Report to Health Scrutiny & Policy Development Committee
25th February 2015

Report of: Director of Public Health

Subject: Sheffield health inequalities plan

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Summary:
The Sheffield Health and Wellbeing Board has developed and approved a Health Wellbeing Strategy for the City. One of the specific outcomes in this strategy is that *health inequalities are reducing.* An action plan has been developed and was approved by the Health and Wellbeing Board in June 2014. It is now being implemented. Progress will be formally reviewed after 1 year.

The Health Scrutiny and Policy Development Committee has requested a report on the health inequalities plan and progress to date in its implementation.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	√
Other	

The Scrutiny Committee is being asked to:
Comment on the action plan, consider progress against the identified actions, and consider any recommendations they may wish to make to the Health and Wellbeing Board.

Background Papers:

Sheffield Joint Strategic Needs Assessment –
https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/JSNA.html
Sheffield Health and Wellbeing Strategy –
https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/joint-health-and-wellbeing-strategy.html
Sheffield Health inequalities plan –
https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/tackling-health-inequalities.html

Category of Report: OPEN

Report of the Director of Public Health
Sheffield Health Inequalities Plan

1. Introduction/Context

1.1 Inequalities in health in Sheffield have been well documented for over a century. They are significant and persistent, in spite of much good work that has been done to address them. Their nature and extent are documented in the Joint Strategic Needs Assessment and elsewhere. The roots of health inequalities lie in the unequal nature of society, and they will persist as long as society remains unequal. But this does not mean that we cannot do anything about them.

1.2 The Fairness Commission considered health inequalities in detail and made a number of general recommendations as well as more specific ones relating to inequalities in the health system, mental health and wellbeing, and carers. The Joint Strategic Needs Assessment, as well as describing the health inequalities in the City, also made a number of recommendations. The Health and Wellbeing Board has identified addressing health inequalities as one of its priorities (the other being the integration of health and social care). It has approved a Health and Wellbeing Strategy that identifies five Outcomes which describe what it wishes to achieve for the people of Sheffield. One of these is that *health inequalities are reducing* and nine actions are identified in support of that. However there are also actions in support of another Outcome, *health and wellbeing is improving,* which will when implemented also have a significant impact on health inequalities.

1.3 The Health and Wellbeing Board approved the Health Inequalities Plan in June 2014. The plan describes how the actions contained in the strategy will be implemented. A report on progress in implementing the plan is due to be taken back to the Health and Wellbeing Board in June 2015.

1.4 The Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee requested a report on the health inequalities Plan,

including a report on progress in implementing it. This paper provides that report.

2. Main body of report, matters for consideration, etc

2.1 The Health and Wellbeing Strategy was developed during 2012 to 2013 by the Health and Wellbeing Board. The development included extensive consultation with partner agencies, health and social care provider organisations and members of the public. The strategy was formally approved in September 2013.

2.2 Outcome 3 of the strategy is that *health inequalities are reducing.* There are 9 actions that were identified to achieve that, as follows:

Action 3.1

Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.

Action 3.2

Agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community based organisations.

Action 3.3

Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined up city localities.

Action 3.4

Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.

Action 3.5

Ensure every child has the best possible start in life, including: focussed action, reducing infant mortality, improving parent/child atunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.

Action 3.6

Recognising that the City has growing numbers of new arrivals, including Roma, develop appropriate strategies to ensure families are appropriately accessing health, social care and education services.

Action 3.7

Commission disease specific interventions, including a programme to improve the physical health of the severely mental ill and those with a learning disability.

Action 3.8

Support quality and dignity champions to ensure services meet needs and provide support.

Action 3.9

Work to remove health barriers to employment through the health, disability and employment plan.

1.3 In addition to the above, there are a number of actions that appear under outcome 2 *Health and wellbeing is improving,* which will when implemented also have a significant impact on health inequalities. These are:

Action 2.1

Promote a citywide approach to emotional wellbeing and mental health, focussing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.

Action 2.4

Support the “More More” initiative to encourage people to be more physically active as part of their daily lives.

Action 2.5

Commission and implement an integrated approach to reducing levels of tobacco use through integrated work on: 1 – helping people to stop smoking, 2 – smoke free environment, 3 – smokefree children and young people, 4 – community based action on illegal tobacco, 5 – social marketing and communications to reduce smoking prevalence and de-normalise tobacco use, 6 – reduce smoking prevalence amongst pregnant women.

Action 2.6:

Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the ‘hidden harm’ to children living in households where adults abuse alcohol or drugs.

