Public Document Pack

Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 12 December 2013 at 1.45 pm

English Institute of Sport, Coleridge Road, Sheffield S9 5DA

The Press and Public are Welcome to Attend

Membership

Councillor Julie Dore	Leader of the Council
Dr Tim Moorhead	Clinical Commissioning Group
Dr Amir Afzal	Clinical Commissioning Group
Dr Margaret Ainger	Clinical Commissioning Group
Ian Atkinson	Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children, Young People and Families
Councillor Harry Harpham	Deputy Leader/Cabinet Member for Homes & Neighbourhoods
Margaret Kitching	South Yorkshire and Bassetlaw Cluster
Councillor Mary Lea	Cabinet Member for Health Care and Independent Living
Jayne Ludlam	Executive Director, Children, Young People & Families
John Mothersole	Chief Executive
Dr Ted Turner	Clinical Commissioning Group
Richard Webb	Executive Director, Communities
Dr Jeremy Wight	Director of Public Health
Pam Enderby	Healthwatch Sheffield

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, or you can ring on telephone no. 2734552. 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.

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA
Sheffield City Council ● Sheffield Clinical Commissioning Group

12 DECEMBER 2013

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. **Sheffield Health and Wellbeing Board's Plans for Integrating Health and Social Care**
To receive a presentation.

4. **Health Inequalities in Sheffield**

5. **The Confidential Inquiry into Premature Deaths of People with Learning Disabilities (2013): Its Critical Implications for Health and Health Inequalities in Sheffield**

6. **Director of Public Health Report for Sheffield 2013** (Pages 5 - 28)

7. **Better Outcomes for Children and Young People's Pledge** (Pages 29 - 32)

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

9. **Minutes of the Previous Meeting** (Pages 33 - 42)
To approve the minutes of the meeting held on 26 September 2013.

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 27 March 2014 at 2.00 pm

This page is intentionally left blank

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

New standards arrangements were introduced by the Localism Act 2011. The new regime made changes to the way that members' interests are registered and declared.

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.

Under the Council's Code of Conduct, members must act in accordance with the Seven Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership), including the principle of honesty, which says that 'holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest'.

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.

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, and has been published on the Council's website as a downloadable document at -http://councillors.sheffield.gov.uk/councillors/register-of-councillors-interests

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 Lynne Bird, Director of Legal Services on 0114 2734018 or email **lynne.bird@sheffield.gov.uk**

This page is intentionally left blank

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of: Dr Jeremy Wight, Director of Public Health

Date: 12th December 2013

Subject: Director of Public Health Report for Sheffield 2013

Author of Report: Louise Brewins, 0114 205 7455

Summary:

Directors of Public Health have a statutory duty to produce an annual report on the health of the local population. This is the first annual report since the transfer of public health from the NHS to the Council in April 2013. In this year's report we provide an overview of what the Public Health Outcomes Framework is telling us about health in Sheffield and where we need to improve on that. We then describe some of the opportunities we now have to address these public health problems. We also make a number of recommendations for taking up these opportunities.

Questions for the Health and Wellbeing Board:

Identify any areas of the report where clarification or further information is required, particularly in relation to alignment with the Health and Wellbeing Strategy or the Joint Strategic Needs Assessment.

Recommendations:

To note the information contained in the report and in particular the recommendations for improving health and wellbeing in the City. This year's report makes eleven recommendations based on an analysis of the new opportunities that now exist as a result of the transfer of public health leadership to the Council, for addressing public health problems in the City.

Reasons for Recommendations:

It is good practice for Director of Public Health reports to contain recommendations aimed at improving the health of the population.

Background Papers:

Full and summary reports can be accessed from www.sheffield.gov.uk/publichealthreport.

NEW OPPORTUNITIES: DIRECTOR OF PUBLIC HEALTH REPORT FOR SHEFFIELD 2013

1.0 SUMMARY

1.1 Directors of Public Health have a statutory duty to produce an annual report on the health of the local population. This is the first annual report since the transfer of public health from the NHS to the Council in April 2013. In this year's report we provide an overview of what the Public Health Outcomes Framework is telling us about health in Sheffield and where we need to improve on that. We then describe some of the new opportunities we now have to address some of these public health problems. We also make a number of recommendations for taking up these opportunities.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 The health of the people of Sheffield is better than it ever has been. Death rates from the major diseases continue to fall steadily. Life expectancy for men and women has improved again. It is also particularly good to see that the latest analysis of inequality in life expectancy across the City shows a narrowing of the gap for women.

2.2 Health inequalities remain a real concern however, particularly when issues such as how long people can expect to live free of disability or ill health which can limit daily life (rather than simply how long people can expect to live in either good or bad health) are taken into account. There are also a number of public health outcomes where further improvement can and should be made, especially in relation to vulnerable and at risk groups of people.

3.0 MAIN BODY OF THE REPORT

3.1 The report makes eleven key recommendations for taking up a number of opportunities for improving health and reducing health inequalities in Sheffield. Overall the aim is to capitalise on the opportunity we now have to combine public health resources with the wider reach of the Council and thus achieve a shift in focus towards prevention, a shift that is essential if services are to be sustainable.

3.2 The full report may be accessed from www.sheffield.gov.uk/publichealthsheffield A summary version is attached and is also available to download from this website. Paper versions of the summary have already been circulated to Board members although additional copies will be available at the meeting.

3.3 The 'Sheffield Health and Well Being' profiles for each of the 28 electoral wards have also been updated. These may be accessed via the DPH report website alongside a range of other health and wellbeing ward and neighbourhood based information.

4.0 QUESTIONS FOR THE BOARD

4.1 Identify any areas of the report where clarification or further information is required, particularly in relation to alignment with the Health and Wellbeing Strategy or the Joint Strategic Needs Assessment.

5.0 RECOMMENDATIONS

5.1 To note the information contained in the report and in particular the recommendations for improving health and wellbeing in the City.

6.0 REASONS FOR THE RECOMMENDATIONS

6.1 It is good practice for Director of Public Health reports to contain recommendations aimed at improving the health of the population.

6.2 Recommendations have been made in areas where there is particular scope to improve the health of the people of Sheffield through combining public health expertise with the scale and outreach of the City Council.

DIRECTOR OF PUBLIC HEALTH REPORT FOR SHEFFIELD 2013

New Opportunities

DIRECTOR OF PUBLIC HEALTH REPORT FOR SHEFFIELD 2013

Contents

1. Introduction 4
2. The Public Health Outcomes Framework ..8
3. New Opportunities 14
   - The early years 14
   - Vulnerable children and young people 16
   - Sexual health 17
   - Physical activity 19
   - Tobacco control 19
   - Older people's wellbeing 20
   - Healthy communities 21
   - Mental health and wellbeing 23
   - Reducing alcohol consumption 24
   - Health and work 25
   - Health checks 26
4. Recommendations 28
   - Progress on 2011 recommendations 28
   - Recommendations for 2013 30
5. Health and wellbeing across Sheffield 33

More information 36

1 Introduction

This is my first annual report since the transfer of public health leadership at local level from the NHS to the City Council. That transfer was justified by the observation that the root causes of the health of populations are much more readily influenced by local authorities than by the NHS. In Sheffield, the City Council has adopted a vision for public health that welcomes its new role and responsibilities. It makes a commitment to 'turn the Council into a public health organisation, so that every contact the Council has with the people of Sheffield is designed to have a positive impact on their health'.[1] Despite the unprecedented financial challenges facing it, by combining public health expertise with the resources available, the Council now has great opportunities to address the causes of the causes of ill health, and so turn that vision into reality. I want to show in this report what some of those opportunities are.

In past years, as a report "on the health of the population" Director of Public Health annual reports were the place where health data – mortality rates, vaccination coverage, etc. – were published for the first time. This is no longer the case, as that is all published elsewhere. Public Health Outcomes Framework (PHOF) indicators are available online and frequently updated.[2] Health data for Sheffield are brought together in our Joint Strategic Needs Assessment. People no longer need to turn to the Director of Public Health's annual report to find this information.

What the Director of Public Health report can and should do is provide intelligence and understanding to complement the data and information that is available elsewhere. In so doing it can highlight the most important public health problems we face, set out how they can be addressed, and make recommendations for doing so.

So we start by providing an overview of the health of the people of Sheffield, based on the Public Health Outcomes Framework (PHOF) indicators. The two overarching indicators of the public's health, which are included in the Public Health Outcomes Framework, are healthy life expectancy and differences in healthy life expectancy between communities.[3] Unfortunately, local data for these are not yet available. We do, however, have other measures that are closely related.

Disability free life expectancy at age 16 is the number of years that a person of that age can expect to live without disability (which for this purpose is defined as living without self-reported illness or disability that limits their daily activity). In Sheffield, the disability free life expectancy for young men at 16 is 45.8 years, indicating that on average they can expect to live free of disability until approximately age 62. Overall life expectancy at 16 is, however, a further 62.4 years, indicating that they can expect to live until age 78. The difference of 16 years between life expectancy (78 years) and disability free life expectancy (62 years) indicates that the last 16 years of life are spent with disability.

For young women at age 16 in Sheffield the figures are 45.4 years for disability free life expectancy, and 66 years for life expectancy overall. This means that they can expect to become disabled at the same age as men (the difference between 45.4 and 45.8 years for disability free life expectancy is not significant), but because overall life expectancy is longer, they can expect to live the last 20 years of their lives disabled.

We are all too familiar with the differences in life expectancy that exist across the different communities in the City, but the differences in disability free life expectancy are significantly greater. Whereas the slope index of inequality for life expectancy (the best single measure of differences in life expectancy between different people in any population) is 8.7 years for men, and 7.4 years for women (see chapter 2), the slope index of inequality for disability free life expectancy is nearly twice as much: 15.6 years for men, and 14.5 years for women. This means that not only do people from disadvantaged communities die earlier than those from better off backgrounds, but they live for a longer period with disability before dying.

So Sheffield, like the rest of the Country, is very unequal. Socio-economic differences between different sectors of the population are the root cause of health inequalities. This is why the report of Sheffield's Fairness Commission[4] is a key document for public health in the City. Because we recognise that every part of the Council can have an impact on the root causes of ill health – poverty, poor educational achievement, unemployment, social capital, poor housing, poor air quality etc. - we have designed the new public health arrangements in a way that is intended to make the most of the opportunities we now have, and hence have the maximum beneficial impact on the health of the public.

TO HAVE A POSITIVE IMPACT ON PEOPLE'S HEALTH.

1 http://meetings.sheffield.gov.uk/council-meetings/cabinet/agendas-2012/agenda-25th-january-2012 (Item 11) | 2 www.phoutcomes.info/ | 3 Life expectancy, usually expressed as life expectancy at birth, is the length of time someone can be expected to live. Healthy life expectancy is the length of time someone can be expected to live in good health.

4 https://www.sheffield.gov.uk/your-city-council/policy--performance/fairness-commission.html

HEALTH SERVICES DO MAKE A SIGNIFICANT CONTRIBUTION TO POPULATION HEALTH.

