducted a cycling inquiry earlier in the year to review the impact of cycling on the local economy, environment and health. The inquiry endorsed the aim of the Get Britain Cycling report, to increase the proportion of all local journeys undertaken by bicycle to 10% by 2025 and 25% by 2050, along with implementing a range of other measures to support an increase in cycling. This was then endorsed by Cabinet in July 2014.

Reducing speed limits on roads will also contribute to a modal shift away from car usage to more walking and cycling. Sheffield currently has seven 20 mph zones, and there is a commitment to increase this number to 108 over time. Whilst improved road safety alone justifies 20 mph limits, air pollution and traffic noise drop when speed is reduced and streets become more pleasant and attractive places. Increased use of shared public space contributes to an increase in social capital.

Recommendations

- The Council should develop and implement a programme of signposting walking routes with the time it takes to reach the destination.
- Sheffield people should consider traveling short distances on foot or by bicycle rather than by car, and sign up to 'Move More' at www.movemoresheffield.com.
- The Council should commit to increasing the number of 20 mph zones within the City as quickly as possible.

3.3 Reducing meat consumption

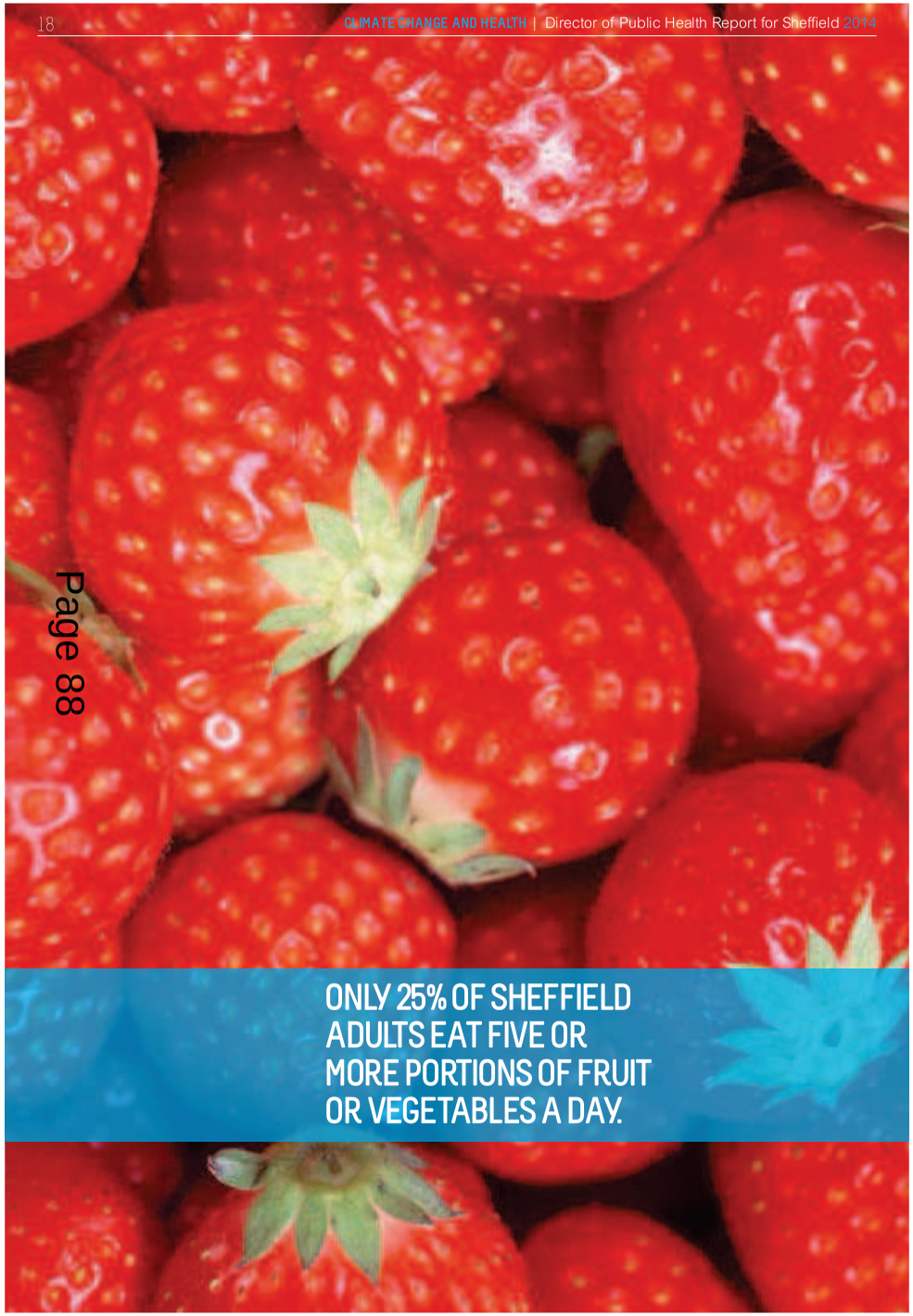
Jess Wilson, Sheffield City Council

Why is this important?

Meat production and associated transport is a major cause of greenhouse gas emissions, and excess meat consumption, particularly processed meat consumption, is bad for health. Changing our diet can therefore benefit both climate and health.

Current position

Global meat production is predicted to more than double between 2000 and 2050. For many people meat is now artificially cheap and plentiful due to agricultural subsidies. Once regarded as a treat, it is now a staple part of many



ONLY 25% OF SHEFFIELD ADULTS EAT FIVE OR MORE PORTIONS OF FRUIT OR VEGETABLES A DAY.

A DIET OF LESS MEAT AND LESS HIGHLY PROCESSED FOOD WOULD BE HEALTHY AND SUSTAINABLE.

people's diet. In 2009 meat consumption in the UK (84 kg/person) was double that of the worldwide average (42 kg/person).

Meat production is a driver of deforestation and land use change which generates greenhouse gas emissions and destroys valuable carbon sinks and wildlife habitat. It produces significantly more greenhouse gases than vegetable production. For example, producing beef releases 30 kg of CO_2 per kg, while carrots, potatoes and rice produce 0.42, 0.45 and 1.3 kg respectively. 14.5% of greenhouse gas emissions can be attributed to livestock. Beef production account for 41% of the sector's emissions.

Compared to growing crops for direct consumption, rearing animals for food uses large areas of agricultural land (30% of the world's land surface is used to feed livestock) and vast quantities of water (almost 50 times more water is needed to produce 1 kg of beef than is needed to produce 1 kg of vegetables). This creates both environmental and social justice arguments for eating less meat.

Overconsumption of meat in the west is contributing to the obesity epidemic, whilst many people in the developing world experience drought and famine that could be alleviated if more food were grown for human direct consumption. For example the grain that is currently grown to feed livestock would be enough to feed about 840 million people following a vegetarian diet.

More than 10 times the amount of fossil fuel energy is used to produce 1 Kcal of meat based protein than is used to produce 1 Kcal of grain based protein. It is estimated that if everyone in the UK abstained from eating meat for just one day a week it would save 13 million tonnes of carbon per year – a greater saving than taking 5 million cars off the road.

A diet consisting of less meat and less highly processed food would be more healthy and sustainable. This change should incorporate eating more fruit and vegetables, less fat, salt and sugar, and eating seasonal and locally produced food. Switching to a healthier diet would lead to a reduction in cardiovascular disease, fewer cancers (especially bowel cancer) and in conjunction with being more physically active, contribute towards an overall reduction in obesity and premature mortality in the City. Overall, diet in Sheffield is poor. Only 25% of Sheffield adults eat five or more portions of fruit or vegetables a day, lower than the national average of 28%. An estimated 580 deaths in Sheffield a year could be prevented if diets complied with national nutritional guidelines.

What can we do?

Whilst there is little evidence about how to effectively reduce meat consumption per se, the effectiveness of strategies to change eating habits is well reported. To reduce meat consumption we need to encourage individuals to choose to eat less meat by raising awareness of the health benefits, including lower risk of cancer, and environmental impact, and also influence the cultural norms that serve as barriers to behaviour change. Changing socially constructed ideas of what constitutes a 'normal' meal, for example the belief that it must contain meat in addition to vegetables and carbohydrates, will also be necessary.

Social marketing and pricing mechanisms could bring about change in meal choices by challenging conventions of sociable dining, or intervening in the form and content of meal routines. Local level interventions might include hospitals, schools and workplace canteens promoting meat free options, or excluding meat on some days each week. Any diet related work, such as teaching cooking skills, or weight management interventions, is an opportunity to promote meat free options.

Sheff Steak-Out is a city-wide campaign to encourage the citizens of Sheffield to adopt a meat free day to help minimise the human impact on the environment. The campaign has a 5-point plan to help raise awareness of eating and living more sustainably through:

- **Eating less meat**
- **Shopping locally and buying locally grown and sourced produce**
- **Growing your own, from herbs to veg to fruit**
- **Reducing reliance on ready meals**
- **Reducing waste by buying only what you need and saying no to excessive packaging**

Ultimately, our aim is for people to have a better knowledge and understanding of the true value of food and the benefits for everyone when more sustainable choices are made.
Helen Davies, Sheff Steak-Out
Twitter @SheffSteakOut

Recommendations

- Sheffield City Council and local hospital Trusts should develop their food purchasing arrangements to reflect environmental and health factors, including reduced reliance on meat and dairy in menus.
- Sheffield people should consider reducing the amount of meat they eat by adopting at least one meat free day per week.

3.4 Warmer homes

Chris Shaw, Robert Almond,
Sheffield City Council

Why is this important?

In 2012 31% of total carbon emissions in England came from the domestic sector, mainly from heating homes. Fuel poverty, and cold damp housing, are significant causes of poor health. Homes that are better insulated are healthier, cheaper to heat (so reducing fuel poverty), and their heating involves lower carbon emissions. At the same time rising indoor temperatures in summer months increase mortality and morbidity from respiratory and cardiovascular diseases, an effect made worse by heat exhaustion and air pollution. High temperatures and strong sunlight lead to high levels of ozone and increased levels of aeroallergens, both of which are damaging to health.

Current position

The Government's 2011 Carbon Plan was clear that, if we are to reach our target of cutting our greenhouse gas emissions by 80% by 2050, 'energy efficiency will have to increase dramatically across all sectors'. As 80% of the buildings which will be occupied in 2050 have already been built, the rate of refurbishment and adaptation

DOMESTIC CO_2 EMISSIONS ARE FALLING.

for the current stock has to accelerate.

Investment in house insulation and more efficient heating should lead to warmer homes and reduce excess seasonal mortality and morbidity. Currently the greatest weather related health risk is that of illness due to cold weather, caused by a significant proportion of our housing stock being old and poorly insulated, and by high energy prices and low incomes.

Sheffield was already reducing emissions from domestic property between 1995 and 2005 through property adaptation and improvement. Since then, annual domestic CO_2 emissions per capita have fallen faster, with a 20% drop, from 2.5 tonnes to 2.0 tonnes over the period 2005-12. This compares with a fall from 2.5 tonnes to 2.2 tonnes for England as a whole over the same period.

The Council has invested in local initiatives that make the most of national funding programmes for energy efficiency upgrades in housing, such as the Decent Homes Programme for social housing and the Free Insulation Scheme. This ran from 2009-2012, and reached 80% of private sector properties in the City, generating savings of over 28,000 tonnes of carbon emissions per year.

This illustrates the positive outcomes from large scale domestic retrofit programmes for heating and insulation. The current Council-endorsed Sheffield Heat & Save partnership offers discounted prices on heating and insulation, weighted towards the most vulnerable households, but national changes are affecting its impact.

The Sheffield Housing Company (SHC) is currently building 305 homes in north and south Sheffield. The properties achieve Code for Sustainable Homes level 3 ensuring that; the fabric conforms to high energy efficiency standards, white goods are designed for low water usage, the homes reduce energy demands and are orientated to maximise light and solar gain, and each home is a lifetime home which ensures generous and flexible space standards. Cycle stores are provided for every property. 30% of the properties are fitted with rain water harvesting tanks, and 10% of their energy requirements will come from photovoltaic panels.