Action 2.8

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

1.4 A draft action plan was compiled which identified how the above actions would be implemented, who would be responsible for that and the appropriate timescales. This draft health inequalities plan was consulted on during the spring of 2014, and as a result of that consultation an additional action was identified as follows.

Action 3.10

To promote health literacy and earlier engagement with health services in disadvantaged communities.

1.5 The final approved version of the Health Inequalities Plan therefore contains 15 specific actions. A full copy of the plan can be found at https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/tackling-health-inequalities.html.

1.6 The actions identified have been chosen because they relate to causes of ill-health that are amenable to intervention, where relatively large numbers of people are affected, where a cause is unevenly distributed across society, and where the adverse health consequences are severe. It contains a range of actions, some of which will have an impact in the relatively short term, whilst others will impact only in the medium to longer term.

1.7 Each action has an identified lead officer, and is broken down into a number of specific tasks which will be necessary to deliver the action, with intended timescales and reporting arrangements.

1.8 The Health and Wellbeing Board approved the Health Inequalities Plan in June 2014, and requested an annual report on its implementation.

1.9 The current position with regard to the implementation of the plan is detailed in appendix 1.

3 What does this mean for the people of Sheffield?

3.1 Health inequalities are a matter of life and death. Although there are many different ways in which health inequalities can be measured, the best overall indicator is the slope index of inequality of life expectancy which indicates a life expectancy gap of just over 9 years for men and just under 7 years for women (2011-13 data).

3.2 There are however many different ways of describing health inequality. For example difference of infant mortality between different ethnic groups, or differences in life expectancy between people with learning disabilities or serious mental illness and those without. Implementation of this plan should help to reduce inequalities as measured in a range of different ways, as is detailed within the plan.

3.3 Health inequalities are at root a manifestation of socio-economic inequality. Health inequalities will continue as long as society remains unequal and if socio-economic inequalities widen, then the impact of this plan may simply be to stop health inequalities widening further.

4. Recommendation

4.1 The Scrutiny Committee is recommended to consider the plan, comment on its implementation, and consider any recommendations for the Health and Wellbeing Board.

Appendix 1: Update on Actions, February 2015

Action 3.1

Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.

Action to date

Communities of interest have been identified (see list below) and initial analysis undertaken covering availability of data about the health status of each group and, where data available, what this is telling us about the health disadvantage experienced. A number of community of interest health profiles (produced by Public Health England) and local Health Needs Assessments (HNAs) already exist and these are used where relevant.

Communities of Interest

- Homeless people
- People with serious mental ill health
- People with learning disabilities
- People with physical disabilities (includes sensory and cognitive impairments)
- Lesbian, Gay, Bisexual and Transgender
- Black and Minority Ethnic Communities (including migrants and asylum seekers and refugees)
- Carers

What are we planning to do next?

Recommendations to the H&WB Board about priorities for further data collection and analysis are currently being prepared. An implementation plan will be established when priorities agreed. This is likely to consist of a combination of health needs assessments and rapid reviews.

Action 3.2

Agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community based organisations.

Actions to date

Health Trainers Health trainers provide support to people to improve their health and wellbeing by increasing confidence and skill . They use a social prescribing model using with referrals from GP Practices. There are now Health Trainers in each of the Community Wellbeing Programme areas, including a City Centre based worker for vulnerable groups. Last year there were 1569 service users and 12,368 points of contact.

Community Health Champions. These volunteers are mainly recruited from disadvantaged communities and draw on their own local knowledge and life experience to undertake community interventions or provide one to one support to improve health wellbeing and social connectedness. CHCs work in areas of the City with the most need. Between 2009 and 2013, the total number of Health Champions was 400, supporting over 10,000 people.

Practice Champions Practice Champions is a recently established lottery funded initiative. It is delivered by VCF organisations particularly supporting GP Practices around appropriate use of NHS services and working with the practice on priority areas of work. There are 160 Practice Champions working with 4 GP Practices. The volunteers also enable links with other community interventions such as Social cafes.

Community Wellbeing Programme Current contracts are being extended for a year. The contracts will be changed to strengthen the work regarding building and supporting social capital as a way of improving health and wellbeing. Last year there were 21,258 Beneficiaries and 68,173 Points of Contact.

The CWP provides the framework for other public health interventions. A current example is the Eat and Heat Project – tacking fuel and food poverty. CWP providers are developing projects appropriate to their neighbourhood, working with other local organisations including food banks to identify vulnerable households and to support take up of available services.