Rather than simply transfer the public health team into a single directorate within the Council, we have put in place a "distributed" model that places public health expertise at a senior level in each of the three service Portfolios. Along with the specialist public health staff, the bulk of the public health financial resource has also been distributed to the Portfolios, in order for them to use this human and financial resource to address the City's public health problems. Each Portfolio has been made explicitly responsible for ensuring that the City makes progress against certain of the Public Health Outcomes Framework indicators. In doing this, the full resources of the Council (not just the relatively small amount of the public health grant) should be brought to bear on the problems that we face.

However in recognising the importance of the Council's contribution to improving health in the City, we must not forget the very important contributions that the NHS can and will continue to make. Health services do make a significant contribution to population health, and although the public health team has transferred out of the NHS, we will continue to work closely with NHS commissioners (the Sheffield Clinical Commissioning Group and NHS England Local Area Team) and providers of services to maximise the impact of clinical health services on Sheffield's health.

Specialist public health advice to the Clinical Commissioning Group is led by a team co-located within their offices, supported as necessary by other public health staff based in Portfolios. The NHS England Local Area Team also has an important public health role in commissioning vaccination and immunisation, and screening programmes, as well as primary care. We will continue to monitor these, and seek regular assurance that these programmes are delivered safely and effectively.

Chapter two of this report gives an overview of what the Public Health Outcome Framework indicators are telling us about the health of Sheffield, and where we need to work to improve that. We highlight both indicators where the City is doing less well than the rest of the Country, or other Core Cities, as well as those indicators (such as breastfeeding or smoking) where we are no worse than other areas, but nevertheless there is great health gain to be made if we were to improve.

Chapter three then describes some of the new opportunities that we now have to address some of these public health problems. The Council has adopted a public health vision for the City and committed itself to becoming a public health driven organisation, in order to improve health and wellbeing for all. It is by taking up the kind of opportunities described here, and others, that this will actually happen.

Chapter four reports on progress made in implementing recommendations that I have made in previous years' reports, and **chapter five** contains ward and neighbourhood health and wellbeing data and tools.

Our distributed model of public health has undoubtedly brought challenges with it, but I believe it provides us with the best opportunity to address the City's public health problems by harnessing the full power of the Council. The Council as a whole does, of course, face some very significant challenges, not least because of the huge reductions in the resources available as a result of cuts in the revenue support grant. But that makes it all the more important that we prioritise, and properly resource, public health initiatives that prevent ill health, and so reduce demand on Council (and NHS) services and the scale of those challenges in the future. Failure to invest in specialist public health staff, with expertise in assessing, designing and delivering preventive interventions, would be seriously short sighted.

THE COUNCIL IS COMMITTED TO BECOMING A PUBLIC HEALTH DRIVEN ORGANISATION.

Jeremy Wight
Director of Public Health

The Council is going through changes that will over the space of a few years turn it into a very different organisation than in past decades. The addition of public health to its many responsibilities is not, however, just an add-on. Specialist public health skills can and should be used to help shift the focus of Council business much more towards prevention, a shift that is essential if services are to be sustainable. The new Council will be shaped by the Strategic Outcomes it has chosen, and public health has an important contribution to make to each of these.

The last year has brought enormous changes and challenges for public health in Sheffield, as in the rest of the Country. It has not been an easy year, and I am enormously impressed with the way that the public health teams have continued to work so hard despite all the organisational and personal upheaval. I am very grateful to them all for this.

I hope you enjoy reading this report.

Acknowledgements

As always, the writing and production of the Director of Public Health's annual report has been a collaborative effort. I am extremely grateful to the various public health and other supporting staff who have contributed sections or otherwise helped to produce this report. Without them it would not, of course, have been possible. Responsibility for the content rests with me.

Jeremy Wight
Director of Public Health
October 2013

2 The Public Health Outcomes Framework

The Public Health Outcomes Framework is a new national set of indicators designed to help councils identify how well they are doing in relation to improving the health of their local population. In this chapter we look at what the Public Health Outcome Framework indicators are telling us about the health of Sheffield, and where we need to work to improve that. We highlight the indicators where the City is doing less well than the rest of the Country as well as those indicators where, although we are no worse than other areas, there is great health gain to be made if we were to improve.

Page 13

Life expectancy

There are two over-arching indicators in the Public Health Outcomes Framework (PHOF) that focus on life expectancy. The intention is that these will be based on healthy life expectancy, or how long someone can expect to live in good health. The figures for these indicators are not yet available. For our analysis of the PHOF therefore, we focus on general life expectancy, which is defined as the length of time someone can be expected to live (in either good or bad health).

Life expectancy for both men and women in Sheffield is improving year on year. For men (in the three years 2009-2011) life expectancy at birth was 78.4 years and for women 82.1 years. As the graph in Figure 1 shows however, life expectancy in Sheffield still falls short of the England average of 78.9 years for men and 82.9 years for women.

A different picture of health emerges however when we look at the gap (or inequality) in life expectancy between the most and least deprived people in Sheffield. This indicator is known as the 'slope index of inequality in life expectancy'. Figure 2 shows the gap in life expectancy between the most and least deprived men in Sheffield and Figure 3 the gap for the most and least deprived women. For men the gap has recently remained relatively static following a narrowing trend. The gap now stands at 8.7 years (2009-2011). For women, the gap has recently narrowed, following a period of widening, and currently stands at 7.4 years (2009-2011). Both gaps are wider than the national average.

This represents a significant health inequality. Socio-economic differences between different sectors of the population are the root cause of health inequalities. This is why Sheffield's Fairness Commission, and the report it produced earlier this year, is such an important document for improving public health in the City.

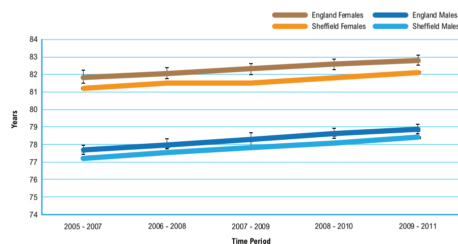
In addition to the over-arching life expectancy indicators, the Public Health Outcomes Framework contains over 60 indicators that cover the spectrum of public health: the wider determinants of health, health improvement, health protection and preventable mortality. Taken together, the indicators are intended to provide an overview of how long people live and how healthy they are at all stages of life.

The following table (pages 10 -12) sets out the indicators where Sheffield is doing less well than the rest of the Country as well as those indicators where, although we are no worse than other areas, there is great health gain to be made if we were to improve. For each indicator we provide details of our position relative to England (and other major cities in the Country) and the opportunities for improvement.

Overall Sheffield's health compares well with the national average and is often the best when compared with other similar cities. Nevertheless, as this chapter highlights, there is still considerable potential for improvement.

LIFE EXPECTANCY IS IMPROVING YEAR ON YEAR.

Figure 1
Life Expectancy at birth



Source: Public Health Intelligence Team, Sheffield City Council

Figure 2
Slope Index of Inequality: Male Life Expectancy at Birth, Sheffield

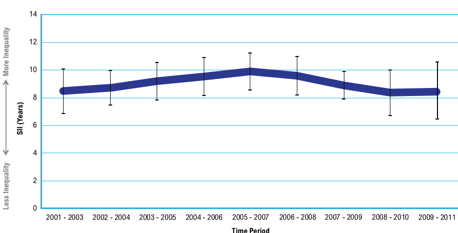


Figure 3
Slope Index of Inequality: Female Life Expectancy at Birth, Sheffield

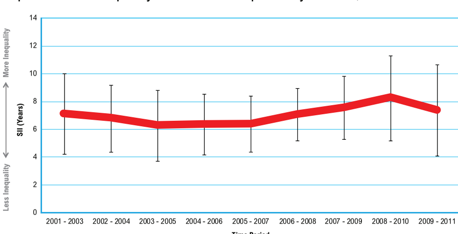


Figure 2 and 3 source: PH Births, April PHR Snapshots, PH Mortality (Year of registration), IMD2010 Deciles. Shows 95% confidence intervals around the SII gap.

Produced by Public Health Intelligence Team, SCC,19/09/2013.

PHOF Indicator	Sheffield Position	Opportunities for improvement
Child poverty **PHOF Indicator 1.1** The proportion of children living in households where income is less than 60% of median household income before housing costs.	Just over 24% of Sheffield children live in poverty compared with 20.6% nationally - this is significantly higher than the national position	The Council is actively implementing its Child Poverty Strategy to address the anticipated impact of welfare changes on the poorest families with children
Pupil absence **PHOF Indicator 1.3** The proportion of half days missed (authorised and unauthorised) by primary and secondary school pupils	In 2011-2012 was 5.5% in Sheffield compared with 5.1% in England - this is significantly higher than the national position.	This figure has been steadily reducing and is expected to come into line with the England average over the next few years.
16-18 year olds not in education, employment or training **PHOF Indicator 1.5**	7.7% of Sheffield's 16-18 year olds were not in education, employment or training in 2012 compared with 5.8% nationally. This is significantly higher than the England average although our position is improving.	Youth unemployment has been identified in our Joint Strategic Needs Assessment as a key priority for the Health and Wellbeing Strategy[5] to address.
Re-offending **PHOF Indicator 1.13** The percentage of offenders who re-offend from a rolling 12 month cohort.	The rate of re-offending has remained static over the last few years. Latest data (2010) indicate Sheffield is significantly higher than the England average at 28.2% compared with 26.8% but one of the lowest out of the eight biggest cities in the Country.	Work has recently commenced on an in-depth health needs assessment of offenders' health in South Yorkshire and this will be used to identify recommendations for improvement.
Homelessness acceptances **PHOF Indicator 1.15** Statutory homeless households, crude rate per 1,000 estimated total households, all ages.	The Sheffield rate of 5.1 per 1,000 households (2012-13) is significantly higher than the England average of 2.4 per 1,000.	Sheffield's homeless strategy identifies the local approach to reducing the impact of homelessness on the most vulnerable in our society. Our Joint Strategic Needs Assessment[6] recognises the need to address this disparity.
Social isolation **PHOF Indicator 1.18** The percentage of people who participated in the national Adult Social Care Users Survey who said they had as much social contact as they wanted with people that they liked.	For 20011 - 2012, only 41.3% of Sheffield respondents considered they had enough social contact with people they liked compared with 45.8% nationally.	Social care and other council services can make a significant contribution to tackling loneliness and social isolation, by supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. This is identified as a particularly important factor in taking forward our approach to improving mental health and wellbeing in the City.
Teenage conceptions **PHOF Indicator 2.4** Conceptions in women under 18 years per 1,000 females aged 15-17 years.	The City rates have reduced from 52.8 per 1000 in 2001 to 35.2 per 1000 in 2011. This is still significantly higher than the national average of 30.7 per 1000.	Continued implementation of Sheffield's Teenage Pregnancy Action Plan is identified as the priority for maintaining further reductions in the City's teenage pregnancy rate.