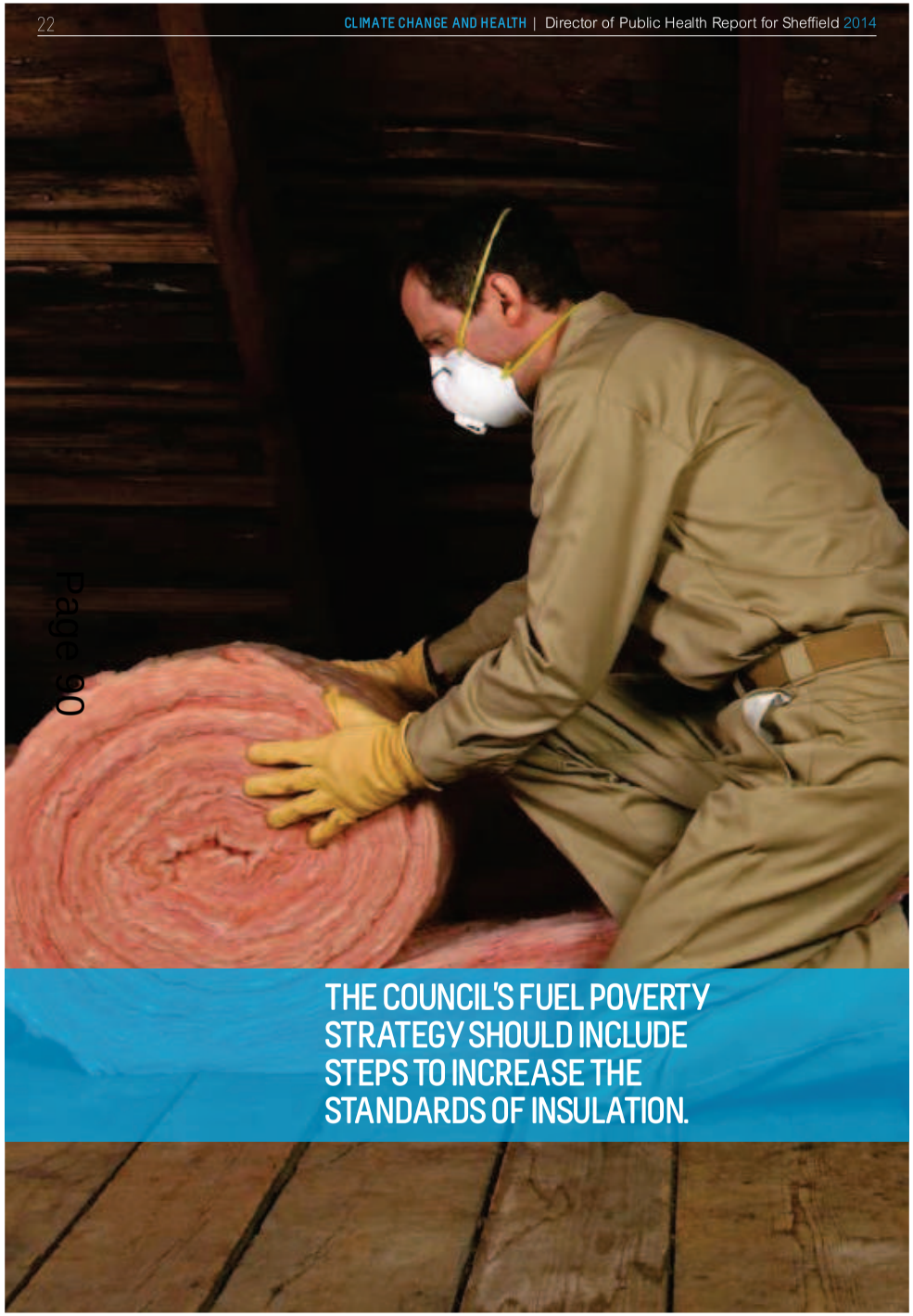
While advances have also been made in energy efficiency in the private rented sector, it lags behind other tenures. According to the Homes & Communities Agency, the average energy rating (Standard Assessment Procedure, SAP) in the social sector has risen from 47 to 57, while in the private sector it has risen from 41 to only 47.

What can we do?

It is important that the City continues to improve the thermal efficiency of the existing stock. The challenge is to insulate older, typically solid-wall or hard to treat cavity wall, homes. The average SAP rating for a council owned property in Sheffield now exceeds 70. There is already a target for the City under the Home Energy Conservation Act (1995) to raise the minimum SAP rating of viable council housing to 65 (the minimum necessary to take a household out of fuel poverty) by 2023/24.

Although improved thermal efficiency will reduce cold related illness and fuel costs, and may help the building to remain cool in hotter weather, it may also increase the risk of overheating during periods of hot weather. Ventilation must be maintained to prevent a rise in indoor air pollutants, and condensation, dampness and mould.

There is also an imminent opportunity within the domestic private rented sector. The Tenant's Energy Efficiency Improvement Regulations will be in force by 1 April 2016, and will empower tenants in the domestic private rented sector to request consent for energy efficiency measures



THE COUNCIL'S FUEL POVERTY STRATEGY SHOULD INCLUDE STEPS TO INCREASE THE STANDARDS OF INSULATION.

SHEFFIELD RIGHTLY HAS AN AMBITION TO BE A 'COMPETITIVE CITY OF EUROPEAN SIGNIFICANCE'.

to be installed, that may not unreasonably be refused.

Recommendations

- The Council's forthcoming fuel poverty strategy should include steps to increase the standards of insulation in the private rented sector, so that the average SAP for the sector is 65 by 2020, and the minimum SAP is 65 by 2025.
- Health and care professionals should systematically identify the people and properties most vulnerable to fuel poverty, and ensure that advice and assistance is available to them to address that.

3.5 Strengthening the local economy and increasing social capital

Jeremy Wight, Chris Shaw,and Chris Nield, Sheffield City Council

Why is this important?

Sheffield is part of a globalised economy that is dependent on cheap oil and ever increasing consumption of natural resources, both of which are major contributors to carbon emissions and climate change. Globalisation of the economy, and the increasing dominance of multinationals, has a tendency to lead to poorer working conditions, lower wages and increased inequality.

Socio-economic inequality is not only bad for the health of the less well off, but also the health of the better off. It leads to disconnection at local level, lack of connectedness and erosion of social capital. This leads to reduced levels of mental wellbeing and increased levels of physical illness.

Current position

Sheffield rightly has an ambition to be a 'Competitive City of European Significance'. There has been major international investment into the City, in particular into the advanced manufacturing park. We will shortly have one of the most advanced factories in the world within the City's boundaries. However the industrial and commercial sector generated 1.3Mt CO_2 in 2012, which though down from 1.8Mt CO_2 in 2005, still accounted for 41% of the City's emissions.

Sheffield has not yet recovered from the global economic crisis of 2007-8, with unemployment, underemployment and poor quality employment still a significant social problem. This is undoubtedly a major driver for poor health, and lies behind the 8 year gap in life expectancy across the City, as well as the other aspects of health inequality.

What can we do?

A city such as Sheffield cannot divorce itself from the global economy, and nor should it seek to. But we do need the economy to develop in a way that is good both for the climate and health. The Stern Review in 2006 argued that the economic costs of addressing climate change were significantly less than the cost of not doing so. Locally, the 'Mini-Stern Review' of the Sheffield City Region (SCR) looked at options for de-carbonising the economy. It found that the SCR could reduce its carbon emissions by 16.5% by 2022 (compared to 1990) through investment in energy efficiency measures and small scale renewables. This would require investment of £7.8Bn, but generate annual savings (in energy bills) of £1.02Bn, giving a payback time of 7.7 years, and annual savings for the lifetime of the measures. If external factors, including reduced consumption consequent on increased energy prices and the decarbonisation of the national electricity supply are included, an overall drop of 44% could be achieved.

More recently, the New Climate Economy Report: Better Growth, Better Climate has argued that 'countries at all levels of income now have the opportunity to build lasting economic growth at the same time as reducing

SHEFFIELD IS LEADING THE REGION ON INCREASING UPTAKE OF LOW EMISSION VEHICLES.

the immense risks of climate change', and set out a ten point plan to do so. The report recognises that cities are the engine of economic growth, but argues that the way they are developing has to change. Two particular recommendations that could have resonance for Sheffield are that there should be a substantial reduction in the capital cost of low carbon infrastructure investment, and that innovation in low-carbon and climate-resilient technologies should be scaled up. Sheffield should build on its cutting edge engineering capabilities to develop further the low carbon industries of the future, including carbon capture and storage. The low carbon sector group of the Local Enterprise Partnership (LEP) clearly has a potential role to play here.

Sheffield is leading the region on increasing uptake of low emission vehicles. We are working with businesses to provide subsidised electric vehicles and charging points, as well as establishing a network of public access points for rapid charging and fast charging of electric vehicles across South Yorkshire. Work is also underway on setting up infrastructure to use natural gas, bio-methane and hydrogen as a vehicle fuel. These alternative fuels produce less air pollution and carbon emissions, benefitting both the environment and health.

At the same time, we must make sure that the way the local economy develops is one that increases rather than undermines social capital, building on the ideas of the Transition Towns movement. This places emphasis on small scale local projects in areas of food, transport, energy, and housing, among other things, as a means of shifting away from high energy, high carbon, climate damaging economies to ones that are more locally based, resilient, and nurturing of social capital and health. Sheffield's 'Successful Centres' policy of promoting local shopping centres and encouraging independent traders contributes towards this. We should also question our overall consumerist lifestyles, not least since there is scant evidence that above a certain threshold increasing material wealth and consumption leads to greater wellbeing.

Recommendations

- Sheffield City Council and the Local Enterprise Partnership should work to implement the findings of the Mini-Stern Review and explore opportunities for low carbon infrastructure investment and the development of low carbon technologies.
- Sheffield City Council, working with voluntary sector and other organisations, should continue work to develop social capital in local communities.

3.6 Developing a low carbon health and social care economy

Jeremy Wight, Sheffield City Council and Tim Furness and Marion Sloan, NHS Sheffield CCG

Why is this important?

Being responsible for the health and wellbeing of the City means not only preventing ill health and treating illness, but also striving to ensure that the way the health and social care system is managed and run, minimises damage to the climate, and thereby to the health of people in the future.

Current position

The carbon footprint of the NHS, public health and social care system in Sheffield has been estimated at about 320 kilo tonnes of CO_2, just over 10% of the City's overall carbon footprint. Of this, approximately half is attributable to the activities of Sheffield Teaching Hospitals, though this has reduced significantly in recent years.

Public health and social care services can help reduce the demand for NHS care, and therefore have an impact on the overall NHS carbon footprint.

Nationally, 57% of the health and social care system's carbon footprint is attributable to embedded carbon in goods and services procured, including 16% attributable to pharmaceuticals and 9% to medical instruments. 15% of the overall footprint is attributable to building energy use and services commissioned from outside the public sector, and 13% due to travel.

What can we do?

First, any activity that reduces the demand for health and social care, will reduce activity and hence CO_2 emissions, as well as save money. However the overall net reduction in emissions will depend on how the resources that are released, are redeployed.

Secondly, increased efficiency of management and business processes is likely to lead to both reduced cost and reduced carbon emissions. For example, greater efficiency of building energy use, e.g. through insulation, or better heating systems, will save both money and carbon. Increased efficiency can also include a reduction in travel and transport where it is possible to do this without compromising clinical outcomes.

Thirdly, new technologies can help increase efficiency and reduce cost and carbon emissions. For example the appropriate use of telecare and telehealth should reduce the need for travel.

Fourthly, behaviour changes among staff, patients and clients could improve both their health and reduce carbon emissions. For example, more active travel and reduction in the consumption of meat and animal products.

The Climate Change Act of 2008 requires a reduction in carbon emissions of 80% by 2050 based on a 1990 base line, with reductions of 34% by 2020 and 50% by 2025. The carbon footprint of the health and social care system in England in 1990 was 35Mt CO_2e, so the 2012 figure of 32Mt CO_2e represents a fall of less than 9%. Significant further reductions, of the order of a further 28% of the 2012 figure, will be required if the 2020 targets are to be met. Actions should include the following.

First, there needs to be an explicit recognition, at the highest level, that further significant step changes in the way that health and social care is planned, commissioned for, and delivered, will be necessary to achieve further significant reductions in carbon dioxide emissions.

ADOPT A SUSTAINABILITY MANIFESTO FOR HEALTH AND SOCIAL CARE.

Secondly, the principles of sustainable development should be considered throughout the commissioning cycle and procurement process. This would mean that sustainability considerations were given equal weight to financial and clinical considerations.

Thirdly, health and social care providers need to be encouraged further to consider carbon hot spots in their businesses. Their procurement of goods should include the 4 steps in the "procuring for carbon reduction hierarchy of interventions" approach, namely reducing demand, increasing efficiency, substitution and innovation, and supply chain management.

Finally, leaders of the health and social care system in the City have a duty to be exemplars of sustainable behaviour. General Practitioners in particular are visible members of the community, and their adoption of active travel, public transport, and low carbon work-styles could be influential.

The Yorkshire Ambulance Service (YAS) has been leading the nation's ambulance services on a carbon reduction strategy. YAS established the Green Environmental Ambulance Network (GrEAN) in 2011 with the aim of bringing together the 13 UK ambulance services to deliver cost savings and carbon reductions that result in improved patient care. The network encompasses fleet, estates, ancillary services, finance, procurement as well as paramedics and other staff. Overall its aims are to:

- Raise awareness of carbon consumption
- Reduce the impact of the ambulance service on air emissions, carbon emissions and public spending
- Share information on trials being carried out across the country
- Quantify the amount of money and carbon that can be saved through the carbon management and reduction programme
- Improve ambulance fuel economy and aerodynamics
- Network effectively to reduce the carbon footprint of the British ambulance services
- Save money through carbon reduction

For more information see: - http://aace.org.uk/implement-a-carbon-management-programme-in-your-organisation-with-grean/

Recommendations

- The Health and Wellbeing Board, and Sheffield's NHS Foundation Trusts, should adopt an explicit sustainability policy aimed at ensuring that Sheffield meets its carbon reduction obligations by 2020. This should be underpinned by the adoption of a sustainability manifesto for the health and social care system in the City.
- The Health and Wellbeing Board should give urgent consideration to the ways in which the implications for carbon emissions of different approaches to the delivery of health and social care in the City can be evaluated. A system of carbon accounting needs to be developed.

3.7 Preparing for extreme weather events

Ruth Granger, Sheffield City Council and Peter Whitwam, Rotherham Borough Council

Why is this important?

A first step to adaptation to future climate change has to be to reduce the vulnerability and exposure of populations to the climate variability that they are already experiencing.