Locality Working Public Health staff are working closely with the LAPs and the locality teams to achieve a joint neighbourhood approach engaging libraries and Housing Plus. The new CWP contract with VCF providers focuses on building social capital and asset based community development. Developing health and wellbeing networks is proving a successful approach for engaging local stakeholders

Developing Resilience Sheffield Executive Board has led an initiative to develop resilient communities. A task and finish group gathered evidence from a wide range of agencies working with communities. A report has been written describing a 'Fuzzy Framework' for building community resilience. A stakeholder workshop was held to take this forward and the feedback has been used to further develop the strategy. The Local Area Partnership Chairs have also been consulted about taking this forward.

Evaluation Reports from Sheffield and Leeds Universities and the data collected as part the national Health Trainer data base (DCRS) provide evidence of the success of the Sheffield Community Wellbeing, Health Trainer and Health Champions Programmes.

What are we planning to do next?

Health Trainers Working closely with primary care particularly supporting achievement of integrated Health and Social Care. The Public Health team is co-ordinating a multiagency bid to the Health Foundation. The proposal is to use HTs to empower people to take control over their own health, wellbeing and help them make healthier lifestyle choices.

Health Champions Currently agreeing a new contract with Sheffield Cubed to build on the success of this programme and to increase numbers of volunteers and give greater focus on social capital outcomes.

Practice Champions In order to sustain this work and work with more practices we are seeking funding for Practice Champions this as the funding ends in May 2015.

Community Wellbeing Programme A new Evaluation Framework is being developed with Sheffield and Sheffield Hallam University to measure social capital at individual, organisational and community level. It is anticipated that a new commissioning strategy will be developed as part of the wider work around the Integrated Health and Social Care Strategy.

Locality working A community development strategy is being developed

Developing resilience The resilience multi-agency working group are pulling together City approaches to building skills and capability into one City proposal/approach . They are also capturing stories of success in relation to the 'Fuzzy Framework'. The document will then be revised so it presents as a more challenging document. SEB members will then be asked to consider how they could support this document with a full SEB discussion in February.

Evaluation A report being written by Sheffield and Sheffield Hallam Universities

Action 3.3

Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined up city localities.

Actions to date

A Housing Delivery Investment Plan has been produced. The Air Quality Action Plan is being implemented but is due for a refresh.

What are we planning to do next?

Review of Air Quality Action Plan

Action 3.4

Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.

Actions to date

Actions to date have focused on understanding what the issues are in Sheffield, reviewing the evidence base of what works to improve access, and putting together a proposal for action based on this. This proposal has been discussed and approved by both the Council's H&WB Strategic Outcome Board and the CCG's Clinical Executive Team.

What are we planning to do next?

Our next step is to create project plans to implement the following actions:

- Ensure that increasing health literacy is an integral part of all community development commissioning and service delivery.
- Ensure that all city strategic and service plans that refer to service access address both demand issues (people's ability to recognise they need a service and can navigate the system) as well as supply issues (services are easy to use and accessible).
- Provide training and information on how the health care and social care system works to staff working directly with community members.
- Support services to understand which people or groups find their services difficult to access and what they need to do differently:
    - Support services to conduct 'did not attend' (DNA) audits: this will give specific service-level information about why some people or groups (for example, carers, BME groups, people with disabilities) find particular services difficult to access, and will tell services what they need to do differently.
    - Support the VCFS, Healthwatch and other volunteers to conduct audits of how much 'work' is involved in using services (for example transport, childcare, interpreters, time off work), then support services to make recommended changes.
    - Identify and implement specific actions from existing and proposed Health Equity Audits (current audits underway include access to primary care services for people with learning disabilities, and access to end of life care services for BME and other population groups).

Action 3.5

Ensure every child has the best possible start in life, including: focussed action, reducing infant mortality, improving parent/child atunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.

Action to date

A new *Best Start* strategy is under development and about to be consulted on. The City *Infant Mortality Strategy* is being implemented. A new contract for a service to address maternal smoking has been let (see action 2.5). Breast feeding peer support and doula programmes continue.

What are we planning to do next?

Consult on and implement the *Best Start* strategy.

Action 3.6

Recognising that the City has growing numbers of new arrivals, including Roma, develop appropriate strategies to ensure families are appropriately accessing health, social care and education services.