5 https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html
6 https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA/positionstatement.html

Page 14

PHOF Indicator	Sheffield Position	Opportunities for improvement
Health checks **PHOF Indicator 2.22** The percentage of eligible population aged 40-74 offered and taking up an NHS Health Check.	As at 31st March 2013, 40.8% of the annual eligible population in Sheffield who had been offered a health check had taken it up. This is significantly below the national average of 49.1%.	This position will improve in 2013-14 when all of our GP practices (where relevant) will be delivering the programme. Latest data for August 2013 shows take up had increased to 44%.
Breastfeeding **PHOF Indicator 2.2** The percentage of infants that are totally or partially breastfed at age 6-8 weeks.	50.8% of Sheffield babies in 2012-13 were being breast fed at 6-8 weeks after birth. Whilst much better than the national average, this position has remained virtually unchanged over the last 4-5 years, and almost a third of babies breast fed at birth are no longer breastfeeding at 6 to 8 weeks.	The need to increase breastfeeding even further is identified as a priority within the Council's health improvement and commissioning plans.
Obesity in 10 and 11 year olds **PHOF Indicator 2.6** Proportion of children in Y6 (aged 10-11 years classified as over-weight or obese).	Data for 2011-2012 indicate that around a third of all 10-11 year olds in Sheffield are overweight or obese. This is much too high.	The previously rising trend in childhood obesity has stopped as a result of the Sheffield 'Let's Change for Life' programme. There is still further improvement needed though and this is why it remains a priority for our health improvement plans for the future.
Smoking **PHOF Indicator 2.14** Prevalence of smoking among persons aged 18 years and over	Latest estimates for 2011-2012 indicate that 21.6% of Sheffield people aged over 18 years smoke compared with 20% nationally	Reducing the prevalence of smoking must continue to be a top public health priority and will be taken forward as part of the Tobacco Control Programme.[7]
Childhood vaccination and immunisation **PHOF Indicator 3.3** Several indicators are used to measure coverage for a number of conditions.	Sheffield is either doing significantly better than or similar to the national average on all the indicators for uptake in the children's vaccination and immunisation programme.	Responsibility for commissioning this programme (and similar programmes for adults) transferred to NHS England on 1st April 2013. It is part of the Director of Public Health's responsibility to hold NHS England to account for safe and effective delivery of the programme in the local area.
Mortality attributable to air pollution **PHOF Indicator 3.1** Overall mortality burden estimated to be attributable to long term exposure to particulate (human made) air pollution (2010-2012)	In Sheffield this is likely to be equivalent to between 230 and 290 deaths per year.[8] Whilst this is similar to England, these deaths are almost all entirely preventable and are unequally distributed across the City.	Sheffield's Air Quality Action Plan aims to improve air quality and it is important that this is delivered comprehensively across the City but with particular attention being paid to those communities most at risk.

7 Tobacco control programmes include protecting people from exposure to second hand smoke, reducing the availability and supply of illegal tobacco products and help for those who want to quit.
8 Committee on the Medical Effects of Air Pollution (2012) Statement on estimating the mortality burden of particulate air pollution at the local level – 95% confidence interval range shown.

PHOF Indicator	Sheffield Position	Opportunities for improvement
Late presentation of people with HIV **PHOF Indicator 3.4** Percentage of adults (aged 15 years or more) newly diagnosed with HIV CD4 counts available within 91 days and indicating a count of less than 350 cells per mm3	A little under half of all patients newly diagnosed with HIV in Sheffield are diagnosed late. Whilst similar to the picture nationally, the concern is that 90% of deaths within 1 year of diagnosis are in those who are diagnosed late.	The City's Sexual Health Commissioning Strategy represents a coordinated approach to developing a comprehensive sexual health system. This will include increasing access to early HIV testing.
Premature mortality from all cancers **PHOF Indicator 4.5** Age-standardised rate of mortality from all cancers in people under 75 years of age per 100,000 population.	Almost 42% of all premature deaths in the City are caused by cancer. This makes it the leading cause of death in people under 75. Despite a reduction over the last 10-20 years, Sheffield's rate remains significantly higher than the national average.	Over half of all premature deaths from cancer are considered preventable. A large number of cancer deaths before age 75 could be prevented by changes in lifestyle (such as stopping smoking), as well as by earlier detection and treatment.
Premature mortality from cardiovascular disease (CVD) **PHOF Indicator 4.4** Age-standardised rate of mortality from CVD in people under 75 per 100,000 population.	The premature mortality rate has fallen year on year in Sheffield, and at a faster pace than nationally. Nevertheless although the gap between Sheffield and the rest of the Country has narrowed, the rate remains significantly higher than the national average	Over two thirds of premature mortality associated with CVD is preventable. The NHS Health Check programme, together with timely prevention and early intervention are anticipated to bring further improvements in this area over the next few years.
Premature mortality from respiratory disease **PHOF Indicator 4.7** Age-standardised rate of mortality from respiratory disease in people under 75 per 100,000 population.	Respiratory disease is the third leading cause of premature death in Sheffield. Approximately 70 respiratory deaths per year are preventable.	The single most important factor in taking action to reduce this will be implementation of the Council's Tobacco Control Programme (to reduce the level of smoking).
Premature mortality from liver disease **PHOF Indicator 4.6** Age-standardised rate of mortality from liver disease in people under 75 per 100,000 population.	Liver disease is the only major cause of premature death for which the rate is increasing. Premature mortality from liver disease accounts for just over 70 deaths in people under the age of 75 years per year. Over 90% of these are preventable.	The common avoidable causes of liver disease are alcohol consumption and obesity, both of which are amenable to public health interventions.
Preventable sight loss **PHOF Indicator 4.12** Visual impairment due to age related macular degeneration (over 65s), diabetic eye disease (over 12s) or glaucoma (over 40s) per 100,000 population	There are approximately 160 cases of preventable sight loss per year. Rates are increasing and are higher than the average for England	One of the key priorities for achieving improvements in this area is to increase take-up of sight tests, especially among vulnerable and high risk groups such as the elderly, deprived people and Black and minority ethnic communities.

THERE ARE SIGNIFICANT OPPORTUNITIES FOR IMPROVING PUBLIC HEALTH IN SHEFFIELD.

3 New Opportunities

Since the implementation of the 2012 Health and Social Care Act it is the Council's responsibility to improve health and wellbeing in the local population. Combining specialist public health skills and resources with the Council's scale and reach opens up new and extensive opportunities to do this. In this chapter we feature examples of these opportunities from each of the Council's service portfolios - Children, Young People and Families, Communities and Place.

3.1 The early years

Context

There is now overwhelming evidence that conception through to the early years is a crucial phase of human development and is the time when focussed attention can bring rewards for society.[9] Supporting parent-infant relationships is a priority for Sheffield. We know that the mental and physical health of mothers during and immediately after pregnancy can have lifelong impacts on the child. Factors such as nutrition, smoke exposure and decisions about immunisation will impact on the child's future health and wellbeing.

Sheffield performs well when compared with other cities for some outcomes but there are those, such as Early Years Foundation Stage Attainment, that remain a challenge. For all of these outcomes there are variations within the City both by geography and by communities of interest.

Opportunities

Through public health moving into the Council, a number of programmes to improve outcomes in the early years have been brought together. These include: Pregnancy and Early Years Health Champions; the Doula project; and Breastfeeding Peer Support. This provides the opportunity to develop a more integrated holistic model for whole system change to achieve better health outcomes such as improved breastfeeding rates.

Development of proposals for the lottery funded Fulfilling Lives: A Better Start programme provides an opportunity to use this to develop a citywide strategy for investment in evidence based prevention in the early years. This would be based on effective partnerships between families, communities and organisations, ensuring infants and their families receive the best possible support in all the contacts they receive.

The Council now has the explicit lead responsibility for the health of the children of Sheffield. It also now has the opportunity to use public health skills to articulate the case for a shift in resources towards prevention and to help to design and implement whole system change to bring this about.

Outcomes

If this opportunity is taken forward we would expect to see the following outcomes:

- better social and emotional development in children (PHOF Indicator 1.2)
- improved educational attainment, increased aspirations and improved job

9 Wave Trust, (2013) Conception to age 2 – the age of opportunity.

THE COUNCIL HAS THE OPPORTUNITY TO USE THE SKILLS THAT PUBLIC HEALTH STAFF BRING.

prospects (PHOF Indicators 1.3 and 1.5)

- healthier and happier children, for example, reduced infant mortality (PHOF Indicator 4.1), reduced smoking, alcohol and substance misuse, reduced levels of obesity (PHOF Indicator 2.6), improved emotional health and wellbeing (PHOF Indicator 2.8)
- reduced aggression, crime and antisocial behaviour into adulthood (PHOF Indicator [illegible])

Page 17

Recommendation

The Council should use proposals developed as part of the Fulfilling Lives: A Better Start bid to inform focussed investment in the early years and evidence based prevention and early intervention.

3.2 Vulnerable children and young people

Context

The Sheffield Every Child Matters Survey (ECM 2012) identified that the number of Y10s (14 and 15 year olds) saying they feel sad or depressed 'most of the time' has increased from 9% in 2011 to 14% in 2012. The main reasons given were problems at home and feeling unable to cope with things.

Vulnerable young people in Sheffield are now able to access Community Youth Teams (CYTs) to help them access education, training and employment, and reduce offending as well as providing a range of health promotion interventions. In the last 18 months 'Youth Justice Liaison and Diversion' and 'Ending Youth and Gang Violence' government initiatives have enabled CYTs to develop specific health assessments and interventions to reduce the number of first time entrants to the youth justice system, the number of young people not in education, employment or training, and youth violence.

Opportunities

The move of public health into the Council provides opportunities to integrate the work done by different partners addressing vulnerability. This includes work with looked after children, those engaged in Youth Justice and those not in education, employment or training. Services to support children and young people's emotional wellbeing and mental health need to be developed further. This will involve designing and commissioning a prevention and early intervention emotional wellbeing and mental health service to develop resilience in children and young people and provide them with access to counselling support.

In doing this, the Council now has the opportunity to use the skills that public health staff bring in reviewing the evidence of effective interventions, and bringing together partners to provide a consistent offer, based upon need, available to all children and young people. The Council has a proven track record for involving children and young people and engaging them in consultation. There is now an opportunity to incorporate the information that comes from this with the existing evidence base to ensure that services are needs led and outcome focussed.

Outcomes

There is evidence that integrated delivery supports vulnerable young people by:

- reducing the proportion of young people not in education, employment or training (PHOF indicator 1.5)
- improving emotional health (PHOF Indicator 2.8)
- improving family functioning
- reducing offending behaviours (PHOF indicator 1.4)
- reducing risk taking behaviours such as substance or alcohol misuse and risky sexual activity (PHOF indicator 3.2).[10]

Recommendation

The Children and Young People's Joint Commissioning Group should lead the redesign and commissioning of a universal prevention and early intervention emotional wellbeing and mental health service for children and young people, to commence April 2014.

10 Wave Trust, (2013) Conception to age 2 – the age of opportunity.

AN OPPORTUNITY TO PLAY A CLEAR LEADERSHIP ROLE IN IMPROVING SEXUAL HEALTH OUTCOMES.

3.3 Sexual health

Context

The consequences of poor sexual health can be serious, including unwanted pregnancy, avoidable illness including HIV/AIDS, and even death. Treatment of sexually transmitted infections (STIs) prevents them spreading, so these are preventive services. In Sheffield, poor sexual health is concentrated amongst those who are the most vulnerable, including men who have sex with men, young people and minority ethnic groups.