Current position

In the UK, the most significant early impacts of climate change are likely to be increases in the frequency and severity of extreme weather events. An extreme event can be defined as any weather event or hazard which has the potential to adversely impact on human health. This can include drought, heatwaves or cold weather, storm events, flooding, earthquakes and volcanic ash

WE NEED TO HELP OUR COMMUNITIES TO BECOME MORE RESILIENT TO CLIMATE CHANGE.

release. Summer temperatures are projected to increase, with more frequent hot spells. Whilst winters are predicted to become milder, there will still be cold spells, and winter rainfall will increase, as will the number of storms and floods.

Public Health England have calculated that since 2002-03 there have been on average 26,500 excess winter deaths a year in England, with the UK having approximately twice the rate of excess deaths compared to some colder countries such as Finland. This will have included excess winter deaths in Sheffield. The 2003 heatwave caused excess deaths (extra deaths that would otherwise have not occurred) across Europe, including approximately 2000 excess deaths in England.

Floods cause substantial harm to property, business and livelihoods. Two people died in the Sheffield floods of 2007, and the social and wellbeing impacts were significant. All groups are affected, but the negative effects tend to fall disproportionately on the most vulnerable and disadvantaged in society. Disadvantaged groups also have fewer resources to be able to protect themselves against the effects of extreme weather and to recover from extreme weather events.

What can we do?

First, we need to help our communities to become more resilient to climate change. This will require both physical adaptive measures as well as steps to increase the social capital and resilience of communities themselves. Physical measures include works such as river channel clearance to reduce the risk of floods. Sheffield City Council has recently been successful in securing funding for further flood defence schemes in the Lower Don Valley and elsewhere.

As part of its Flood Risk Management Strategy (2013) the Council has successfully registered 6 schemes for Government flood grant in aid funds for the period 2014 to 2021. This programme aims to improve the standard of flood protection to around 6,000 households and 2,000 commercial properties as well as providing capacity to support the building of thousands of homes across the City. The schemes seek to address flooding from the City's main rivers. A Lower Don Valley Flood Protection scheme is scheduled to begin construction in late 2014 with further schemes being planned for the Upper Don. A sustainable drainage scheme will also support new house building in the Manor and a flood protection scheme for the Upper Blackburn Brook. The programme will also provide opportunities to regenerate riverside locations and deliver wider environmental benefits.

We also need to take steps to protect people, in particular the vulnerable, from overheating. 90% of hospital wards are vulnerable to overheating. Cost effective cooling of existing homes is possible, and passive cooling should be built into new homes.

Social measures should include steps to increase social capital, thus ensuring that people, families and communities have a suitable level of mental and physical health, wellbeing and connectedness to be resilient to sudden and disruptive events.

The national Cold Weather and Heatwave Plans are implemented in Sheffield by local organisations and use alerts from the Meteorological Office to determine when to cascade information to staff about anticipated cold weather or heatwave events.

Public sector organisations have emergency planning arrangements in place. Organisations in Sheffield have responsibilities under the Civil Contingencies Act to prepare and respond to emergencies including those caused by extreme weather events. In addition the Council's Major Incident Plan, which documents how the organisation will

WE NEED TO DEVELOP AND STRENGTHEN THE CITY'S 'GREEN INFRASTRUCTURE'.

respond to any emergency, includes specific plans on responding to extreme weather incidents such as flooding. However we need to improve the way we help communities to prepare themselves for extreme weather emergencies, for example by encouraging households to sign up to alerts about weather warnings including floods.

Local Health Resilience Partnerships (LHRPs) have been established to oversee the health service's plans for emergency preparedness. The LHRP must also lead the health sector's contribution to wider multi-agency planning for extreme weather events undertaken by the Local Resilience Forum.

Recommendations:

- The Health and Wellbeing Board should consider how to enforce and report on actions set out in the Heatwave Plan for health and social care facilities such as care homes before next summer.
- All organisations should promote uptake of The Environment Agency's 'Floodline Warnings Direct' service https://fwd.environment-agency.gov.uk/app/olr/home for local residents and businesses to help preparedness for flooding. This could be promoted by providing a link to sign up for the alerts on organisations' internet sites.
- The Local Health Resilience Partnership (LHRP), and Local Resilience Forum (LRF), should audit local organisations' plans for dealing with the health consequences of severe weather events, and ensure that they are adequate.

3.8 Designing healthy urban spaces and places

Jeremy Wight and Louise Brewins, Sheffield City Council

Why is this important?

The design of our urban environment has a critical role to play in helping the people of Sheffield to adopt lifestyles that are both healthier and have a lower carbon footprint, both as a result of that behaviour change as well as through more carbon efficient infrastructure. By improving the quality of our urban environment we can help to deliver a greener, stronger and healthier Sheffield. Our City needs to become a place that is not only resilient to the adverse effects of climate change, but also one that encourages behaviour that improves health and the environment. We need to develop and strengthen the City's 'green infrastructure' by ensuring that the design and development of land, open spaces, water and public buildings in Sheffield contributes directly to reducing CO_2 emissions, increases resilience to extreme weather effects and promotes healthier places in which to live and work.

Current position

The European Commission defines green infrastructure as 'the use of ecosystems, green spaces and water in strategic land use planning to deliver environmental and quality of life benefits. It includes parks, open spaces, playing fields, woodlands, wetlands, road verges, allotments and private gardens. Green infrastructure can contribute to climate change mitigation and adaptation, natural disaster risk mitigation, protection against flooding and erosion as well as biodiversity conservation.'

The Green Infrastructure Strategy for South Yorkshire (2011) shows that the green capital of South Yorkshire (i.e. natural assets and resources) has the potential to become one of the strongest and most distinctive features of the area, but it is currently falling short of reaching this potential. Key gaps in policy and provision could be acting as barriers to future development. Two major aspects of development include de-centralised energy generation and sustainable urban drainage systems.

WE WANT TO BE THE FIRST DECENTRALISED ENERGY CITY IN THE UK.

What can we do?

In the UK, and in Sheffield, our energy systems are largely centralised and reliant on imported fossil fuels. We want to be the first decentralised energy city in the UK, to be self-sufficient in energy, derived from low carbon sources, and to offset all emissions. The City is recognised as a leader in the field of decentralised energy, as a result of its well established city centre district energy network connected to the Energy Recovery Facility at Bernard Road, and the numerous smaller scale community heating schemes across the City. Nevertheless we also need to encourage other renewable energy systems, whether these are at the domestic or larger scale, and the work of organisations such as Sheffield Renewables. Planning policies should facilitate this.

Modern cities struggle to cope with heavy rainfall, which can lead to serious flooding. Most rainwater that is diverted into our drains does so as a result of the amount of paving and hard surfaces in the area. Our sewers are not large enough to cope with the amount of water that runs off our roofs. Sustainable urban drainage systems (SUDs) offer an alternative to traditional underground drains that will alleviate pressure on the existing drainage system and reduce flash flooding. Measures include controlling rainwater at source (through installing water butts in gardens, increasing the number of homes and buildings with green roofs, and using permeable paving), building infiltration trenches, filter drains, swales and basins and creating more ponds and wetlands. The planting of more trees and shrubs in the City could be part of sustainable urban drainage systems and reduce heat island effects. They can also attract wildlife and contribute to recreational green space, thus benefitting physical and mental health.

As discussed elsewhere in this report, a major shift from motorised transport to active travel, and from private cars to public transport, could both reduce greenhouse gas emissions (and other forms of air pollution) and improve health. Our planning policies should therefore prioritise public transport over private car use, and walking and cycling over both.

Sharrow primary school is an excellent example of a small project on a single public building that was designed to have maximum environmental and community benefits. A key feature is the School's green roof which helps to alleviate extreme rainfall, humidity, noise, pollution and to provide insulation. The roof was designed to be multi-functioning, requiring low input, no artificial fertiliser or irrigation, to use locally sourced re-cycled materials, create a garden and be resilient to the local climate. The roof was declared a local nature reserve in 2009.

Recommendations

There are many actions we can and should be taking to promote a greener, healthier and resilient environment for Sheffield residents to live and work in, but in particular:

- The Council should ensure that health issues are built into local development and regeneration plans and integrate adaptation principles into the local planning framework.

4 Recommendations

Each year the DPH report makes recommendations about improving the health of the local population and directs these recommendations towards particular organisations or groups. In this chapter we begin by looking at the progress made against the recommendations in the previous DPH report (2013). This is followed by a summary of the recommendations made in the individual sections of this 2014 report.

4.1 Progress on 2013 Recommendations

The Council should:	Progress
focus investment in evidence based prevention and early intervention in the early years.	Early years services are aligned with Best Start Sheffield principles to deliver a universal and targeted model of prevention and early help based around Children's Centres. A new Best Start volunteer programme will be commissioned to include baseline training, co-ordinated support for volunteers and for specialist activities. It will provide a structured pathway to help volunteers maximise outcomes from volunteering opportunities.
redesign and commission a universal prevention and early intervention emotional wellbeing and mental health service.	A Health Needs Assessment of Comprehensive Emotional Wellbeing and Mental Health and a universal prevention pilot at Park Academy have been completed. This pilot has been extensively evaluated and resulted in approval to go ahead with the procurement of an extension to support work across 3 further families of schools, linking with MAST and the citywide targeted counselling resource in Community Youth Teams.
progress the development of a sexual health commissioning strategy.	Progress has been made to ensure appropriate representation on the Sexual Health Integration Board. A sexual health clinical advisory group has been established and a review of the Sheffield Sexual Health Service is underway. This external peer review includes scrutiny of current reporting and governance arrangements and is expected to make recommendations about the future development of a broader sexual health commissioning group by October 2014.

The Council should:	Progress
prioritise initiatives to make being physically active the norm by building physical activity into daily life.	The 'Move More' Board has been established to facilitate a culture change in physical activity over the next five years. Significant engagement is being made through its holistic approach to increasing and building physical activity into daily life. As part of the Tour de France Legacy, Sheffield City Council has entered into partnership with British Cycling. The partnership also saw Sheffield hold its first mass participation bike ride in 2014 which was attended by 2,000 people.
fully support a citywide programme to reduce the availability and supply of illicit tobacco.	An action plan outlining key actions to reduce the availability and supply of illegal tobacco 2012-15 is in place. Key actions are; Developing partnerships and engagement with local and regional agencies; engaging health and community workers to raise awareness of the programme; generating and sharing intelligence to identify the extent of illegal tobacco use; and marketing and communications. A small team of Tobacco and Alcohol Enforcement Officers are based in Sheffield City Council Trading Standards Team.
identify commissioning priorities for people who live in care homes.	Following the 2013 Needs Assessment, residential care homes for older people have been asked to choose activities to support residents with dementia, and residents at risk of falls or new residents. Nine care homes have signed up for a pilot period until March 2015. The Care Home Activities Group will use existing data to decide which wellbeing priority is the most pertinent to the care home at this time. Care homes will be asked to evaluate the achievement of outcomes relating to residents' wellbeing.
seek to enhance the resilience and social capital of the most deprived communities in Sheffield.	The Community Wellbeing Programme addresses the wider determinants of health inequalities by developing social capital. It supports delivery of the Health Trainers and Health Champions programmes. Practice Champions were successfully introduced as a new development from the existing Health Champions' project. Community resilience has been promoted by: enhancing the public health skills of front line staff; creating a Public Health Learning and Development post; the 'Make Every Contact Count' approach; and the Community Development and Health course.
renew its approach to improving mental wellbeing in the City.	The programme working group now meets, with lots of interest and commitment from partners. An action plan will follow, aiming to raise awareness of the 5 ways to wellbeing: **Connect; Give; Be active; Take notice; Keep learning** and to maximise opportunities to influence individual wellbeing and community resilience. While delivering a programme for the Joint Health and Wellbeing Strategy, this work will be overseen and supported by the Mental Health Partnership Board.
promote schemes to ensure all parts of SCC exert influence to address alcohol harm.	224 individuals (87%) completed an alcohol assessment after being issued with a Fixed Penalty Notice. 1,327 received identification and brief advice and 2,025 received alcohol triage assessment through the community based Single Entry and Assessment Point. The 1,810 treatment places included extended brief interventions, 'talking treatments' and community based prescribing. 55 offenders completed a community sentence as part of their alcohol treatment.

The Council should:	Progress
increase employment opportunities especially for those affected by mental health conditions.	Secured funding to deliver a pilot with SCC Learning and Skills team, Job Centre Plus and GPs in North Sheffield to increase employment of residents on Employment Support Allowance with a mental health condition. Reviewing supported employment provision across the City and Adult Social Care, the CCG and VCF sector. Consultation planned in October and November 2014, pathway to be designed by December 2014 and the Commissioning Strategy by Spring 2015.
contribute towards improved uptake of the Health Check.	Health Checks have been included in the CCG's 'basket of services' to ensure universal coverage of all GP practices across Sheffield. Practices serving the most disadvantaged communities have been offered additional support in setting up and running the Health Check programme. There are current discussions at the SCC Employee Health and Wellbeing Steering Group about how Health Checks can be offered to employees in the workplace.