Sheffield was ranked 83rd highest (out of 326 local authorities) in England for rates of STIs in 2011. In that year, 4350 acute STIs were diagnosed in Sheffield residents, a rate of 783.1 per 100,000. 70% of these were amongst 15-24 year olds.[11] The Framework for Sexual Health Improvement in England (2013) highlights both the clinical and cost effectiveness of implementing integrated models of sexual health services.

Useful information on young peoples' views of sexual health services is available from the Every Child Matters survey. This has been used to inform our overall approach to commissioning these services.

Opportunities

The Council now has statutory responsibility for commissioning the majority of sexual health services. It therefore has an opportunity to play a clear leadership role in improving sexual health outcomes and reducing sexual health inequalities by commissioning services differently through cross portfolio working, jointly developed service specifications and aligning of budgets. Sheffield's Joint Strategic Needs Assessment recommends focusing on reducing the number of teenage conceptions, unplanned pregnancies, and the incidence of STIs in high risk groups.

Sexual health commissioning is led by the Children, Young People and Families Portfolio of the Council, while the Communities Portfolio commissions sexual health promotion and prevention activity using the Aids Support Grant. A multi-agency HIV Task Group has already been established with representation from the Council. This group aims to increase access to early HIV testing through targeted outreach work and campaigns, and will inform future commissioning of HIV prevention and treatment services through consultation with service users.

The Council is also well placed to address the wider determinants of sexual health. For example the Citywide Learning Board can champion the delivery of comprehensive Personal, Social and Health Education in schools and colleges. The Council's Children, Young People and Families (CYPF) Portfolio can commission targeted sexual health interventions for looked after children, teenage mums and vulnerable young people. There are opportunities for the planning and licencing teams in the Council's Place Portfolio to work with saunas and parlours across the City and to have a single commissioning approach to supporting women working in street prostitution.

Outcomes

Taking the opportunities outlined above should lead to:

- a reduction in teenage conceptions (PHOF Indicator 2.4)
- increased detection and treatment of STIs amongst women working in street prostitution and/or in the City's saunas and parlours (PHOF Indicators 2.21, 3.2 and 4.8)
- reduced HIV transmission and hence incidence of new cases (PHOF Indicators 3.4 and 4.8)

11 HPA Sheffield Local Authority sexually transmitted infections epidemiology report: 2011.

SHEFFIELD OFFERS UNRIVALLED OPPORTUNITIES FOR BEING PHYSICALLY ACTIVE.

Recommendation

The Council should continue to develop a comprehensive sexual health system for the City, including targeted action to increase chlamydia screening and access to early HIV testing, and to reduce teenage conceptions. There should be appropriate input from all Portfolios for this work.

3.4 Physical Activity

Context

Only 54.6% of Sheffield adults achieve the recommended 150 minutes of at least moderate intensity physical activity per week; and 30.4% of adults are physically inactive. Sedentary behaviour is said to be becoming the 'silent killer'[12] with an estimated 6-10% of all deaths from the major non-communicable diseases being attributed to physical inactivity.[13] People should be encouraged to build physical activity into their daily lives making simple changes i.e. using stairs instead of taking lifts, taking active breaks and reducing the amount of time they spend being sedentary.

Opportunities

With the transfer of public health to the Council, responsibility for the health of the population, and the ability to improve it through encouraging physical activity, now rest with the same organisation.

Planning applications should prioritise the need for all people to be physically active by building activity into their daily life. Local facilities should be accessible on foot, bicycle or other active modes of transport. The Highways PFI can deliver wider social and public health benefits by ensuring pedestrians and cyclists are given the highest priority. Safer routes to school can be developed to promote active travel for children, young people and their families. Sheffield also offers unrivalled opportunities for being physically active and is clearly a 'green' City with a third of the City located within the Peak District National Park, 78 parks and 4,000 ha of woodland.

Outcomes

Increasing population wide levels of physical activity will lead directly to improvement in the following Public Health Outcome Framework indicators:

- Percentage of physically active adults (PHOF Indicator 2.13i),
- Percentage of physically inactive adults (PHOF Indicator 2.13ii)
- Utilisation of green space for health/exercise reasons (PHOF Indicator 1.16)
- Percentage Children in YR (age 4-5) overweight or obese (PHOF Indicator 2.6i)
- Percentage Children in Y6 (age 10-11) overweight or obese (PHOF Indicator 2.6ii)
- Excess weight in adults - overweight or obese (PHOF Indicator 2.12)
- Sickness absence rates (PHOF Indicator 1.9)
- Rates of recorded diabetes (PHOF Indicator 2.17)
- Mortality attributable to air pollution (PHOF Indicator 3.1)
- Under 75 preventable mortality from cancers (PHOF Indicator 4.5ii)
- Under 75 preventable mortality from cardiovascular disease (PHOF Indicator 4.4ii)

Recommendation

The Council should systematically prioritise initiatives to encourage Sheffield people to 'Move More', making being physically active the norm by building physical activity into their daily life.

3.5 Tobacco control

Context

21.6% of the Sheffield adult population smokes. Smoking is Sheffield's single greatest cause of preventable illness and early death. A recent review of the tobacco control programme across South Yorkshire highlighted that although there has been progress on reducing rates of smoking, this has slowed.

12 DH, Physical Activity, Health Improvement and Protection (2011) Start Active Stay Active. A report on physical activity for health from the four home countries Chief Medical Officers.

13 Min Lee I, Shiroma EJ et al. (2012) Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. The Lancet, Volume 380, Issue 9838, Pages 219 - 229, 21 July 2012

For some years, approaches to reducing smoking have centred on helping people to quit via accessible stop smoking services in line with national quit target requirements, rather than other tobacco control actions. Whilst stop smoking services are an effective part of tobacco control, a more comprehensive commissioned tobacco control programme, in line with the World Health Organisation's 'six strands approach', is required to reduce smoking prevalence.

Opportunities

Local authorities have always played an important role in the enforcement of Smokefree legislation and action on cheap and illicit tobacco. The Council is now also responsible for planning, commissioning and delivering many tobacco control interventions. This includes:

- continuing to work in partnership with Trading Standards to implement the Sheffield 'cheap and illicit tobacco action plan'
- working with the Council Housing Service to embed the Smokefree Homes and Cars scheme into routine practice as a way to reduce exposure to second-hand smoke
- working with colleagues in Licensing to support and educate local businesses and key stakeholders on legal requirements for shisha tobacco premises

Overall impact can be maximised by implementing a commissioning strategy which involves:

- stop smoking support which prioritises action amongst population groups most likely to smoke
- enforcement related to cheap and illicit tobacco
- activities to prevent uptake of smoking
- communications and social marketing
- promotion of smoke free homes, cars and public spaces

Outcomes

Taking these opportunities should lead to substantial health gain, with improvement in a wide range of Public Health Outcome Framework indicators over and above a reduction in smoking prevalence itself (PHOF Indicator 2.14). These will include:

- child poverty (PHOF Indicator 1.1)
- sickness absence rates (PHOF Indicator 1.9)
- low birthweight babies (PHOF Indicator 2.1)
- infant mortality (PHOF Indicator 4.1)
- under 75 mortality from causes considered preventable (PHOF Indicator 4.3)

Reduction in smoking will also contribute towards the overarching PHOF indicators of healthy life expectancy and differences in life expectancy and healthy life expectancy between communities.

Recommendation

The Council should fully support a citywide programme to reduce the availability and supply of illicit tobacco, which will include targeted enforcement action by Trading Standards.

THE OVER 80'S IN SHEFFIELD ARE EXPECTED TO TREBLE IN NUMBER OVER THE NEXT 25 YEARS.

3.6 Older People's Wellbeing

Context

The over 80s, who make up the fastest rising population group in Sheffield, are expected to treble in number over the next 25 years. Substantial increases in the number of care home residents, and care homes needed to support this population, can affect the social and economic characteristics of a local community. Consequently, there are concerns about the current relationship between care homes and the communities where they are located.

The more innovative providers have come to recognise that the current model of a care home is not sustainable. Instead, care homes are regarded as part of a community. This not only brings benefits to the residents themselves, but also opportunities for the wider community to benefit from the resource.[14] The Council sees change in care homes in the context of its wider strategic aim for improving the lives of older people wherever they live.[15]

Opportunities

The transfer of public health to the Council provides an opportunity to connect the role of the care home with other community based services. This has the potential to reduce social isolation, improve wellbeing and contribute towards a stronger community infrastructure. There is now an opportunity for Council staff, who are working to develop care homes as community resources, to work with public health colleagues on this agenda. There are also opportunities to use health needs assessment skills to undertake a systematic approach to analysing the needs of care home residents as part of the planning process. Approaches such as Five Ways to Wellbeing,[16] the Settings Approach[17] or the Life Story Approach[18] provide an opportunity to connect the role of the care home with other community based services.

Outcome

Developing care homes as a community resource will improve the following Public Health Outcome Framework indicators:

- Social isolation (PHOF Indicator 1.18)
- Self- reported wellbeing (PHOF Indicator 2.23)
- Injuries due to falls in people aged 65+ (PHOF Indicator 2.24)
- Health related quality of life for older people (PHOF Indicator 4.13)

Recommendation

The Council should use the Care Homes Well Being Needs Assessment, currently in preparation, to inform commissioning priorities for people who live in care homes. In addition, the Council should take further steps to address isolation and loneliness by working with the NHS to build on the community support worker model, and the Lowedges, Batemore and Jordanthorpe pilot.

3.7 Healthy communities

Context

Despite the improvement in absolute levels of health, the less well-off neighbourhoods in Sheffield are characterised by lower life expectancy, high levels of chronic disease and significantly higher overall levels of anxiety and depression.

The Healthy Communities Programme addressed these inequalities by employing a model of health which built on the skills and talents of local people and the assets within communities. Commissioning voluntary sector organisations

14 Waddicor, H., (2013), Care Home Market & Fees Analysis 2013-14 | 15 A City for all Ages – Making Sheffield a Great Place to Grow Older
16 http://neweconomics.org/projects/five-ways-well-being | 17 Health Service Executive 2011, The Health Promotion Strategic Framework | 18 www.lifestorynetwork.org.uk

DEVELOPING THE PUBLIC HEALTH ROLE OF FRONTLINE COUNCIL STAFF WILL HELP TO 'MAKE EVERY CONTACT COUNT'.

MENTAL ILL HEALTH AND POOR MENTAL WELLBEING ARE MAJOR COMPONENTS OF HEALTH INEQUALITIES.

to provide this programme helped to connect individuals and organisations, and enabled access to a range of community services in a one stop shop approach. Interventions to increase awareness of health inequalities and develop the public health role of frontline Council and other staff were also achieved by the Healthy Communities team through Making Every Contact Count and Training the Trainers courses.

Following transfer of public health to the Council, local councillors have developed a social model of health and reviewed the Healthy Communities Programme with regard to this model. The key elements of the review include a strengthened locality approach, development of social capital in the most deprived communities, and investment addressing the 'root causes' of ill health.