4. Recommendations in 2014

1. The Council should develop and implement a programme of signposting walking routes with the time it takes to reach the destination.
2. Sheffield people should consider traveling short distances on foot or by bicycle rather than by car, and sign up to 'Move More' at www.movemoresheffield.com.
3. The Council should commit to increasing the number of 20 mph zones within the City as quickly as possible.
4. The Council and local hospital Trusts should develop their food purchasing arrangements to reflect environmental and health factors, including reduced reliance on meat and dairy in menus.
5. Sheffield people should consider reducing the amount of meat they eat by adopting at least one meat free day per week.
6. The Council's forthcoming fuel poverty strategy should include steps to increase the standards of insulation in the private rented sector, so that the average SAP for the sector is 65 by 2020, and the minimum SAP is 65 by 2025.
7. Health and care professionals should systematically identify the people and properties most vulnerable to fuel poverty, and ensure that advice and assistance is available to them to address that.
8. The Council and the Local Enterprise Partnership should work to implement the findings of the Mini-Stern Review and explore opportunities for low carbon infrastructure investment and the development of low carbon technologies.
9. The Council, working with voluntary sector and other organisations, should continue work to develop social capital in local communities.
10. The Health and Wellbeing Board, and Sheffield's NHS Foundation Trusts, should adopt an explicit sustainability policy aimed at ensuring that Sheffield meets its carbon reduction obligations by 2020. This should be underpinned by the adoption of a sustainability manifesto for the health and social care system in the City.
11. The Health and Wellbeing Board should give urgent consideration to the ways in which the implications for carbon emissions of different approaches to the delivery of health and social care in the City can be evaluated. A system of carbon accounting needs to be developed.
12. The Health and Wellbeing Board should consider how to enforce and report on actions set out in the Heatwave Plan for health and social care facilities such as care homes before next summer.
13. All organisations should promote uptake of The Environment Agency's 'Floodline Warnings Direct' service https://fwd.environment-agency.gov.uk/app/olr/home for local residents and businesses to help preparedness for flooding. This could be promoted by providing a link to sign up for the alerts on organisations' internet sites.
14. The Local Health Resilience Partnership (LHRP), and Local Resilience Forum (LRF), should audit local organisations' plans for dealing with the health consequences of severe weather events, and ensure that they are adequate.
15. The Council should ensure that health issues are built into local development and regeneration plans and integrating adaptation principles into the local planning framework.

PROGRESS IS BEING MADE IN SHEFFIELD BUT THERE IS STILL A LOT MORE TO DO.

5 Glossary

Adaptation (Climate change)	Any change made to natural or human systems in response to climatic changes which reduces risks or exploits beneficial opportunities.
Aeroallergens	Any airborne substance, such as pollen or spores, which triggers an allergic reaction (e.g. hay fever).
Arthropods	An invertebrate animal having an external skeleton, a segmented body, and jointed appendages. Arthropods include insects, spiders, and crustaceans.
Biodiversity	The degree of variation of life.
Carbon accounting	The processes used to "measure" amounts of carbon dioxide equivalents emitted by organisations or systems of organisations.
Carbon capture (and storage)	The process of capturing waste carbon dioxide from large sources, such as fossil fuel power plants, transporting it to a storage site, and depositing it where it will not enter the atmosphere, normally underground.
Carbon footprint	The "total" amount of greenhouse gas emissions caused by an organisation, event, product or person.
Carbon sink	A natural or artificial reservoir that accumulates and stores some carbon-containing chemical compound for an indefinite period.
Cryptosporidiosis	A parasitic disease that affects the intestines and is typically an acute short-term infection that is often spread through contaminated water.
Deforestation	Removal of a forest or stand of trees where the land is thereafter converted to a non-forest use. Examples include conversion of forestland to farms or for housing.
Fossil	Energy sources formed by natural processes such as decomposition of buried dead organisms. They contain high percentages of carbon and include coal, petroleum, and natural gas.
Global warming	The observed rise in the average temperature of the Earth's climate system.
Greenhouse gas	A gas in the atmosphere that absorbs and emits radiation within the thermal infrared range. The main greenhouse gases in the Earth's atmosphere are water vapor, carbon dioxide, methane, nitrous oxide, and ozone. Greenhouse gases greatly affect the temperature of the Earth.
Infiltration trenches	A shallow, excavated ditch that has been filled with rubble or stone to create an underground reservoir.
Legionnaire's disease	A serious lung infection caused by legionella bacteria. The bacteria are commonly found in sources of water, such as rivers and lakes. However, they can rapidly multiply if they find their way into artificial water supply systems such as air conditioning systems.

Leptospirosis	A type of bacterial infection spread by soil or water contaminated with the urine of animals (commonly rodents). In its most severe form, leptospirosis is also known as Weil's disease.
Lyme disease	A bacterial infection spread to humans by infected ticks. Ticks are tiny arachnids found in woodland areas that feed on the blood of mammals, including humans.
Mitigation (Climate change)	Strategies to reduce or prevent human induced emission of greenhouse gases and enhance carbon sinks (e.g. new technologies, renewable energy, changing consumer behaviour).
Passive cooling	Building design approach that focuses on heat gain control and heat dissipation in a building in order to improve the indoor thermal comfort with low or nil energy consumption.
Pathogens	In the broadest sense a pathogen is anything that can produce disease. Typically the term is used to mean infectious agents such as bacteria or viruses.
Permafrost	Soil at or below the freezing point of water for two or more years and mostly located in high latitudes such as land close to the North and South poles.
Resilience	An individual's or community's ability to properly adapt to stress and adversity.
Salmonella	A group of bacteria that can cause food poisoning. Foods such as eggs, chicken, pork and dairy produce can carry salmonellas. Fruit and vegetables can also become contaminated if they have been in contact with livestock, manure or untreated water.
Social capital	The pattern and intensity of networks of people and the shared norms, values and understandings that arise from and facilitate co-operation within and among those networks.
Standard assessment procedure (SAP)	Methodology developed by the Building Research Establishment to assess and compare the energy and environmental performance of dwellings. The SAP quantifies a dwelling's performance in terms of energy use per unit floor area, a fuel-cost-based energy efficiency rating and emissions of CO_2. The higher the SAP rating the better.
Sustainable urban drainage system	A sequence of management practices and control structures designed to drain surface water in a more sustainable fashion than some conventional techniques.
Swales and basins	Swales are grassed depressions which lead surface water runoff from the drained surface to storage or a discharge system (e.g. a basin) typically using the green space that may run alongside a road or development. A basin is a dry or wet pond designed to attenuate storm water runoff for a few hours and to allow the settlement of solids.
Telehealth and telecare	Technology such as personal alarms and health-monitoring devices used to help people live more independently at home. They help to reduce the number of regular visits someone may need to make to the GP or hospital.
Thermal efficiency	How well a device, such as a boiler or refrigerator, converts energy into heat.
U-Value	A measure of heat loss in a building element such as a wall, floor or roof. A low U value usually indicates high levels of insulation.
Urban heat islands	A metropolitan area that is significantly warmer than its surrounding rural areas due to human activities. The main cause of the urban heat island effect is from the modification of land surfaces, which use materials that effectively store short-wave radiation.
Verocytotoxin producing E-Coli (VTEC)	A group of bacteria that cause infectious gastroenteritis. The main source for VTEC is cattle and other ruminants. Transmission to humans occurs through consumption of contaminated food or water, or exposure to a contaminated environment involving direct or indirect contact with animals or their faeces.
Wetlands	Land area that is saturated with water, either permanently or seasonally, such that it takes on the characteristics of a distinct ecosystem. Main types include swamps, marshes, bogs and fens.

Your views

We are keen to hear your views on this report. If you would like to make any comments please contact the Director of Public Health:

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More information

An online version of this report,
and the full report with references, is available at:
www.sheffield.gov.uk/publichealthreport

This document can be supplied in alternative formats,
please contact 0114 205 7457

Sheffield City Council
www.sheffield.gov.uk

DP16106

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SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Dr Jeremy Wight, Director of Public Health
Date:	26th March 2015
Subject:	Air Quality and health in Sheffield
Author of Report:	Dr Olufunke Adedeji, Consultant in Public Health 0114 2057464 Dr Ogo Osammor, Air Quality Officer 0114 273 4655 Magdalena Boo, Health Improvement Principal 0114 205 7470

Summary:

This report is to inform the Health & Wellbeing Board (HWB) about Air quality as a public health priority in Sheffield, to draw attention to the level of air pollution in the city, particularly with respect to nitrogen dioxide (NO_2) gas and PM_{10} fine dust particles, and to provide an update on progress towards achieving target outcomes of:

- A reduction in pollutants;
- A measurable improvement in air quality; and,
- A reduction in mortality attributable to air quality;

Poor air quality adversely affects human health, and has recently been estimated to account for up to 500 premature deaths per year in Sheffield, with health costs of around £160 million per year (PHE, April 2014, SCC, 2012, Environment Select Committee, 2010).

Sheffield declared an Air Quality Management Area (AQMA) in 2010, across the entire urban area of the city, for breaching the health based EU limit values for NO_2 and PM_{10}.

As a result, the Council produced an Air Quality Action Plan (AQAP) 2015 to cover, the period up to 2015, with the aim of reducing NO_2 and PM_{10} levels in order to improve the health of local people. Simon Green, Executive Director of Place Portfolio is the Delivery Champion. The Director of Public Health is the Vision Champion and is reporting in this capacity to HWB. The AQAP will be refreshed in 2015.

£54k from the PH Grant is currently invested in this work annually to support public health priorities. The service will be reviewed, re-scoped, re-specified and tendered in 2015 to ensure this investment supports public health outcomes.

This report will briefly summarise:
What we know about air quality in Sheffield e.g. trends from baseline
What we are doing to improve air quality in Sheffield, by implementing the AQAP 2015 and what is the likely impact on health, in terms of both morbidity and mortality

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Questions for the Health and Wellbeing Board:

This report is intended to facilitate discussion by the HWB on:

- What is the likely impact on air quality, in quantitative terms, of the implementation of the AQAP 2015 and will that have sufficient impact on reducing ill health and mortality?

- If what we are doing is not likely to have sufficient impact on reducing morbidity and mortality, how can we secure these outcomes, including through investing more or differently?

Recommendations:

- The Health & Wellbeing Board notes the current data on air quality in Sheffield;
- The Health & Wellbeing Board supports the ongoing investment from the public health grant in this work;
- That further work is undertaken to assess what the likely impact of implementation of the AQAP on air pollution is likely to be, and further, what the impact will be of any consequent reduction in air pollution on health.
- The Health & Wellbeing Board is involved in the review and refresh of the Air Quality Action Plan 2015, in particular to consider whether it is sufficiently ambitious given the scale of the public health problem.

Reasons for Recommendations:

- Improving air quality in Sheffield will contribute to reducing morbidity and mortality attributable to air pollution;
- £54,000 of the public health grant is annually invested in this work;
- We cannot currently be confident about the likely impact of the AQAP on health in Sheffield.
- The Air Quality Action Plan 2015 refresh is an opportunity for the Health & Wellbeing Board to engage in this agenda which impacts on many key aspects of population health;

Background Papers:
Sheffield Air Quality Action Plan 2015
Air Aware Campaign Materials

AIR QUALITY AND HEALTH IN SHEFFIELD

1.0 SUMMARY

This report is to inform the Health & Wellbeing Board (HWB) about air quality as a public health priority in Sheffield, also to draw attention to the level of air pollution in the city, particularly with respect to nitrogen dioxide (NO_2) gas and PM_{10} fine dust particles, and to provide an update on progress towards achieving target outcomes of:

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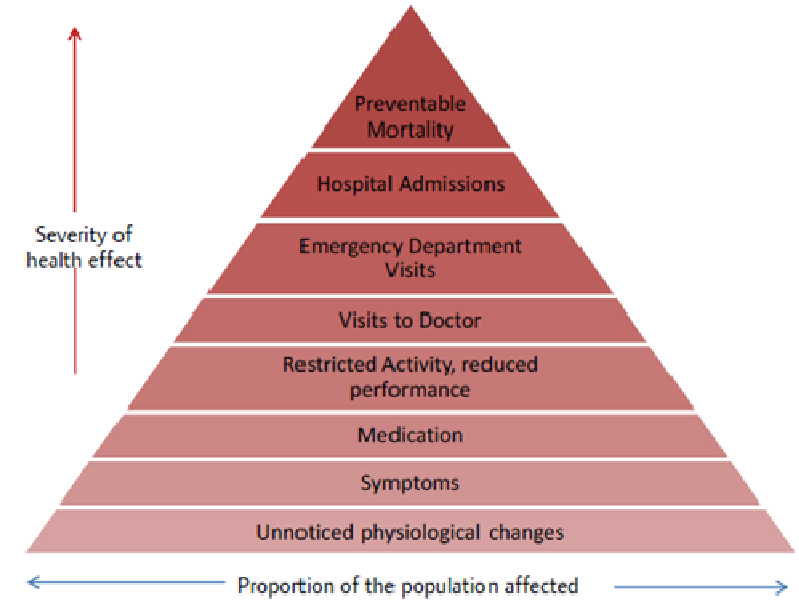
This report will briefly summarise:
What we know about air quality in Sheffield e.g. trends from baseline
What we are doing to improve air quality in Sheffield – implementing the AQAP 2015, and what is the likely impact on health, in terms of both morbidity and mortality

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 Air quality is a major public health issue for the city. An estimated 300-500 premature deaths per year in Sheffield are attributable to poor air quality (PHE, April 2014, SCC, 2012).

Image 1: Impact of Air Pollution on Health



WHO, 2005

2.2 The impacts on life expectancy and ill health are unequal, with more effects on the young, the old and those with pre-existing heart and lung conditions. For individuals who are particularly sensitive and exposed to the most elevated levels of air pollution, the reduction in life expectancy is estimated to be as high as nine years (SCC, 2012).

2.3 Air quality is worse along busy road corridors and in the more disadvantaged areas. Poor air quality is therefore a significant contributor to health inequalities in the City.