Opportunities

The Council's Communities Portfolio has significant opportunities to address health inequalities. Developing the public health role of Council staff would provide a large workforce with skills to deliver public health messages and interventions as part of their day to day work. The new model for housing staff – 'Housing plus' – would be a good example of this. This can be achieved by developing a public health workforce strategy as part of the Council's organisational development strategy, and using public health staff to develop their colleagues. Using the skills, experience and contacts of the Healthy Communities staff in the Council's new locality model would enable that to be used to develop social capital and increase community resilience.

Outcomes

The specific Public Health Outcome Framework indicators that would be improved are:

- social isolation: (PHOF Indicator 1.18)
- gap in the employment rate between those with a long-term health condition and the overall employment rate (PHOF Indicator 1.8)
- under 75 mortality from causes considered preventable (PHOF Indicator 4.3)
- self-reported well-being (PHOF Indicator 2.23)

Recommendation

The Council should seek to enhance the resilience and social capital of the most deprived communities in Sheffield by:

- using the skills and experience of the Healthy Communities staff as part of the new locality model
- increasing the capacity of lay workers and volunteers, by working in collaboration with the Voluntary, Community and Faith sector
- enhancing the ability of mainstream services to promote community resilience through developing their public health skills.

3.8 Mental health and wellbeing

Context

According to the Public Health Outcomes Framework indicators that reflect wellbeing (PHOF Indicator 2.23), the people of Sheffield have worse mental wellbeing than the national average, and most of the Core Cities.

Mental ill health and poor mental wellbeing are also major components of health inequalities. They are not evenly distributed across our communities and we see the same pattern of mental health inequalities as we do for physical health inequalities. The other important health inequality related to mental health is the greater prevalence of physical illness, increased mortality, and shorter lives, of people with serious mental illness compared to those without. There are also strong links between mental ill health and poor mental wellbeing, and alcohol and substance misuse.

Nationally, there is broad consensus about the kind

Page 21

GOOD HOUSING, SOCIAL CONTACT & EMPLOYMENT CONTRIBUTE TO IMPROVED MENTAL WELLBEING.

of initiatives that can lead to improved mental wellbeing for populations.[19] There is also increasing evidence that investment in programmes to increase resilience, connectedness and social capital in communities can be effective in increasing mental wellbeing.

Opportunities

A number of programmes to promote mental health were commissioned by the former NHS public health team, and these have been continued since transfer to the Council. These include, support towards employment, advocacy for older people, and supported access for particular Black and minority ethnic groups. In addition the Healthy Communities Programme incorporated a significant element of mental wellbeing promotion.

With the transfer of public health skills, resources and responsibilities to the Council, there are now opportunities to promote mental wellbeing through the full range of Council activities. Improving housing and the natural environment, reducing loneliness and levels of problem debt, promoting social capital, meaningful employment and cultural activities would all contribute to improving mental wellbeing in the City.

The work programme – Building mental wellbeing and emotional resilience - within the Health and Wellbeing Strategy needs to be developed and implemented. A strategy for improving mental wellbeing has been developed, and is in final draft form. This identifies a combination of a universal approach to improving public mental health as well as targeted initiatives to protect and promote mental wellbeing within specific groups as both being needed.

Outcomes

The Public Health Outcomes Framework measures most directly related to mental wellbeing are as follows although there is a much wider range of indicators that could also be expected to improve if wellbeing overall were better:

- adults in contact with secondary mental health services who live in stable and appropriate accommodation (PHOF Indicator 1.6)
- self-reported wellbeing (PHOF Indicator 2.23)
- suicide rate (PHOF Indicator 4.10)

Recommendation

Through the implementation of the Health and Wellbeing Strategy work programme, ***Building mental wellbeing and emotional resilience***, the Council should invest in public mental health, and instigate a renewed approach to improving mental wellbeing in the City, building on the actions identified in the draft Mental Wellbeing Strategy for the City.

3.9 Reducing alcohol consumption

Context

The 2012 Government Alcohol Strategy highlighted the importance of addressing behaviours related to 'binge drinking' and associated offending behaviour, with a particular focus on the 'Night Time Economy'. Alcohol consumption is a public health priority both because of increasing mortality rates of liver disease and because of the wider social harm caused by alcohol abuse.

Sheffield's Alcohol Strategy 2010-14 identified the scoping, and implementation, of alcohol related criminal justice interventions as a way to reduce harm arising from alcohol use.[20/21] There is growing evidence of the effectiveness of brief intervention approaches in reducing alcohol use. In criminal justice settings, giving simple feedback and a leaflet to 'increasing risk' drinkers was assessed as being as effective as long term interventions.

The Fixed Penalty Notice Waiver scheme is designed to increase access to alcohol screening and assessment for low level criminal justice offenders. Individuals who are given a Notice then have the choice either to pay an £80 fine, or to attend one hour long session at the alcohol treatment provider. Full engagement in the process leads to the fine being waived.

Opportunities

The transfer of the Sheffield Drug and Alcohol Commissioning Team (DACT) to the Council's Communities Portfolio has led to further support for the scheme among the Community Safety team. For example, as the scheme expands outside the city centre, colleagues co-located with DACT and working in the City's communities on issues such as cohesion, can promote the use of the scheme to their local police colleagues.

The scheme is an example of effective initiatives that can be employed to address alcohol related harm in Sheffield by joining the efforts of DACT with other parts of the Council. Joint initiatives, such as with the Licensing Department to address alcohol consumption and related harm, should be pursued in order to have the biggest impact with less resource. In addition, review of Sheffield's Alcohol Strategy 2010-14 will present further opportunity for joint working between the DACT and other departments, including Licencing and Trading Standards.

Outcomes

Increase in using the scheme across the City should result in a reduction of hospital admissions via A&E and reduced mortality from alcohol-related liver disease. These in turn will contribute to the following PHOF outcomes:

- hospital admissions for alcohol related conditions. (PHOF Indicator 2.18)
- under 75 mortality from liver disease. (PHOF Indicator 4.6)

Recommendation

The Council should use its outreach to raise awareness of, and promote, schemes such as the Fixed Penalty Notice Waiver, and ensure that all parts of the organisation that have an influence on alcohol consumption and related harm, collaborate to address this issue.

3.10 Health and Work

Context

It is widely acknowledged that good employment has a positive impact on an individual's health status. Equally, poor health and disability are significant barriers to employment in the City. This inter-relationship is recognised nationally in the Public Health Outcomes Framework, and locally in the Joint Strategic Needs Assessment and in the Health and Wellbeing Strategy.

19 Five ways to wellbeing - NEF | 20 Kaner E. et al (2013) Effectiveness of screening and brief alcohol intervention in primary care (SIPs trial: pragmatic cluster randomised controlled trial.) British Medical Journal (Open Access) 2013; 346:e8501doi:10.1136/bmj.e8501.Published 9 January 2013. | 21 NICE 'Alcohol-use Disorders: preventing harmful drinking' 2010

THE COUNCIL CAN ENCOURAGE PEOPLE TO TAKE UP THEIR HEALTH CHECK INVITE.

Health and disability barriers to employment ultimately have an economic cost, as evidenced by:

- sickness absence costs the economy around £15 billion a year
- for employers the costs of sick pay and managing absence are estimated at £9 billion
- the State spends £13 billion annually on health related benefits.

Healthcare professionals may not always consider the impact good employment might have on the health of a patient. Equally, many employment agencies do not adequately recognise and address health and disability as barriers to employment.

Opportunities

The transfer of public health to the Council aligns incentives for health improvement and economic benefit in a way that did not exist before. There is now an opportunity to create referral pathways and develop understanding of individuals and organisations which reduces these barriers to employment. This has the potential to both improve health outcomes and to increase economic success across the City and its Region

Outcomes

The following Public Health Outcome Framework indicators are likely to improve as a result of greater alignment between health and work programmes:

- employment and sickness absence rates (PHOF Indicators 1.8 and 1.9)
- child poverty (PHOF Indicator 1.1)
- self-reported wellbeing (PHOF Indicator 2.23)
- under 75 mortality from causes considered preventable (PHOF Indicator 4.3)

Recommendation

The Council, health and employment organisations should jointly take action to increase employment opportunities by removing health barriers, especially for those affected by mental health conditions and where appropriate, for the same group, seek to develop employment as a way out of poor health.

3.11 Health checks

Context

The NHS Health Check is a risk assessment and management programme intended to prevent or delay the onset of diabetes, heart and kidney disease and stroke, as well as identify previously undiagnosed cases of disease. Local authorities in England are obliged to offer health checks to people aged 40-74 years.

People who have had a health check can then be treated if necessary, or helped to reduce their risk of developing disease by making lifestyle changes. If someone is at higher risk, these changes may be combined with medical treatments or NHS support.

From April 2013, responsibility for the NHS Health Check programme transferred from the NHS to Sheffield City Council.[22] The Council is required to seek continuous improvement in the percentage of eligible individuals taking up their offer of a health check. The programme in Sheffield has been running since August 2012, and by the end of August 2013 had offered 20,165 health checks of which 8,936 (44%) had been taken up.

Opportunities

The Council directly employs approximately 7,700 people (plus a further 8,000 staff in schools). It also commissions a range of organisations to deliver services on its behalf, with these organisations employing thousands more people. Council employees have daily contact with thousands of people in Sheffield. This means the Council has extensive reach into all communities in Sheffield through all these routes, and could play a key role in encouraging staff, and those employed through contracts, to attend for their health check, when invited. The same extensive reach could assist with encouraging people with greatest need, including those living in deprived areas, and people from certain ethnic minorities who are more at risk of developing heart disease and diabetes, to take up the invitation.

Outcomes

Action would contribute mainly to achievement of the Public Health Outcomes Framework indicator 'Take up of the NHS Health Check programme by those eligible' (PHOF Indicator 2.22). Improving uptake of the NHS Health Check will also contribute substantially to the achievement of a number of other Public Health Outcomes Framework indicators, namely:

- healthy life expectancy (Overarching PHOF Indicator)
- differences in life expectancy and healthy life expectancy between communities (Overarching PHOF Indicator)
- diet (PHOF Indicator 2.11)
- excess weight in adults (PHOF Indicator 2.12)
- proportion of physically active and inactive adults (PHOF Indicator 2.13)
- smoking prevalence – adults (PHOF Indicator 2.14)
- recorded diabetes (PHOF Indicator 2.17)
- alcohol-related admissions to hospital (PHOF Indicator 2.18)
- mortality rate from causes considered preventable (PHOF Indicator 4.3)
- under 75 mortality rate from cardiovascular disease (PHOF Indicator 4.4)
- under 75 mortality rate from cancer (PHOF Indicator 4.5)
- under 75 mortality rate from liver disease (PHOF Indicator (4.6)
- under 75 mortality rate from respiratory disease (PHOF Indicator 4.7)
- preventable sight loss (PHOF Indicator 4.12)
- estimated diagnosis rate for people with dementia (PHOF Indicator 4.16)

Recommendation

The Council should:

- encourage employees to take up their NHS Health Check when they are invited (and encourage their family members to do likewise)
- use contracting mechanisms to ensure its contractors are encouraged to support their employees to take up their NHS Health Check invite
- use its existing outreach into disadvantaged communities to encourage the uptake of health checks and so reduce, rather than widen, health inequalities in the City.

22 Draft NHS Health Check programme best practice guidance, May 2013. Department of Health and Public Health England. http://www.healthcheck.nhs.uk/news/nhs_health_check_programme_best_practice_guidance/

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 (2011). This is followed by a summary of the recommendations made in the individual sections of this 2013 report.

4.1 Progress on 2011 Recommendations

1. The new Health and Well Being Strategy should prioritise early intervention and prevention activity focusing in particular on:

Recommendation	Progress
Implementing an evidence-based programme of ill health preventive interventions.	The Healthy Communities Programme has been shown to increase confidence, self-esteem and motivation; these factors are the foundation for improving health and building community resilience. Lay workers and volunteers employed by VCF organisations are particularly important to this approach.
Increasing access to primary care screening at an early stage.	Uptake rates for many vaccination & immunisation and screening programmes improved significantly. Responsibility for commissioning these services transferred to NHS England in April 2013.
Capacity of individuals & communities to take control of their own health.	Programmes supporting individuals to control their own health and self-care are delivered by: Health Trainers; Introduction to Community Development and Health; Health Champions and Expert Patients.
Increasing the capability of NHS and Council workforces to support individuals to improve their health	'Making Every Contact Count' supports front line staff to become competent in initiating conversations about health with service users. 'Training of Trainers' courses ensure this model can be cascaded by managers to then train their own workforce in public health messages.

2. Commissioners of health and social care should aim to:

Recommendation	Progress
Increase awareness of the importance of community assets and social connections for health.	A 'social model' of public health has been adopted by the Council. Evidence about developing assets and community connections has been used in the planning of the Healthy Communities Programme and this approach has been strengthened. Evaluation reports for Health Trainers and Health Champions indicate that social connectedness makes a significant difference to improving health.
Commission for development of resilience and wellbeing.	The Healthy Communities Programme increases confidence, self-esteem and motivation; these factors are the foundation for improving health and building community resilience. Many of those involved in the Programme go on to make significant changes in their lives.
Add to the evidence base in evaluation of local interventions.	The Joint Strategic Needs Assessment (JSNA) provides the evidence base for Sheffield's Health & Wellbeing Strategy. The latest JSNA was published in July 2013.
Ensure that specialist healthcare public health input into the local health and social care economy is maintained and nurtured.	'This is delivered through a dedicated specialist public health team co-located with the CCG, with support from relevant Council-office based public health staff. Unfortunately as a result of the transition to the Council, and financial pressures in the Council, a number of key specialist public health posts have remained unfilled, with a resulting failure to take forward work in important areas of public health.

3. Over the next 12 months, and in preparation for the transition of Public Health into the Local Authority, NHS Sheffield and Sheffield City Council should:

Recommendation	Progress
Work with members & officers to reflect on their role in creating conditions for people to lead flourishing lives.	A 'social model' of public health has been developed which encapsulates a new approach, building on greater integration with the wider locality working of the Council. The Local Government Association 'peer challenge' of public health in Sheffield, conducted in December 2012, identified the need to increase awareness of public health issues among all councillors and recommended that this should be done.
Work with VCF sector organisations to develop a capable and competitive third health sector.	VCF organisations retain a key role in delivering public health programmes in the City. Infrastructure support is still provided through funds from the public health grant, but now integrated with the wider Council approach to support for this sector.
Work with GPs to address the 'causes of the causes'.	Previously undertaken through the work of the Healthy Communities Programme. New locality based public health working arrangements must not lose these connections with GP practices.
Seek to make the whole Council a health promoting organisation.	Initial work undertaken to develop the public health role of staff as part of the Council's organisational development strategy. This includes 'Making Every Contact Count' training the trainers course, induction, and training focussed on specific groups.

4. Once established, the new Clinical Commissioning Group for Sheffield should:

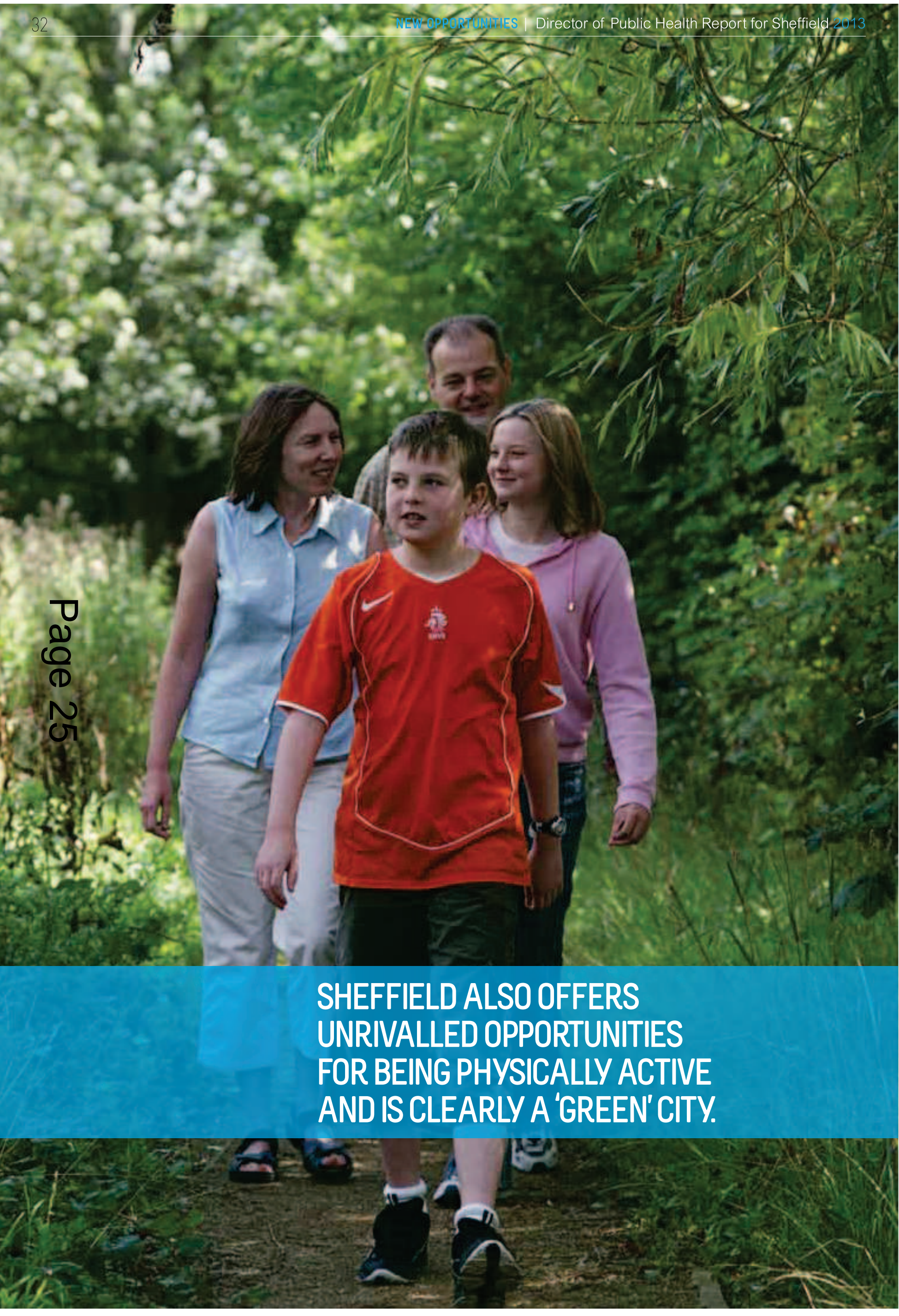
Recommendation	Progress
Maintain a focus on identifying and managing variation.	The CCG introduced a citywide personalised care planning scheme from GP practices (linked to population risk stratification) and supported the development of GP associations that are able to shape existing services and innovate in creating new primary care services to more closely match the needs of their local population.
Tackle unwarranted variation in cancer treatment and outcomes.	Most cancer treatment services are now commissioned by NHS England rather than the CCG. The CCG is continuing to monitor cancer service indicators and outcomes to inform its input to commissioning discussions.
Maintain a focus on diabetes and chronic obstructive pulmonary disease (COPD) with the aim of reducing unwarranted variation.	The CCG has been working with the Council to ensure a successful NHS Health Checks programme is implemented aimed at the early detection and treatment of vascular risk and diabetes. The CCG has continued to commission COPD community clinics and has increased the contracted number of pulmonary rehabilitation places.

4.2 Recommendations in 2013

The Council should:

1. Use proposals developed as part of the Fulfilling Lives: A Better Start bid to inform focussed investment in the early years and evidence based prevention and early intervention.
2. Ensure the Children and Young People's Joint Commissioning Group leads the redesign and commissioning of a universal prevention and early intervention emotional wellbeing and mental health service for children and young people, to commence April 2014.
3. Continue to develop a comprehensive sexual health system for the City, including targeted action to increase chlamydia screening and access to early HIV testing, and to reduce teenage conceptions. There should be appropriate input from all Portfolios for this work.
4. Systematically prioritise initiatives to encourage Sheffield people to 'Move More', making being physically active the norm by building physical activity into their daily life.
5. Fully support a citywide programme to reduce the availability and supply of illicit tobacco, which will include targeted enforcement action by Trading Standards.
6. Use the Care Homes Well Being Needs Assessment, currently in preparation, to inform commissioning priorities for people who live in care homes. In addition, the Council should take further steps to address isolation and loneliness by working with the NHS to build on the community support worker model, and the Lowedges, Batemore and Jordanthorpe pilot.
7. Seek to enhance the resilience and social capital of the most deprived communities in Sheffield by:
   - using the skills and experience of Healthy Communities staff in the new locality model
   - increasing the capacity of lay workers and volunteers, by working in collaboration with the Voluntary, Community and Faith sector
   - enhancing the ability of mainstream services to promote community resilience through developing their public health skills.
8. Through the implementation of the Health and Wellbeing Strategy work programme, Building mental wellbeing and emotional resilience, invest in public mental health, and instigate a renewed approach to improving mental wellbeing in the City, building on the actions identified in the draft Mental Wellbeing Strategy for Sheffield.
9. Use its outreach to raise awareness of, and promote, schemes such as the Fixed Penalty Notice Waiver, and ensure that all parts of the organisation that have an influence on alcohol consumption and related harm, collaborate to address this issue.
10. Take joint action with health and employment organisations to increase employment opportunities by removing health barriers, especially for those affected by mental health conditions and where appropriate, for the same group, seek to develop employment as a way out of poor health.
11. Contribute towards improved uptake of the NHS Health Check through:
    - encouraging employees to take up their NHS Health Check when they are invited (and to encourage their family members to do likewise)
    - using contracting mechanisms to ensure council contractors are encouraged to support their employees to take up their NHS Health Check invite
    - using existing outreach into disadvantaged communities to encourage the uptake of health checks and so reduce rather than widen health inequalities in the City.