2.4 Reducing exposure of individuals to air pollution, as well as reducing the production of pollutants may reduce health effects, although further research is needed on the relationship between long and short term exposure and health impacts (DH, 2006). Therefore, public information and awareness on reducing exposure, such as the recent "Air Aware" campaign in Sheffield, may be beneficial. The campaign information can be accessed from the website https://www.sheffield.gov.uk/environment/air-quality/air-aware-sheffield.html

3.0 MAIN BODY OF THE REPORT

3.1 This report will briefly summarise:

- What we know about air quality in Sheffield e.g. trends from baseline
- What we are doing to improve air quality in Sheffield, by implementing the AQAP 2015 and what is the likely impact on health, in terms of both morbidity and mortality

3.2 What we know about air quality in Sheffield?

3.3 Reflecting national trends and many other major cities in the UK, Sheffield currently breaches UK and European Union (EU) health-based thresholds for air quality, particularly NO_2 and PM_{10}, and declared an Air Quality Management Area (AQMA) in 2010, across the entire urban area of Sheffield. The deadline for compliance with EU and National Law on Air Quality Limit Values was 01 January 2015 and the Council is not likely to be compliant of these regulations until 2020 at the earliest (House of Commons, 8 December 2014, SCC 2013).

3.4 Road transport is the most significant overall single contributor to Sheffield's NO_2 emissions. Addressing traffic related emissions, with a particular focus on the most polluting vehicles (buses, taxis and OGVs) would therefore have a significant beneficial impact on Sheffield's air quality (data from Sheffield LEZ study).

3.5 In line with Government regulation, Sheffield City Council has continuously monitored air quality over the past decade through its' monitoring programme including, Local Transport Plan (LTP), Local Sustainable Transport Fund (LSTF) and specific schemes funded programmes.

3.6 Sheffield City Council owns six automatic air quality monitors sited at Tinsley Infant School (PM_{10}, $PM_{2.5}$, NO_2) , Lowfield School (PM_{10}, SO_2, NO_2), King Ecgbert old School site (PM_{10}, 0_3, NO_2), Firvale School (PM_{10}, SO_2, NO_2), Waingate (PM_{10}, NO_2) and The Wicker (PM_{10}, NO_2, O_3). In addition DEFRA own a further two sites in the city centre and at Tinsley. Further detail of what is monitored at each site and maps of air quality are available through the Sheffield City Council website: https://www.sheffield.gov.uk/environment/air-quality/monitoring.html

3.7 Sheffield City Council also funds 'East End Quality of Life (EEQOL)' to conduct community monitoring of NO_2 using diffusion tubes and to communicate the results to community groups and interested individuals in Sheffield. The sites are selected and managed by volunteers based on their perceptions of where air quality is likely to be poor or require monitoring; laboratory analysis of the diffusion tubes and data analysis of the results is provided by the project. The data provides a useful addition to the automatic monitoring sites results.

3.8 Data is therefore collected at hundreds of sites across the Sheffield area. Analysis of the data from these sites identified 51 locations within the AQMA, where the 40µg/m^3 health-based annual average limit for NO_2 was breached in

one or more of the 3 years for which the AQ data was studied (2010-2012) (Sheffield LEZ Study, 2013).

3.9 The Table below shows an estimate of how much these sites are likely to exceed the 40µg/m^3 EU limit in 2013 (Sheffield LEZ Study, 2013). It shows that 41 out of 51 (80.39%) sites would require NO_2 reduction to comply with EU limit and protect health (SCC LEZ Study, 2013).

PERCENT REDUCTION REQUIRED	NUMBER OF SITES
0%	10
0-5%	8
5-10%	12
10-20%	13
20-30%	8
Total	**51**

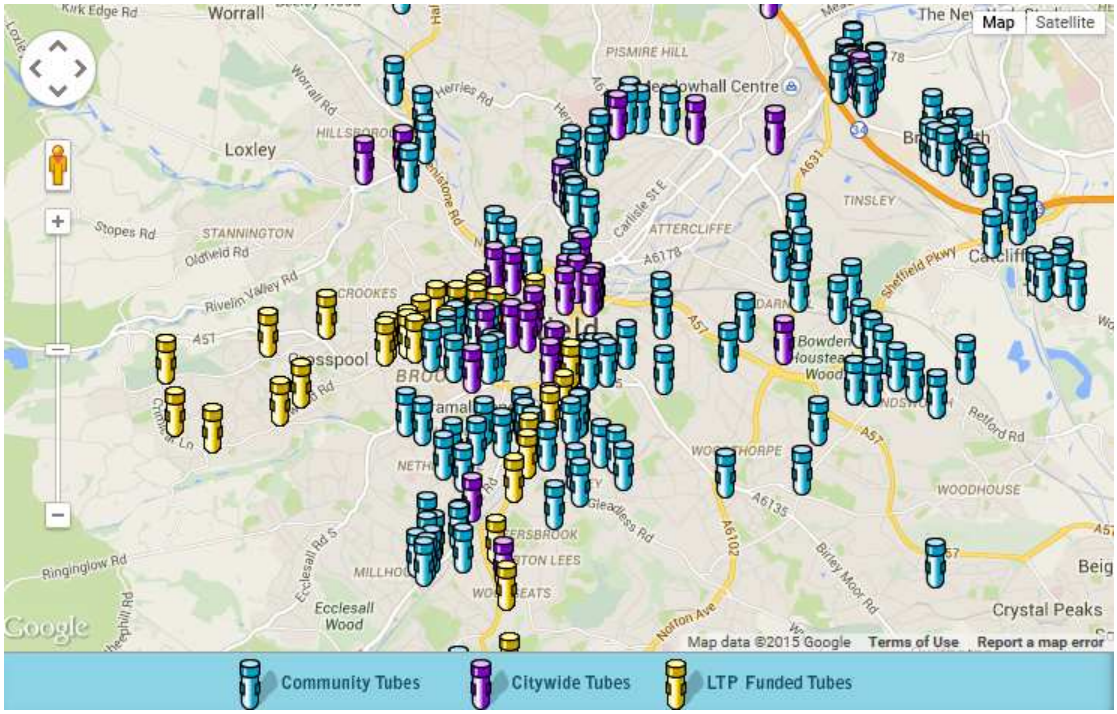
3.10 Analysis of Sheffield's hospital admissions for 'Circulatory diseases' and for coronary heart disease also both show a strong correlation with the annual average concentration of small particulate matter in the relevant neighbourhoods – see Appendix A for details. This observation is important, given there is no safe level for particulate matter, particularly, $PM_{2.5}$ (SCC LEZ Study, 2013).

3.11 Results from Sheffield air quality monitoring can be accessed through the Sheffield City Council website https://www.sheffield.gov.uk/environment/air-quality.html, which links to a Sheffield Air Quality monitoring website with an interactive map https://www.sheffield.gov.uk/environment/air-quality/monitoring.html

3.12 EEQOL monitoring information demonstrates a number of neighbourhoods are breaching NO_2 European annual limit values, particularly areas around busy roads such as Abbeydale Road Corridor http://www.sheffieldeastend.org.uk/AQmonitoring.htm

3.13 Although the majority of the local data is for NO_2, linked to the EU health limit value, the best evidence for health harms from poor air quality concerns fine particulate matter ($PM_{2.5}$) (DH, 2006). The Public Health Outcomes Framework indicator for air pollution 3.01 Fraction of mortality attributable to particulate air pollution concerns $PM_{2.5}$ for this reason. COMEAP cites emerging evidence of the health effects of NO_2 alone, rather than as part of ambient air pollution, but further research is required to quantify the specific health effects (COMEAP, March 2015).

3.14 Sheffield Air Map showing site and type of air quality monitoring (source: http://www.sheffieldairmap.org/view_map.html, accessed 16/03/15)



3.15 What we are doing to improve air quality in Sheffield, including the AQAP actions?

3.16 Sheffield produced an Air Quality Action Plan (AQAP) for Sheffield in July 2012, approved by Cabinet, which sets out how problems with air quality in the city will be tackled.

3.17 The AQAP sets out 7 key actions with designated lead officers who are represented on the AQAP Steering Group - chaired by the Director of Regeneration and Development – and on the AQAP Working Group. Progress against each of these 7 key actions is set out in

Action 1: Assess feasibility for a Low Emission Zone

Action 2: Develop infrastructure for refuelling low emission vehicles

Action 3: Promote smarter travel choices

Action 4: Improve engine performance of commercial diesel vehicles

Action 5: Mitigate the impact of the M1 motorway (particularly in the Tinsley Area)

Action 6: Develop policies to support better air quality

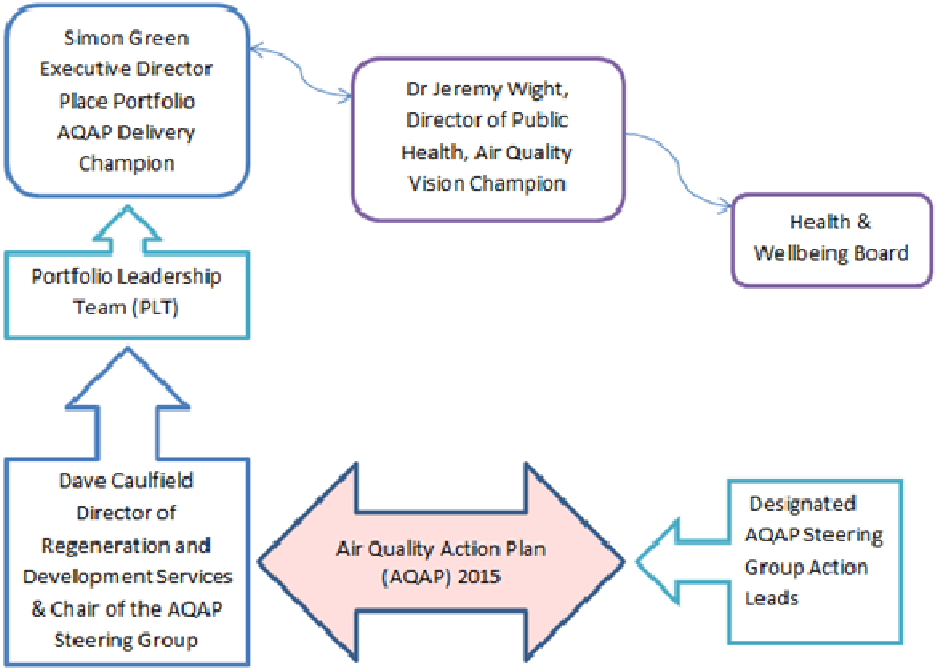
Action 7: Control industrial emissions

(appendix1)

3.18 The governance of the Air Quality Action Plan is described in the diagram below. The senior leads are the Director of Public Health, who is the Vision

Champion (as part of his role on the City's Health and Wellbeing Board) and the Executive Director of the Place Portfolio, who is the Delivery Champion of the Air Quality Action Plan.

Air Quality Action Plan (AQAP) 2015: Governance



3.19 The success of the AQAP is dependent on a major shift away from the use of diesel fuel in the urban area of Sheffield. Without significant investment it is likely that NO_2 limit values will continue to be breached. The success or otherwise of Sheffield in attracting OLEV funding for ultra-low emission vehicles is therefore a critical success factor for the AQAP in Sheffield.

3.20 If the recommended LEZ Strategy, a key action of AQAP 2015, was implemented, the Table below shows an estimate of how by much these sites are likely to exceed the 40µg/m3 EU limit (SCC LEZ Study, 2013).

PERCENT REDUCTION REQUIRED	NUMBER OF SITES (PRE-LEZ STRATEGY)	NUMBER OF SITES (POST-LEZ STRATEGY)
0%	10	33
0-5%	8	2
5-10%	12	6
10-20%	13	8
20-30%	8	1
30-35%	0	1
Total	**51**	**51**

3.21 From the findings presented in the above Table, it can be concluded that the full implementation of the AQAP 2015 would make air quality better at approximately 33 out of 51 (45%) of the sites that exceed the 40µg/m^3 limit, though not before 2020. The forecast improvement in air quality should also have a likely beneficial impact on health, in terms of both morbidity and mortality, though this cannot currently be quantified.

3.22 The likely impact of implementation of the AQAP on particulate air pollution has not been estimated. As a consequence, it is not possible to state by how much the implementation of the Plan will improve health in the City.

3.23 Further modelling is required to estimate the health benefits that could be derived from the different air pollution reduction forecasts in 3.19 (above). In general terms, the best evidence of health impacts of air pollution is from long term exposure to ambient air pollution, therefore any action by Sheffield City Council to reduce exposure over time is likely to be beneficial

4.0 QUESTIONS FOR THE BOARD

4.1 This report is intended to facilitate discussion by the HWB on:

4.2 Whether the implementation of the AQAP will that have sufficient impact on reducing ill health and mortality?

4.3 If what we are doing is not likely to have sufficient impact on reducing morbidity and mortality, how can we secure these outcomes, including through investing more or differently?

5.0 RECOMMENDATIONS

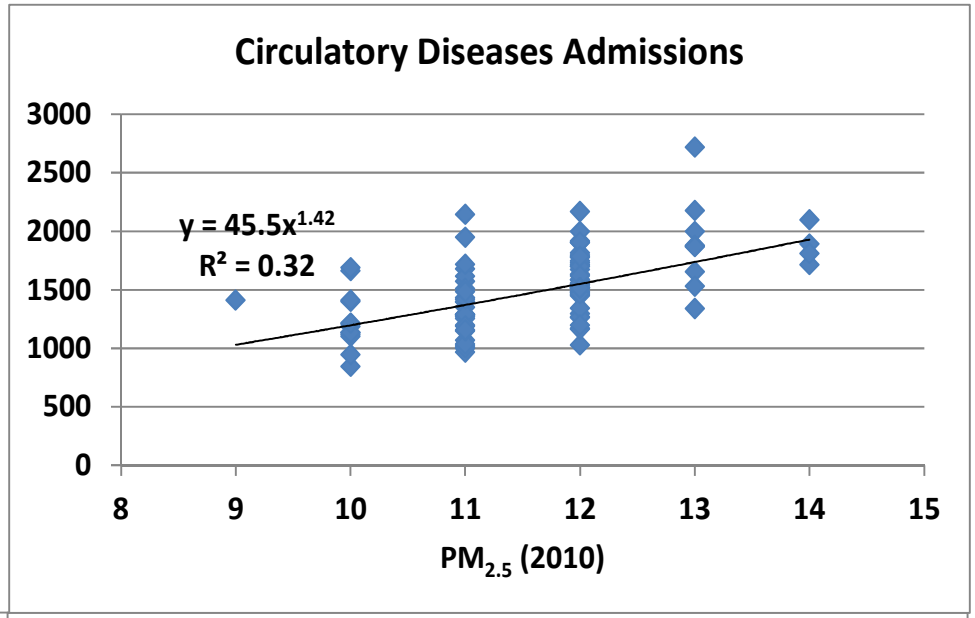
5.1 The Health & Wellbeing Board notes the current data on air quality in Sheffield;
5.2 The Health & Wellbeing Board supports the ongoing investment from the public health grant in this work;
5.3 That further work is undertaken to assess what the likely impact of implementation of the AQAP on air pollution is likely to be, and further, what the impact will be of any consequent reduction in air pollution on health.
5.4 The Health & Wellbeing Board is involved in the review and refresh of the Air Quality Action Plan 2015, in particular to consider whether it is sufficiently ambitious given the scale of the public health problem.

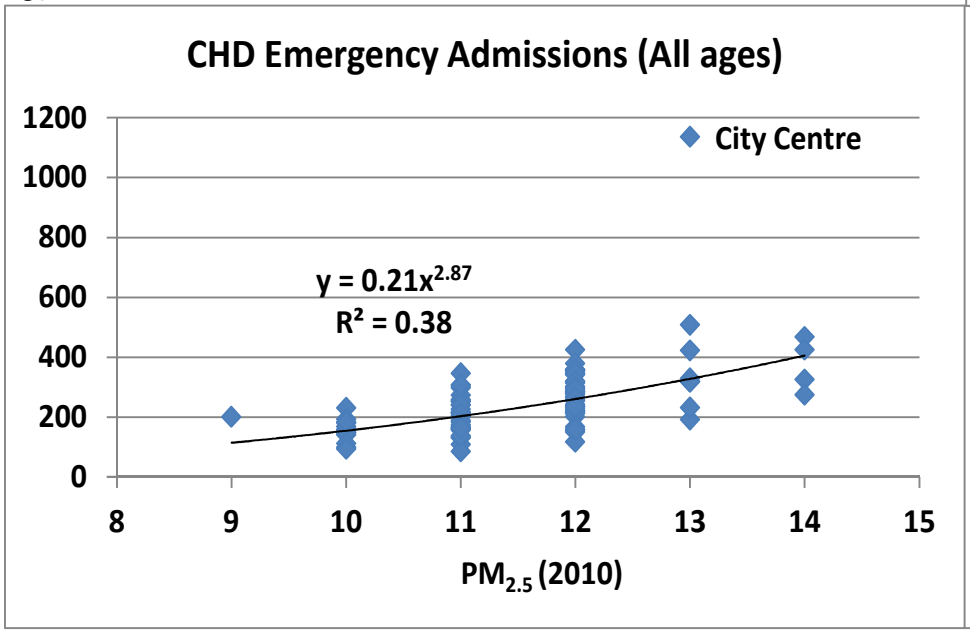
6.0 REASONS FOR THE RECOMMENDATIONS

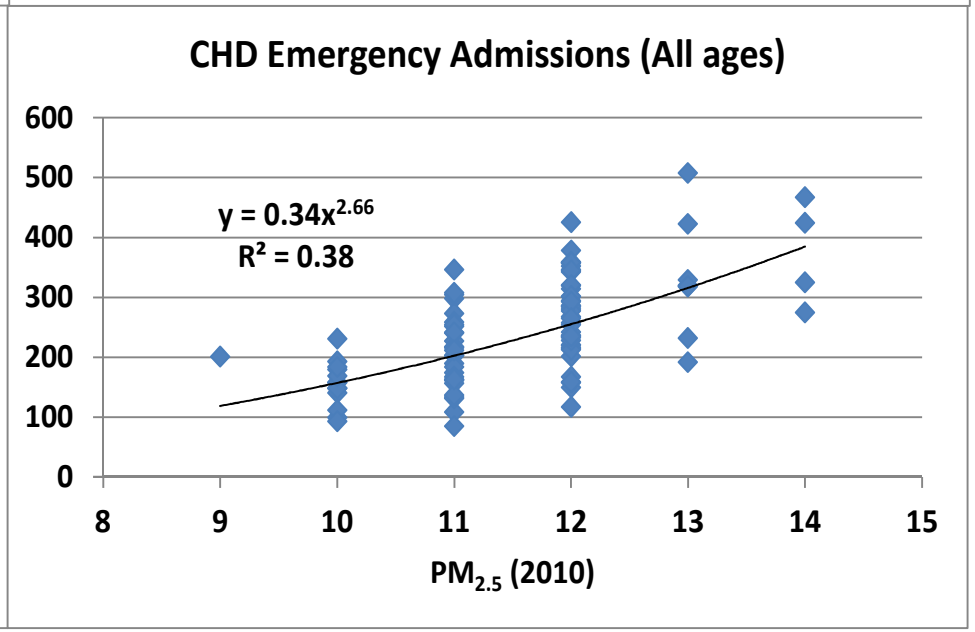
6.1 Improving air quality in Sheffield will contribute to reducing morbidity and mortality attributable to air pollution;
6.2 £54,000 of the public health grant is annually invested in this work;
6.3 We cannot currently be confident about the likely impact of the AQAP on health in Sheffield.
6.4 The Air Quality Action Plan 2015 refresh is an opportunity for the Health & Wellbeing Board to engage in this agenda which impacts on many key aspects of population health;

Report Appendix A – Health Data Analysis

The estimate of annual average concentrations of particulate matter ($PM_{2.5}$) in each Sheffield neighbourhood in 2010 was plotted against the number of hospital admissions per 100,000 population from these neighbourhoods for: a) circulatory diseases and b) coronary heart disease emergencies. The results and the corresponding best-fitting trends are illustrated in the figures below.







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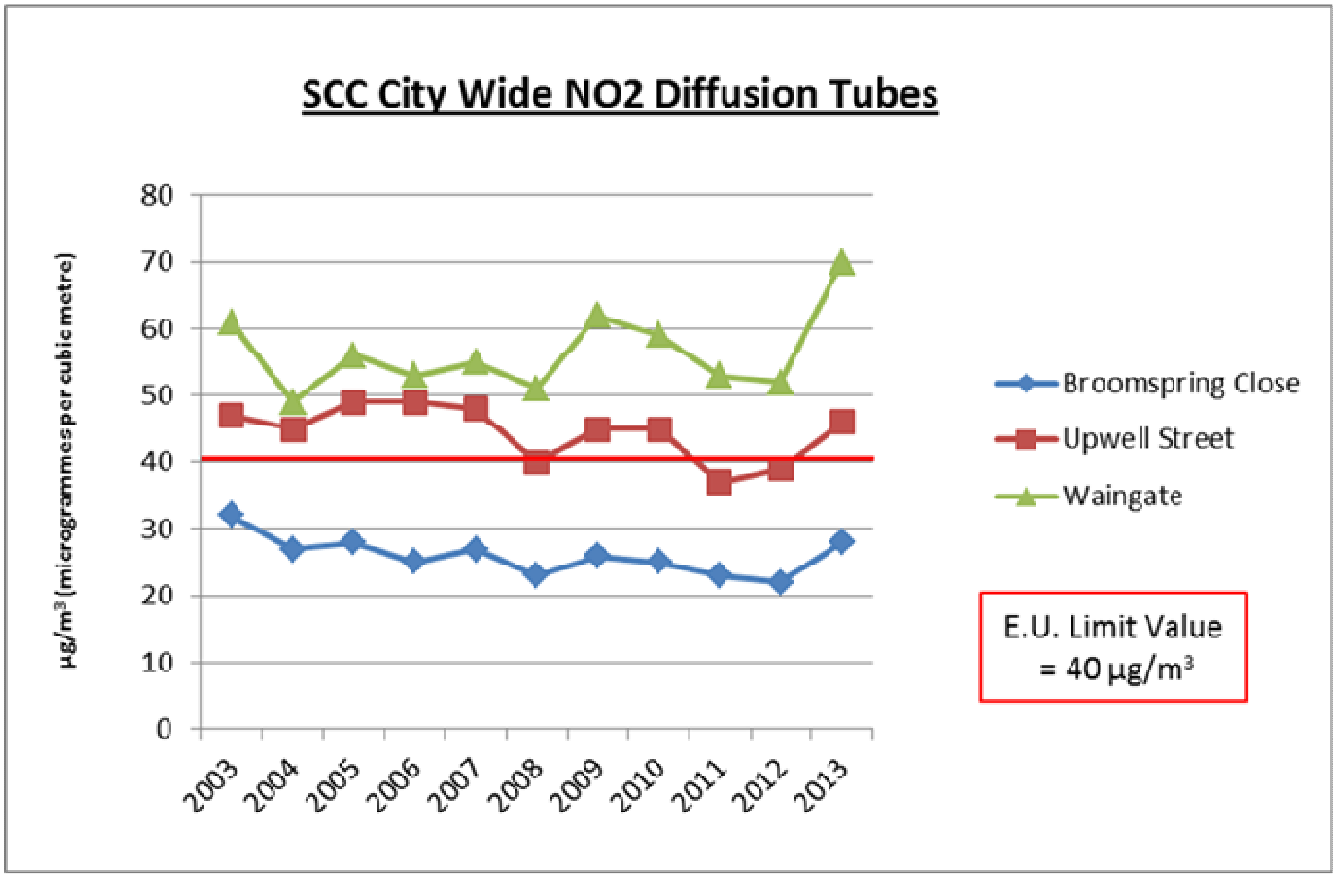
Public Health England, April 2014, estimating local mortality burdens associated with particulate air pollution

APPENDIX B - DASHBOARD OF PERFORMANCE MEASURES COLLECTED FOR SHEFFIELD AIR QUALITY

Overarching theme: Communication Plan	Sheffield City Council Air Quality Actions	Update as of March 2015
	Action 1: Assess feasibility for a Low Emission Zone	Task and finish Work Packages have been developed for the Sheffield Low Emission Zone (LEZ) Strategy and designated leads identified to take forward the recommendations of the LEZ Feasibility Study. A range of pollutant emissions reduction measures are being implemented, including: the introduction of 40[1] new hybrid and 45 new Euro V buses through Sheffield Bus Partnership investment; Clean Vehicle Technology Funded retrofitting of 41[2] buses with Thermo Management Technology; and 175 Yorkshire Ambulance Rapid Response Vehicles to be fitted with Solar Roof Panels.
	Action 2: Develop infrastructure for refuelling low emission vehicles	The Office of Low Emission Vehicles (OLEV) announced a £500m Ultra Low Emissions Vehicle (ULEV) scheme funding package. Sheffield City Council hopes to take advantage of this funding to develop initiatives around Taxi and Bus themes. As part of the scheme OLEV recently announced the launch of a £35m fund (go ultra-low city scheme) to promote the uptake of ultra-low emission vehicles and invites bids from Local Authorities by 20th February 2015. Local Sustainable Transport Fund (LSTF) and OLEV funding has been used to support small and medium enterprises to switch to electric vehicles and for the installation of rapid charging points across South Yorkshire.
	Action 3: Promote smarter travel choices	The council uses a range of information to monitor the methods people use to travel. We aim to reduce the car-related proportion share by providing an attractive range of alternatives, whilst securing the most effective performance of our existing roads through effective Network Management and Control. This has the benefit of reducing congestion and hence reducing air pollution. Capital investment in Network Management includes improved telecommunications between computerised traffic signals operation and major junctions to optimise signal settings and manage the network; a series of parking management schemes to make sure roads aren't unnecessarily obstructed at peak times; and a programme of lorry route management schemes to minimise the impact of lorries in residential or other sensitive areas. Bus Boost schemes are promoted as part of LSTF programmes. Sheffield Bus Partnership has to date

[1] This is estimated to represent 22% of the Stagecoach fleet.
[2] This is estimated to represent 8% of the First fleet to low emission vehicles.

		delivered 9% increase in the number of fare-paying passengers. SCC will bid for Low Emission Vehicles funding from Government to improve the quality of the bus travel experience. A review of the Sheffield bus is underway, to improve co-ordination between operators and frequency of services, the changes likely to be introduced in September. Cycle and Walk boost schemes aimed at commuters are promoted as part of LSTF programmes, alongside School Travel Change Programmes. Progress on improving cycling and walking includes: investment in pedestrian crossings and cycle routes, Streets Ahead-related pedestrian enhancements and opportunities, refresh of SCC cycling strategy/strategic network and the Cycles boost initiative. We await new National Guidance regarding Cycling Delivery Plan. An air quality public awareness campaign, "Air Aware" www.sheffield.gov.uk/AirAware has provided information to local residents on main air quality pollutants, *active travel* as a means of reducing air pollutants and advice on avoiding personal exposure. Other schemes include: Green Driving, Eco Stars and Plugged in S Yorkshire, Car Club and Car Share.
	Action 4: Improve engine performance of commercial diesel vehicles	Focusses on improving emissions produced by taxis, buses and other goods vehicles (>3.5tons). Progress to date includes achieving agreement from partner organisations – 40 x new Stagecoach hybrid buses; 41 x First Group double decker Euro 4 engines to be retrofitted with Thermo Management Technology. Other schemes include: Green driving, ECO stars and Plugged in S Yorkshire.
	Action 5: Mitigate the impact of the M1 motorway (particularly in the Tinsley Area)	Smart motorway construction and discussions to build a barrier along M1 J34 south slip have started – ongoing partnership working with Highways England (previously Highways Agency).
	Action 6: Develop policies to support better air quality	The focus of action is to restrict new sensitive uses (homes, schools) from being developed in areas where national air quality objectives are being exceeded, unless significant mitigation measures are included within those developments. Sheffield Local Plan will have policies aimed at improving air quality and will ensure air quality impacts from new developments across the City are minimised.
	Action 7: Control industrial emissions	The focus of action is to regulate installations which are permitted under the Environmental Permitting Regulations. Formalised site specific Permit conditions are used, which lay down emission limits and measures for industry to comply with. Inspection regimes are undertaken to determine whether the emissions limits and pollution control measures are complied with.