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



5 Health and wellbeing across Sheffield

Sheffield can be divided into various smaller areas such as electoral wards, of which there are 28 in Sheffield and neighbourhoods, of which there are 100. A suite of data tools have been developed to allow for the exploration of patterns and trends in health and wellbeing across these smaller areas. The tools are published on the website of the Director of Public Health Report for Sheffield 2013. Brief details of the tools are given below:

Health & Wellbeing Profiles

Individual profiles may be downloaded for each ward and neighbourhood. These give a comprehensive overview of health and wellbeing in the area. They contain a summary commentary and charts for over 130 indicators grouped under the topic headings of population & ethnicity, deprivation, wider determinants of health, life expectancy and mortality, general hospital activity, adult social care, lifestyle, children & young people, disease groups, and mental health.

Health & Wellbeing Indicator Tools

There is an interactive excel spread sheet for both wards and neighbourhoods. These allow the variation across wards or neighbourhoods for a chosen indicator to be explored. Included are trend data, tables, charts, and the ability to correlate pairs of indicators. Over 130 indicators are included covering the topics of population & ethnicity, deprivation, wider determinants of health, life expectancy and mortality, general hospital activity, adult social care, lifestyle, children & young people, disease groups, and mental health.

Population Trends Tools

Interactive population trend tools are available for wards and neighbourhoods. They include population pyramids, trend charts, and allow a choice of age group.

You can access all of these tools at: www.sheffield.gov.uk/publichealthreport

YOU CAN VIEW THE
FULL VERSION OF THIS REPORT AT
WWW.SHEFFIELD.GOV.UK/
PUBLICHEALTHREPORT

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:

Dr Jeremy Wight
Director of Public Health
Sheffield City Council
Town Hall
Pinstone Street
Sheffield
S1 2HH

Telephone: 0114 205 7462
Email: dphr@sheffield.gov.uk

More information

An online version of this report, and the full report, 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

80% recycled
This document is printed on 80% recycled paper

This page is intentionally left blank

Sheffield Clinical Commissioning Group | NHS England | healthwatch Sheffield | Sheffield City Council

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Sue Greig, Public Health Consultant
Date:	12th December 2013
Subject:	Better Outcomes for Children and Young People's Pledge
Author of Report:	Bethan Plant, 0114 293 0133

Summary:

To introduce a request to the Sheffield Health and Wellbeing Board to sign up to the ***Better Health Outcomes for Children and Young People Pledge***.

The Sheffield Children's Health and Wellbeing Partnership Board recently undertook a review of its work programme priorities and considered the Pledge as part of this process. The Children's Health and Wellbeing Partnership Board has committed to 'sign up' to working to achieve the ambitions outlined in the Pledge and is requesting that the Sheffield Health and Well Being Board also endorses the Pledge.

Recommendations:

- The Board is asked to 'sign up' and endorse the Better Health Outcomes for Children and Young People Pledge, ensuring that as a City Sheffield commits to meet the ambitions outlined in the pledge.

Background Papers: Better Outcomes for Children and Young People Pledge

BETTER HEALTH OUTCOMES FOR CHILDREN AND YOUNG PEOPLE PLEDGE

1.0 SUMMARY

1.1 To introduce a request to the Sheffield Health and Wellbeing Board to sign up to the ***Better health outcomes for children and young people pledge.***

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 Commitment from the Health and Wellbeing Board to deliver the ambitions outlined in the Pledge will ensure that as a city we are working in partnership to promote the health and well-being of our children and young people.

2.2 The Pledge provides a joint commitment to ensure service improvement and re-design to best meet the needs of children, young people and families.

3.0 BETTER HEALTH OUTCOMES FOR CHILDREN AND YOUNG PEOPLE

An alliance of the Department of Health, the Local Government Association, the Royal College of Paediatrics and Child Health and Public Health England recently wrote to Lead Members of Children's Services and Chairs of Health and Wellbeing Boards to invite them to sign up to a Pledge to improve health outcomes for children and young people. The preamble to the Pledge notes that although children and young people growing up in England today are healthier than they have ever been, international comparisons and long term trends are concerning.

The Pledge and invitation is part of a system wide response to the Children and Young People's Health Outcomes Forum Report (2012): http://www.dh.gov.uk/health/2012/07/cyp-report/

The full Pledge can be accessed at: https://www.gov.uk/government/news/new-national-pledge-to-improve-children-s-health-and-reduce-child-deaths.

The Pledge confirms the following shared ambitions:

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

And the following commitments:

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

April 2013 marked the transfer of public health from the NHS to local authorities. Local authorities are now responsible for delivering and commissioning a range of children and young people's public health services for five to 19-year-olds, with responsibility for children under five following from 2015. This puts local authorities and health and wellbeing boards in a prime position to tackle the poor health outcomes experienced by children and young people.

As well as perhaps an unsurprising emphasis upon partnership working and integration, and prevention and early intervention, the Pledge calls for sign up to a shared ambition to optimise the experience of transition into adulthood and, perhaps most importantly, for the

voice of children, young people and families, especially those most vulnerable, to be 'at the heart of decision making, with the health outcomes that matter most to them taking priority'.

The Sheffield Children's Health and Wellbeing Partnership Board recently undertook a review of its work programme priorities and considered the Pledge as part of this process. The Children's Health and Wellbeing Partnership Board has committed to 'sign up' to working to achieve the ambitions outlined in the Pledge and is requesting that the Sheffield Health and Well Being Board also endorses the Pledge.

If all local areas were as good as the best, together we could improve children and young people's quality of life now, and their ability to live fulfilling lives as they move through childhood. Local authorities, health and wellbeing boards, health, schools and wider partners are being invited to share examples of good practice so that learning can be promoted nationally. If we would like to share what our Health and Wellbeing Partnership Board is doing or planning to do to improve health outcomes for children and young people we are invited to email a short description to Samantha.Ramanah@local.gov.uk. All examples will be published on the LGA's website and Knowledge Hub for the National Learning Network for Health and Wellbeing Boards to share learning.

3.0 RECOMMENDATIONS

The Sheffield Health and Wellbeing Board is asked to:

- 'Sign up' and endorse the Better Health Outcomes for Children and Young People Pledge, ensuring that as a City Sheffield commits to meet the ambitions outlined in the pledge

SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 26 September 2013

PRESENT: Councillor Julie Dore (Chair), Leader of the Council
Dr Amir Afzal, Clinical Commissioning Group
Dr Margaret Ainger, Clinical Commissioning Group
Ian Atkinson, Clinical Commissioning Group
Pam Enderby - Healthwatch Sheffield
Councillor Jackie Drayton
Councillor Mary Lea
Jayne Ludlam, Executive Director, Children, Young People & Families
Dr Tim Moorhead, Clinical Commissioning Group
John Mothersole, Chief Executive
Richard Webb, Executive Director, Communities
Dr Jeremy Wight, Director of Public Health

IN ATTENDANCE: Jason Bennett – Healthwatch Sheffield
Joe Fowler – Director of Commissioning, Sheffield City Council
Tim Furness – Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group
Carol Lavelle – NHS Sheffield South Yorkshire and Bassetlaw

....

1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillor Harry Harpham, Margaret Kitching and Dr Ted Turner.

1.2 Carole Lavelle attended the meeting as deputy for Margaret Kitching.

2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

3. PUBLIC QUESTIONS

(a) Public Question in respect of Care for Vulnerable Adults

Adam Butcher asked how all services would work to ensure that the most vulnerable adults in the City were taken care of?

In response, Councillor Mary Lea reported that within Care and Support people were able to remain safe and independent in their own homes with their needs being met.

There was a Safeguarding Board in Sheffield which also had links across

Yorkshire. At the same time, all agencies had Safeguarding responsibilities. The people and policies were in place to ensure that all those who needed a mental capacity assessment were able to have one.

The Council worked closely with the Police to reduce hate crime and projects such as the Safe Places Project worked to protect the most vulnerable. Although there were signs that domestic violence was on the increase, there was a Strategy in place to ensure that those who needed health and support were reached.

In conclusion, Councillor Lea reported that all agencies were working to get things right as much as they could and dealing with gaps where they became apparent.

Tim Moorhead added that agencies had to try and anticipate problems in respect of vulnerable adults. Strategies were in place to respond to homelessness. The Health and Wellbeing Board provided the opportunity to develop joined-up plans. It was important to remember that there were some groups who may fall between plans and their needs needed to be accommodated.

In thanking Mr Butcher for the work he had done locally and the interest he had shown in protecting vulnerable adults, the Chair, Councillor Julie Dore commented that as a Health and Wellbeing Board it was important that everybody shared responsibility for protecting vulnerable adults across the City.

(b) Public Question in respect of Hospital Trust Representation on the Board

Andrew Hanasse referred to the lack of Hospital Trust Representation on the Board. He understood that the Board had responsibility for joined-up care across Sheffield and therefore asked if the Board believed the lack of a Hospital Trust presence would be a disadvantage?

Councillor Julie Dore responded that it had been agreed as a Board to have representation from the Commissioners across the City and the Trusts were Care Providers. It was appropriate for the Board to hold the providers to account. The Board would constantly engage and involve and may invite bodies to a future meeting when considering a specific theme. In answer to the specific question, for the reasons outlined the Chair did not think it was a disadvantage that the Hospital Trust were not represented on the Board.

Tim Moorhead reported that he Co-Chaired the Right First Time Board with a representative of Sheffield Teaching Hospitals which had the aim of improving urgent care in Sheffield. This Board focussed on taking a partnership approach, with commissioners and providers working together to improve services.

(c) Public Question in respect of the Liverpool Care Pathway

Kathryn Williams referred to recent national publicity in respect of the Liverpool Care Pathway and asked whether following recent severe criticism from the families of elderly dying patients that was acknowledged in the end of life care system review on the Liverpool Care Pathway (LCP) led by Baroness Neuberger which reported in July 2013, how were the hospitals and nursing homes in

Sheffield now ensuring that the LCP was either abandoned, phased out or modified to suit each individual patient with the consent of their relatives?

Tim Furness reported that there was currently a Working Group meeting which focused on End of Life Care. That had recognised the outcome of the review and its recommendations and taken them into account in recommending improvements to local care and support.. Work was undertaken locally alongside national work to meet individuals and families needs at the end of life stage.

Councillor Julie Dore commented that she shared Mrs Williams concerns and was astonished that the problems highlighted by families in Liverpool had been allowed to occur. Within Sheffield every approach was a customer focused approach which centred around the customers needs.

Tim Moorhead commented that he believed it was a useful approach to attempt to define the standards that should be expected which was what the LCP had attempted to do. The issue in this instance however was the implementation across the country where the standards were often paid lip service to and not adhered to correctly.

(e) Public Question in respect of the Work Programmes for the Joint Health and Wellbeing Board Strategy

Fiona Goudie referred to the Joint Health and Wellbeing Strategy 2013-18 on the agenda for the meeting and asked, in relation to the Work Programmes included within the report, had the Board established who the Chair’s for each Programme would be and who the members would be?