This figure shows that over time, at two of the sites, NO_2 levels are gradually coming down but has remained stubbornly high at the third site.

Public Health Outcomes Framework Indicator 3.1

There has been no update since 2012, the baseline year for Sheffield Air Quality Action Plan. Sheffield performs better than the England average and in the top 3 of core cities. The percentage of mortality attributable to particulate air pollution has reduced since 2010. However, as this is a % of all mortality this could be due to an increase in mortality from other causes rather than a reduction in mortality attributable to air pollution. Particulate air pollution in this context means $PM_{2.5}$

Public Health Outcomes Framework (PHOF) Indicator 3.1

3.1 Percentage of mortality attributable to particulate air pollution		
Baseline period 2010		
Sheffield 4.7	England 5.1	(2012)
Sheffield 5.1	England 5.4	(2011)
Sheffield 5.5	England 5.6	(2010)

Indicator 3.1	Percentage of mortality attributable to particulate air pollution	Better compared to England (not statistically)	Sheffield General Trend	Sheffield Change Last period	Baseline year: 2010	Latest period: 2012	Core Cities rank (1= best) 3/8

APPENDIX C - Estimating morbidity or illness and mortality or death from air pollution

Ground-level ozone (O_3) and fine particulate matter ($PM_{2.5}$) are associated with increased risk of mortality.
There is strong evidence of an association between acute exposure to particulate air pollution (PM10) and daily mortality, one day later.

This association is strongest for respiratory and cardiovascular causes of death.
The association cannot be attributed to other pollutants including NO_2, CO, SO_2 or O_3 not due to weather.

There is also evidence that the health effect of poor air quality is not limited to mortality or deaths only. Admissions to hospital for respiratory conditions, cardio-vascular conditions, and accident and emergency visits for exacerbation of Asthma (with variation of up to 30-fold for $PM_{2.5}$, and 11-fold for O_3, by neighbourhood), have been shown to increase.

[Ref: The Health Effects Institute (HEI) has recently released an announcement that Johns Hopkins University investigators of the National Morbidity, Mortality and Air Pollution Study (NMMAPS) have updated their previous estimates of the mortality effects of acute exposure to particulate air pollution.]

Cohort studies across major cities have estimated an increase in total mortality of roughly 4% and 5% per 10 microgram per m3 of increase in the long-term level of particulates, after chronic and acute exposures respectively. [Ref: The major U.S. cohort studies are the American Cancer Society Study (Pope et al. 2002) and the Six Cities Studies (Dockery et al, 1993)]

Animal (mice) experiments have also suggested that long-term exposure to air pollution can lead to physical changes in the brain, as well as learning and memory problems, and even depression (L K Fonken, X Xu, Z M Weil, G Chen, Q Sun, S Rajagopalan, R J Nelson. Air pollution impairs cognition, provokes depressive-like behaviours and alters hippocampal cytokine expression and morphology. Molecular Psychiatry, 2011; DOI: 10.1038/mp.2011.76).

The above indicate that despite significant improvements in air quality in recent decades, air pollution and ozone still pose a non-trivial risks to the public health.

Challenges remain around communicating results and implications to the public. Also, the attributable fraction of each pollutant is difficult to disentangle because their analysis varies with patterns of exposure e.g. single, repeat, short-term or long-term; requires many impact assessment strategies, e.g. time series, cohort; assumptions and complex, multi-stage analyses for developing robust and valid risk estimates.

The UK COMEAP (Committee on the Medical Effects of Air Pollutants) acknowledges this complexity in its 2010 report, by summing up that as everyone dies eventually, no lives are ever saved by reducing environmental exposures, but – deaths are delayed resulting in increased life expectancy. Also, measures to reduce air pollution result in effects that are averages or aggregates across the population, and it is not known how the effects are distributed among individuals

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SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 11 December 2014

PRESENT: Councillor Julie Dore (in the Chair), Leader of the City Council
Dr Tim Moorhead (Co-Chair), Chair of the Sheffield Clinical Commissioning Group (CCG)
Dr Nikki Bates, Governing Body Member, Sheffield CCG
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
Dr Zak McMurray, Clinical Director, Sheffield CCG
John Mothersole, Chief Executive, Sheffield City Council
Dr Jeremy Wight, Director of Public Health, Sheffield City Council

In attendance: Joe Fowler, Director Of Commissioning, Sheffield City Council
Tim Furness, Director Of Business Planning and Partnerships, Sheffield CCG
Steven Todd, Strategic Commissioning Manager, Sheffield City Council

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Ian Atkinson, Jayne Ludlam, Laraine Manley and Dr Ted Turner.

2. DECLARATIONS OF INTEREST

Dr Tim Moorhead declared a personal interest in the item numbered 7 on the agenda for this meeting (Pharmaceutical Needs Assessment for Sheffield 2015-18) on the grounds that his Practice dispenses medicines and this formed part of the income of the Practice.

3. PUBLIC QUESTIONS

Mr John Darwin asked a question concerning the role of the Mindfulness approach, particularly with regard to mental health. He stated that he had taught mindfulness for four years and it was clear that mindfulness based approaches had a role in relation to therapy and enhancing peoples' lives. There was no reference to this in the Mental Health Strategy papers as submitted to this meeting of the Board. He asked what role the Board saw with regard to mindfulness approaches, which were good for people and cost effective for the health service. He asked for the Board's comments. He commented that there were a growing number of courses relating to mindfulness, which were concerned with education, rather than theory and were relevant to everyone.

Councillor Julie Dore (Co-Chair of the Board) responded that the item on the agenda relating to Outcome 2 "Health and Wellbeing is Improving" included an action to promote a city wide approach to emotional wellbeing. The issue of mindfulness which Mr Darwin had raised was something which could be looked at within the emotional wellbeing theme and when the Board considered Outcome 2 later at this meeting. She said that she was not aware of other references to mindfulness within the Joint Health and Wellbeing Strategy.

Tim Furness stated that mindfulness approaches were not something which had been raised as part of the engagement concerning the *Sheffield Strategy for Mental Health* being developed by the Mental Health Partnership Board. There was still opportunity to incorporate the issue into the Strategy.

Councillor Jackie Drayton stated that emotional wellbeing was something which was linked to positive behaviours in parents and children.

Dr Nikki Bates stated that the IAPT (Improving Access to Psychological Therapies) team did use mindfulness based approaches and such approaches were also sometimes recommended by GPs in their consultations with patients.

4. UPDATE ON THE JOINT HEALTH AND WELLBEING STRATEGY: OUTCOME 2 - HEALTH AND WELLBEING IS IMPROVING

The Board considered a report of the Co-Chairs of the Board concerning the Health and Wellbeing Strategy: Outcome 2 – 'Health and Wellbeing is Improving'. The report set out what had happened in relation to the 8 key actions over the past year and areas in which the Health and Wellbeing Board could make a difference.

The report was presented by Tim Furness, Director of Business Strategy and Partnerships, NHS Sheffield CCG.

Members of the Board discussed the two main themes of the 'Health and Wellbeing is Improving' outcome area, which were:

- emotional wellbeing; and
- living longer.

In discussing particular actions under each theme, the Board considered what progress had been made in the past year; the main issues and opportunities for the action and what the Board/ Members of the Board could do over the next year in relation to that action. A summary of the discussion is as follows:-

Emotional wellbeing

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.

With regard to the challenge to protect investment in emotional wellbeing, prevention and early intervention, the circumstances of reducing funding meant

that this may become more acute. However, the commissioning plans for mental and physical health aimed to increase investment and community activity and spend more on prevention.

The City did not have a strategy relating to suicide and a more focussed approach was required in that regard. This could be considered as part of the Strategy for Mental Health. There was also a link to transition from childrens to adults' services. The need for work to prevent suicides and promote awareness thereof and the transition from children's to adults' services were recognised in the report as submitted.

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.

There were no additions or further comments.

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.

The relationship with parents and carers was vital and parents should be viewed as partners in parenting initiatives. Work was being done in early years to help develop positive parenting, which was being monitored.

It was not clear whether the ambition of the Strategy was to deal with immediate issues relating to parenting or whether it was intended to deal with breaking the cycle of where parenting breaks down.

There was a strategic programme for early prevention and intervention at the point of crisis to enable families to stay together and prevent children and young people from being brought into care. The Best Start work also included peer support and mentoring to help people before they reached a point of crisis. The strategy was intended to cover both early intervention and universal parenting concerns.

There were actions that individual schools, such Arbourthorne and Tinsley Primary schools were taking in targeting particular activities for the needs of children and families in their communities. This was best practice which could be shared. Arbourthrone Primary had used LAP (Local Area Partnership) funding and private sector funding to transform the former caretaker's house into a lifeskills centre, where young people could learn to look after themselves with activities such as cooking.

Under the 'issues and opportunities' heading on page 8 of the report, the first bullet point should be amended by the inclusion of the word "initiatives" after the words "The delivery of Parenting"**.**

Living Longer

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

Whilst the Move More strategy was intended to encourage people to be more physically active, some people were not able to afford to participate in some physical activities as they were priced-out by the cost, for example, of gym membership.

The Move More strategy included physical activity which might not take place in a gym, such as gardening and dancing. However, the cost of gym memberships did need to be addressed. The chair of the food and physical activity Board, Dr Ollie Hart, had met with schools to try to use them to encourage young people into sport.

The addition of an action under section 3, page 10, as follows:-

To invite Graham Moore and Ollie Hart of the Food and Physical Activity Board to the next Health and Wellbeing Board strategy development meeting.

The Green Commission had heard evidence concerning the approach in Bristol to active travel and Calderdale also had an active travel planning mechanism to encourage walking and cycling. People might increase their physical activity by walking between tram or bus stops. It was also thought that people overestimated how long it took to walk to a destination.

The Board was not necessarily in a position to hold the city to account with regards physical activity, although it should consider how it was able to influence people to engage with the work relating to increasing physical activity. This included making sure that partner organisations were promoting increased physical activity.

The Learning Disabilities Partnership Board was also considering how physical activity might be promoted, including improving access to sports and health services and facilities.

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.

A programme of tobacco control had been launched in April 2014. The introduction of smoke free spaces to protect children under 5 years from exposure to harmful tobacco smoke had been successful. A question was whether people who used electronic cigarettes viewed themselves as non-smokers. There had been a slight increase in the number of women smoking during pregnancy and this also needed to be addressed through the stop smoking relapse prevention service for pregnant women.

Tobacco was a major cause of early death and it was also a large cost to health and social care. It was noted that Greater Manchester Pensions Authority had taken a decision to dis-invest in tobacco. One of the actions for the Board was to ask the South Yorkshire Pensions Authority to review its investment in tobacco. The Board should state in writing that it would wish for the Pensions Authority to seriously consider dis-investment in tobacco and request the Pensions Authority to respond.

In relation to the idea of a similar request to the pensions authority but relating to alcohol, there was a logic in tobacco being put first as it was the biggest single issue.

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.

Consideration would be given to the timetable and logistics in the preparation of a new alcohol strategy and approach to the commissioning of alcohol treatment and prevention services. Alcohol related admissions to hospital had increased in 2012-13. There was concern that the licensing rules were quite restrictive. Other local authorities used planning consents as a means of controlling the availability of cheap alcohol. The extent to which it may be possible to restrict the hours of the sale of alcohol would depend upon a strong case and would be subject to policy. These were issues which could be taken into account in the development of the new alcohol strategy. The involvement of the CCG in addition to the drug and alcohol co-ordination team (DACT) was endorsed and it was recognised that alcohol abuse had a cost to health services in terms of the treatment of in-patients.

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.

It was likely that the CCG would be tasked with commissioning tier 3 community obesity services, in the next year or two. This was, at present, a complicated pathway and it was likely the CCG would be given responsibility depending upon the financial resources that were available. There was concern that the Government approach was to use surgical procedures in relation to obesity and that the funding and targets to combat obesity would follow this approach and there would not be sufficient funding available to the CCG, which would be driven by the Government target. There was evidence to suggest that surgery was effective as a 'rescue' treatment for obesity and whilst it was expensive, it was cost effective. That did not mean that prevention shouldn't be undertaken. If the CCG had control of the entire obesity pathway, an integrated approach to obesity would then be possible. Family nutrition should be recognised in addition to improvements to school food. The Let's Change for Life programme included work in schools to improve nutrition.

The addition to the list of public health initiatives of a reference to community

initiatives concerning food under section 3, page 16 was suggested.

It was noted that there had been a report regarding the number of people in receipt of prescription medication, including statins. It was said that in certain cases, the equivalent benefit would be achieved from not taking the medication, but taking other action, for example doing more physical activity. The prescription of antacids was raised as a concern as they masked the problem of people eating the wrong types of food and drink. However, it was acknowledged that the medication did make people feel better.

Self-care was a minimal intervention approach, which encouraged people to look after themselves and could be relevant in helping people control their weight and general health.

An example was given of Devon CCG, which had decided to deny people operations until their BMI measured below 37. This was driven by cost and budget considerations and rationed access to elective operations and was also evidence of policy makers choosing which interventions they wished to use first.

There was a high incidence of women being prescribed anti-depressants and a question was asked as to whether there was a link to other conditions such as cardio vascular disease. In answer to which it was considered that in cases of severe depression, there was also a greater risk to physical health.

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

There were no additional comments.

Outcome Indicators

The percentage of patients aged over 18 years with a new diagnosis of depression had increased from 6.93 in 2012-13 to 7.43 in 2013-14. This may be due to better diagnosis and treatment of patients with depression or there may in fact be a higher number of cases. Sheffield had a higher rate of depression than the national average, but the increase was in tandem with the national trend.

The Tackling Poverty Strategy consultation had shown that key workers and debt advisers had seen an increase in depression and mental ill health connected to poverty. Women were described as ‘shock absorbers’ in that they protected their families and the impact of poverty and debt may be a higher incidence of mental ill health. Research into child poverty had been undertaken by the Joseph Rowntree Trust indicating the importance of removing people from poverty and providing stable homes.

There was a need to understand for adults, in the same way as had been done for children and young people, the problems and solutions regarding access to services.

There was better diagnosis relating to mental ill-health and activity to reduce the

stigma around poor mental health. Other programmes such as the Move More initiative, which aimed to make people more active might also mean they had more opportunities to meet other people. Consideration also had to be given to prevention of mental ill health.

The Joint Strategic Needs Assessment provided evidence of where there was need and consideration was given to how services were provided to meet that need and identify which interventions would work and in relation to which area of need in the most cost effective way.

The weight management contract was to be put out to tender and a question was how this linked with other aspects of a healthy lifestyle, such as food and an individual's journey mapped out in order to build a clear pathway.

The Board needed to make sure there was a market before it made investment. Learning should take place from, for example, the retail sector in order to overcome problems such as the inverse care law, where availability of care was often inverse to needs of the population. Such learning might be applied to the work on stopping smoking.

Thought had been given to the most cost effective methods of prevention and national and international research had been taken into account and interventions based accordingly. However, some approaches were found not to be delivering. Thought was being given to how people accessed services and how intervention might be made most effective. Interventions needed to be targeted to particular communities where they were most needed.

The same people may be in each indicator area and there may be many interventions into one household, which would require a holistic approach to dealing with the causes of health conditions, such as alcohol consumption and smoking, in that household. The estimated prevalence of smoking for 2011 (19.5%) was thought to be unrealistic as it was out of line with the estimates for 2010 and 2012 (which were 23.8% and 23.2% respectively). The indicator for the proportion of 10 to 11 year olds overweight or obese was more or less static over 3 years. The indicators for alcohol related admissions to hospital and breastfeeding of babies at 6 to 8 weeks were worsening. Nonetheless, Sheffield was comparatively good in terms of the rate of breastfeeding. Activity to increase breastfeeding was targeted at particular communities.

Issues relating to poverty and inequality were reoccurring concerns throughout the outcome, which also had connections with the City's Health Inequalities Action Plan.

Resolved: that the Health and Wellbeing Board:

1. Actively supports the recommendations made under each action in the report as submitted, subject to the following additions having discussed report in some depth:

   Action 2.3:

Under the 'issues and opportunities' heading on page 8 of the report, the first bullet point should be amended by the inclusion of the word "initiatives" after the words "The delivery of Parenting"**.**

- The delivery of Parenting **initiatives** 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.

Action 2.4:
The addition of an action under section 3, page 10, as follows:-

- To invite Graham Moore and Ollie Hart of the Food and Physical Activity Board to the next Health and Wellbeing Board strategy development meeting.

Action 2.7:
The addition to the list of public health initiatives of a reference to community initiatives concerning food under section 3, page 16.

- 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; **and community initiatives concerning food** etc.

2. Supports the ongoing programme of needs assessment.

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

5. UPDATE ON THE INTEGRATED COMMISSIONING PROGRAMME (BETTER CARE FUND)

The Board considered a report of the Director of Business Planning and Partnerships, NHS Sheffield CCG and the Director of Commissioning, Sheffield City Council, concerning the progress of the Integrated Commissioning Programme (Better Care Fund).

Joe Fowler, the Director of Commissioning, Sheffield City Council, introduced the report, stating that the Clinical Commissioning Group and the City Council had agreed to establish a pooled budget in 2015/16 to cover four key areas of work and with the aim of improving service user experience and outcomes and making the best decisions concerning the use of the available resource. He outlined the key developments relating to the 4 following areas:-

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

The governance for the pooled budget would require the alignment of Clinical Commissioning Group and City Council decision making.

Resolved: that 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, as submitted.

6. SHEFFIELD STRATEGY FOR MENTAL HEALTH

The Board considered a report of the Director of Business Planning and Partnerships, NHS Sheffield CCG (and Chair of the Mental Health Partnership Board) concerning the draft Sheffield Strategy for Mental Health. The Mental Health Partnership Board had developed the draft Strategy, which covered the promotion of good mental health and treatment and care for people with mental health problems. The Health and Wellbeing Board was asked to comment upon the principles and priorities in the Strategy and to consider whether it would inform and guide the provision of appropriate mental health service provision over the next 5 years.

Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield CCG (and Chair of the Mental Health Partnership Board) presented the report. Stephen Todd, Strategic Commissioning Manager, Sheffield City Council (with responsibility for Adult Mental Health) was also present.

Members of the Board commented and asked questions, as follows:-

The South Yorkshire Police and Sheffield Health and Social Care Foundation Trust had established a Street Triage pilot to improve joint working in cases of mental health crisis and which was funded by the CCG. It was hoped that this would continue.

Some issues had begun to be identified during the development of the Strategy which would require further consideration by commissioners. These included:

- What people had said about mental health services and how they should change including “Whether care plans still existed?” and “The system makes me feel a nuisance”.
- The relationship between primary care and secondary care.
- Treating people as a whole person and undertaking treatment in partnership with the patient.

The estimated prevalence of psychosis amongst adults aged over 16 in Sheffield

of 50 per 1000 adults was thought to be a life-time prevalence, rather than the number at any one time.

The vision and aims set out in section 7 of the report should be amended so that the sentence “Helping to make Sheffield a place that supports and improves the mental health of all its people” was listed as the first item.

Whilst prevention was a priority, it was not emphasised within the draft Strategy. The prevention of early death of people with psychiatric illness was important and most deaths were caused by smoking related diseases. The Health and Social Care Foundation Trust had decided not to tolerate smoking by employees or patients.

The draft Strategy did not include an action plan. However, the Mental Health Partnership Board would ask all providers and commissioning organisations to respond to the Strategy and to state what, in positive terms, they will do to achieve the Strategy’s aims. An action plan would be developed following this process.

Mindfulness approaches should be included in the strategy outcomes.

The inclusion of transitions in the Strategy was positive. There were several recent developments which might be included, which would ensure the Strategy was up to date. These included the Select Health Committee report on Child and Adolescent services of 5 November 2014; the recommendations of the Health Scrutiny Committee relating to Mental Health; the consideration by the Children’s Trust Executive Board regarding mental health; and capturing young people’s views at the workshop.

Young people suffering a mental health crisis might be taken into custody, which was the wrong place for them and action was needed for the 16 to 25 age group in particular. One school had a pilot scheme, whereby specialist mental health work had taken place.

The Strategy document was not explicit about the age range which it covered. Issues concerning transition and connections needed to be highlighted. It was also considered that it would be beneficial to hold a joint meeting of the Children and Young People and Adult Mental Health Boards.

Adults in mental health crisis were also taken into custody. In cases of crisis, a person might be detained and taken to a place of safety.

Work to develop a care pathway and packages in mental health services brought with it challenges. This aimed to create an outcome based contract and pay for people in ‘clusters’ of care on the basis of need. The challenge was a financial one in that the new process could create cost pressures, and a technical one, as it was important to define outcomes in a way that could be robustly measured.

There was an attempt to focus on individual need and also examine how personal health budgets might apply to mental health.

It was clarified that the action plans would identify what was going to be done with regard to each priority.

Resolved: That the Board endorses the work of the Mental Health Partnership Board in developing the Sheffield Mental Health Strategy and supports the work of the Mental Health Partnership Board in finalising and publishing this Strategy.

7. PHARMACEUTICAL NEEDS ASSESSMENT FOR SHEFFIELD 2015-18

The Board considered a report of the Director of Public Health concerning the Pharmaceutical Needs Assessment (PNA) for Sheffield 2015-18. The Pharmaceutical Needs Assessment provided a framework to allow the strategic development and commissioning of pharmaceutical services to help meet the needs of the local population. The report provided an introduction to the PNA and presented key findings and the draft PNA was appended to the report.

Dr Jeremy Wight, the Director of Public Health, presented the report. The duty to produce a PNA was placed on Health and Wellbeing Boards by the Health and Social Care Act 2012. The first Assessment was to be produced by 1st April 2015 and in accordance with the National Health Service (NHS) (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

The PNA concluded that Sheffield was well served by pharmacies and dispensing doctors. There were good links with other NHS services. Nonetheless, it was recognised that there was potential to develop this much further, particularly in the context of developing integrated primary care services. Local pharmacies were already contributing extensively to raising awareness and understanding of health risks.

There was likely to be increased demographic and cost pressures from patients with long-term conditions and the PNA acknowledged pharmacy's continuing role in helping to meet that need. It found that further development of the public health role of pharmacy and commissioning of relevant services could secure additional improvements in health. Known future other developments were unlikely to generate a significant level of need or demand for additional pharmaceutical provision over the next 5 years.

A question was whether there were aspects of pharmacy provision of which more could be made such as developing a role in contributing to messages about the help and support which was available to people.

Resolved: that the Health and Wellbeing Board, having sought 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, notes that the final version of the Pharmaceutical Needs Assessment will be submitted to the Board for approval in March 2015.

8. BRIEFING ON PREPAREDNESS FOR WINTER AND THE EBOLA VIRUS

The Board considered a report of the Co-Chairs of the Board which provided a briefing on preparedness for winter and the Ebola Virus. The report summarised issues relating to preparedness for winter for health and social care services. This included national resilience funding to provide additional resources to target admissions avoidance and to streamline the admissions process with major providers of healthcare. There were also some complimentary projects that were often community based, which aimed to keep people well and reduce the demand on GPs and hospitals. Additional funds specifically focused on achieving the 4-hour Accident and Emergency target had been allocated to Sheffield Teaching and Sheffield Children's Hospitals by NHS England.

The Surge Planning Group, a sub-group of the System Resilience Group, had been established to facilitate knowledge of winter plans and understanding of interdependencies across the system by the respective health and social care organisations.

In respect of social care, there was a joint business continuity plan between the City Council, Sheffield Teaching Hospitals Primary and Community Services and Sheffield Health and Social Care Trust and Continuing Health Care to support existing service users and vulnerable people. Care homes had individual contingency plans in the event of an enforced emergency closure or evacuation. In relation to prevention and early intervention, Community Support Workers would liaise with GPs to identify vulnerable people and if necessary, refer them to support. The Workers would also manage a network of volunteers to support frail and vulnerable older people with no access to formal or family support. The report outlined other aspects of winter preparedness relating to social care.

The report also provided a briefing on the Ebola Virus outbreak in West Africa. Sheffield CCG and the Foundation Trusts had taken part in an exercise to test the preparedness of health services and partners for dealing with a case of Ebola and the wider consequences for communities. The Royal Hallamshire Hospital Infectious Diseases department was one of the 4 High Level Isolation Centres across the country that could, if required, receive a case of Ebola. South Yorkshire Local Resilience Forum had discussed Ebola preparedness and Public Health England had produced information and guidance.

Resolved: 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.

9. MINUTES OF THE PREVIOUS MEETING

Resolved: that the minutes of the meeting held on 25 September 2014 be approved as a correct record, subject to the following amendments:

Page 3 Paragraph 5.2, second to last bullet point: to amend the sentence "The Council had established a Green Commission to look at how the cost of energy could be reduced" so that it read "The Council had established a Green

Commission, the remit of which included fuel poverty and the cost of energy".

Page 5 Paragraph 6.7. Part 2 of the Resolution be amended after the words "service users" so as to replace the word "to" with the word "and".

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