Councillor Julie Dore reported that the following would lead on each specific work programme:-

- A Good Start in Life – Councillor Jackie Drayton and Dr Margaret Ainger
- Building Mental Wellbeing and Emotional Resilience – Councillor Mary Lea and Dr Ted Turner
- Food, Physical Activity and Active Lifestyles – Councillor Julie Dore and Dr Tim Moorhead
- Health, Disability and Employment – Councillor Julie Dore and Dr Tim Moorhead
- Supporting People at or Closer to Home – Councillor Harry Harpham and Dr Tim Moorhead

Tim Furness commented that Work Programmes had a lot of connection with work already underway and the aim was to enhance this work rather than duplicate it. Councillor Julie Dore further commented that the aim was not to reinvent the wheel but at the same time the Board could not absolve overall responsibility for delivering the Work Programmes.

4. JOINT HEALTH AND WELLBEING STRATEGY 2013-18 APPROVAL

4.1 The Board considered a report of the Co-Chairs of the Board, Dr Tim Moorhead

and Councillor Julie Dore, outlining the draft Joint Health and Wellbeing Strategy for 2013-18 and seeking the Board's approval for the Strategy.

4.2 The Board considered a number of issues in relation to the Strategy as follows:-

- The Strategy was a development from the Strategy which had been agreed the previous year.
- Extensive consultation had been undertaken in the development of the Strategy.
- The Strategy set out the principles and five outcomes representing the aims for the City.
- The action plans would be implemented through the Commissioning Plans of both the Clinical Commissioning Group and the City Council.
- Healthwatch Sheffield extended their thanks for the engagement the Board had with Healthwatch Sheffield in the development of the Strategy.
- The responsibility for the delivery of the actions would be dispersed across a number of organisations.
- The Strategy was a Strategy for the medium term and the Board was not looking to revise it on a yearly basis although a review of how the Board was responding to the Strategy would be undertaken.

RESOLVED: That:-

1. the Health and Wellbeing Board approves the Joint Health and Wellbeing Strategy for 2013-18.
2. the Health and Wellbeing Board's partner organisations commit to delivering the Strategy.

4.3 **REASONS FOR THE DECISION**

1. Following the publishing of its draft Strategy in autumn 2012, the Health and Wellbeing Board had heard from over 1,500 people who had fed into the process of delivering the final Strategy for 2013-18. The Board can be confident that this was an evidence-based Strategy based on the views and perspectives of Sheffield people.
2. It was important to approve this Strategy at this stage so that it can be used to inform the plans for the 2014-15 financial year.

5. HEALTH AND WELLBEING OUTCOME INDICATORS FOR SHEFFIELD

5.1 The Board considered a report of the Director of Public Health detailing an outcome indicator framework providing an overview of how the Joint Health and Wellbeing Strategy outcome areas were progressing.

Members of the report discussed the report as summarised below:-

- The indicators were welcomed and were a good series of proxies for key issues that could be refined and developed if required.

- The information was routinely available and the only officer time was taken in representing the information in the format seen in the report.

- There was not an indicator in relation to adult obesity as the only information available was from GP data which was not systematic.

- The Cabinet Member for Children, Young People and Families welcomed the indicator in relation to Childhood obesity.

- Reducing infant mortality was a priority issue as figures had begun to slightly increase in Sheffield. Although numbers were still small this would be monitored closely.

- Figures may change for the better or worse depending on changing national definitions. Although this couldn't be influenced, where this occurred the reason for this would be highlighted.

- Councillor Julie Dore commented that she welcomed this and the Board had felt it important to publish the information and it would be closely monitored by the Board.

RESOLVED: That the Health and Wellbeing Board agrees the indicators as a key means by which progress on the Joint Health and Wellbeing Strategy outcomes will be reviewed and reported.

5.2 **REASONS FOR THE DECISIONS**

1. The Board had requested such a framework be developed.

6. PRESENTATION ON HEALTHWATCH AND THE HEALTH AND WELLBEING BOARD

6.1 Pam Enderby and Jason Bennett, representing Healthwatch Sheffield, gave a presentation on the work of Healthwatch Sheffield and how the organisation could work together with the Health and Wellbeing Board to deliver the right outcomes for the people of Sheffield.

The following comments were made in the presentation:-

- There was now a legal requirement to involve patients and the public in influencing policy.

- Sheffield LINk had been the precursor to Healthwatch Sheffield. Although LINk had worked well in Sheffield, this had not necessarily been the case nationally. Healthwatch Sheffield was keen to develop the good work done

by LINk in Sheffield.

- Healthwatch Sheffield had a consortium approach to delivery with 3 main organisations at the centre of the work in Sheffield. Voluntary Action Sheffield (VAS) would work on engagement and communication issues. Sheffield Citizens Advice and Law Centre had a remit to signpost and co-ordinate information and Sheffield Cubed would undertake engagement in communities through the health champions and there were health champions who were members of Healthwatch Sheffield's Governing Body.

- Healthwatch Sheffield had a 'Network of Networks' approach and had identified good areas of collaboration and intention to work together across Sheffield.

- There was a big reliance on volunteers who often undertook work which only they could do.

- The priority areas of work for Healthwatch Sheffield were Children and Young People, examining volunteering roles and infrastructure and the development of the Governing Body. Although a Governing Body had been established, there were a number of gaps and there was also a need to pay attention to culturally diverse groups such as Black, Minority and Ethnic (BME) groups.

- Access to G.Ps had been raised as a key area of concern by the public and Healthwatch Sheffield was working to see how they could assist people in improving access.

- Other key areas of work included mental health and the transition between child and adult services, home care and concerns in relation to the responsibilities of staff, Accident and Emergency and the NHS 111 number.

- There was evidence that people still did not know how to complain or compliment in relation to services and there remained a continued problem of access to information.

- Healthwatch Sheffield wished to be involved in the budget consultation which would take place in respect of adult social care.

- In conclusion, Jason Bennett asked the Board how they believed Healthwatch Sheffield could make a unique contribution in Sheffield, how they could add value and how they could be involved in influencing decision making in the City.

- LINk had produced a legacy document which would be used as the basis for Healthwatch Sheffield's priorities. The challenge now was to develop these further.

In response to the presentation, the Board made a number of comments as

summarised below:-

- Thanks were extended to Sheffield LINk for their work over the last few years and it was hoped that there would be a seamless follow on from this.

- Service users needed to appreciate that change was sometimes a positive step and Healthwatch Sheffield would play an important part in making the case for change.

- The Cabinet Member for Children, Young People and Families welcomed children and young people being one of the priorities for Healthwatch Sheffield as she believed that was a gap in LINk. Healthwatch Sheffield would play an important part in consultations around children and young people. The role of young carers also needed to be emphasised.

- Healthwatch Sheffield's involvement in the newly established Council Local Action Partnerships would be welcomed.

- A discussion on home care and residential care would be welcomed.

- Healthwatch Sheffield would be vital in encouraging people to seek self-help.

- Work needed to be undertaken with children with specific needs and disabilities.

- The priority around young people's mental health was welcomed.

- Healthwatch Sheffield should give consideration to people's willingness to share information.

RESOLVED: That Jason Bennett and Pam Enderby be thanked for their presentation and the information be noted.

7. WINTERBOURNE VIEW - SHEFFIELD'S ACTIONS IN RESPONSE TO THE NATIONAL PROGRAMME OF ACTION

7.1 The Interim Head of the Learning Disabilities Service and the Chief Nurse, Sheffield Clinical Commissioning Group submitted a joint report in relation to Winterbourne View and Sheffield's actions in response to the National Programme of Action and seeking the Board's approval for the approach described in the report. Heather Burns, Senior Commissioning Manager, NHS Sheffield CCG, and Anita Winter, Head of Service Sheffield Health and Social Care NHS Foundation Trust attended the meeting to present the report.

7.2 Members of the report discussed the report as summarised below:-

- The issue had been discussed at the Board and Shadow Board on a number of occasions and Members were shocked at the issues highlighted at

Winterbourne View and it was clear that something needed to be done in response.

- In response to a question from a Member, it was stated that the funding body had responsibility for monitoring those placed outside the City. There was a review of homes on a yearly basis and a review every 3 months if an individual was placed elsewhere.

- Where an individual was placed in a home there should be a three way safeguard of which the Care Quality Commission inspection was one element. The review had highlighted deficiencies in all three areas.

- In reference to recommendation 4.2 which aimed to ensure warning signs were not missed, the review had shown that warning signs had been missed with both family members not being heard and the Care Quality Commission not listening to concerns expressed.

- In Sheffield a Peace of Mind Group had been established from the Learning Disabilities Partnership Board. The situation at Winterbourne View was the biggest nightmare any authority could imagine and all agencies needed to work hard to implement the recommendations and ensure that it did not happen again.

- Families of those in the homes were engaged in the reviews and where there were no family members an independent outlook was needed.

- The report and recommendations were welcomed. It was now the responsibility of the Board to ensure the recommendations were actioned effectively. It was questioned whether the Board should have monitoring responsibility for ensuring the recommendations were implemented but it was agreed that the Board should be kept informed.

7.3 RESOLVED: That:-

1. The approach outlined in the report be approved and further updates from the Winterbourne Steering Group be welcomed.
2. The Board seeks assurance that organisations have information-sharing arrangements in their plans to support the need for greater multi-agency working and communication, and to ensure warning signs were not missed.
3. Sheffield City Council committed to work with Sheffield CCG as a priority to find suitable accommodation that meets the needs of people with challenging behaviour, including those currently out of the City.
4. The CCG committed to work with community health services and GP practices so that they were ready to provide suitable health support to this group of people on their return to the City.
5. The CCG committed to work with acute psychiatric and mainstream hospital services to accommodate people with a learning disability who had a crisis in either their mental or physical health.

7.4 **REASONS FOR THE DECISION**

1. The Department of Health recommends the involvement of local Health and Wellbeing Boards in the development of joint action plans.
2. The recommendations will help to mitigate the risks of Sheffield not meeting its Winterbourne obligations.

8. PRESENTATION ON THE HEALTH AND WELLBEING BOARD'S PROGRESS WITH INTEGRATION

8.1 Joe Fowler, Director of Commissioning, Sheffield Council gave a presentation on Integration of Health and Social Care in Sheffield.

8.2 He stated that customers in Sheffield had said that more joined-up care and services was what they wanted and would improve their experience.

8.3 A Joint Commissioning Executive was being established to oversee current business and the development of the integration proposal. The aim was for continued engagement with the public and others.

8.4 Moving forward there was a need to agree the vision for the proposal and to establish governance procedures and establish how better joined-up work could be undertaken with partners.

8.5 The detailed proposal would be submitted to a future meeting of the Board and the decision making bodies at the Council and the CCG.

8.6 Councillor Dore thanked Joe Fowler for the presentation and commented that she looked forward to the Board receiving the detailed proposal at a future meeting.

8.7 RESOLVED: That Joe Fowler be thanked for the presentation and the information be noted.

9. MINUTES OF THE PREVIOUS MEETING

9.1 The minutes of the meeting of the Board held on 27th June 2013 were approved as a correct record.

This page is intentionally left blank