Actions to date

- Implemented a detailed strategic action plan that has brought together key services including health, housing, environment, schools, police, community and VCF to manage impact on Page Hall and develop a framework for supporting migration in the City to other communities.
- A matrix has been developed to track the cost of all interventions in the Page Hall, Fir Vale, Darnall areas.
- Selective licensing at Page Hall – all homeowners have either applied for a new licence or court action is pending for those that have refused to engage in legal process.
- A multi agency team has been established and additional resources have been deployed to tackle the immediate crisis which is selective licensing, waste/ environmental issues and supporting young people. Crime remains low but fear of crime and ASB remains high. Unprecedented demand for local health services remains a risk which is being managed within budgets available.
- Reviewed the Policing Plan for the Page Hall area.
- A new Cohesion Strategy (and family of related strategies) has been commissioned.
- A review of Grant Aid funding in the area has taken place to inform future years funding.
- Mapping community development activities in the area affected by new arrivals

What are we planning to do next?

Stakeholder engagement for the new cohesion strategy – A set of documents that explain how all new arrivals will be helped has been commissioned from Maxine Stavrianakos (H&NS - Head of Service), and it is hoped this will be completed by the end of the financial year. We will be involving all key stakeholders (including health) to shape the new strategy.
This work will also create a family of strategies that will feed into the *Cohesion Strategy – Asylum Strategy, New Arrivals & Migration Strategy etc***.**

The Asylum Strategy will use the 'asylum/immigrants journey' which has been mapped from when they first enter the UK through to the various agencies/ pathways, when they arrive in Sheffield and the support that is available to help them settle, integrate and seek access to work/access to services & support at a local level.
The *Cohesion Strategy* will be the route map that will inform the City's key strategies about how communities work and how we deliver services and support communities through direct Council delivery, working with Partners and VCF. The previous strategy did not reflect our ambitions and not well connected.
Aim also to incorporate education, employment, business issues. Need to develop employment opportunities in the local areas/neighbourhood planning.
Bidding is taking place to secure 'rogue landlord funding' from government (current funding ends 31.3.15).
A detailed short and medium term strategy has been developed for areas affected by rapid migration – Page Hall, Darnall, Burngreave and Grimesthorpe.
A bid that will seek some short term financial support for supporting key services including health, schools, community and housing has been submitted to CLG – outcome of meeting with ministers should be known by the end February.
Alongside this a long-term business case for the city affected by impact on migration in the above areas is being prepared working in partnership with Government Public Transformation team. This work should be completed by October 2015 and will include data mapping of resources, interventions and impact. A new Housing and Health Needs Assessment for Page Hall is underway to help inform the long term business case and will present a series of propositions to government in the autumn.

Action 3.7

Commission disease specific interventions, including a programme to improve the physical health of the severely mental ill and those with a learning disability.

This action overlaps with a number of others in the HIAP, most significantly action 2.8 'maintain a focus on CVD and cancer'. Over the past year the CCG has made significant progress with improving the physical health of people with serious mental illness and learning disability, which was the origin of this action in the HIAP. This work is continuing and is supported by recent national directives on achieving 'parity of esteem'. The CCG's current and future work on commissioning disease-specific interventions (all with a focus on reducing health inequalities) includes: reviewing and improving respiratory services; commissioning a liaison psychiatry service that will also enhance treatment and support for people with alcohol problems; and participating in a review of the City's TB services as part of the recently published national TB strategy.

Action 3.8

Support quality and dignity champions to ensure services meet needs and provide support.

Actions to Date
Healthwatch Sheffield have conducted a mapping exercise of existing dignity champions in the city. We have sent out a Survey Monkey questionnaire (223 by email, 14 by post) to all providers of care (domiciliary and care homes) in Sheffield, accompanied by a supporting letter from the Director of Public Health. Despite this we have only received four responses.

What are we planning to do next?
Conduct a literature search on the benefits of promoting the dignity agenda in terms of positive change for patients. Re-mailing of survey to providers of care, plus an extension of the survey to include health providers. Identify the benefits (or otherwise) of dignity champions, and areas where numbers are low across health and social care. Considerations of dignity will be incorporated into the forthcoming Enter and View schedule planned between February and May. A report on the final mapping, results from Enter and View and potential interviews with providers will be available in October 2015.

Action 3.9

Work to remove health barriers to employment through the health, disability and employment plan.

Action to date

- Produced a baseline study. https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/work-programmes/health-dis-employ.html
- Reviewed existing commissioned employment support across SCC and CCG on behalf of Member Working Group
- Incorporated findings into work with Public Sector Transformation Network, held multi agency session and initial action plan produced
- Currently seeking LEP support to develop increased opportunities across employers
- A £375k jointly funded pilot project between PH and JCP for ESA claimants has gone out to tender and contracts awarded.(SOAR, ZEST and MCDT were successful providers) Evaluation framework developed
- Resource secured to deliver Public Health England's Workplace Wellbeing Charter. Joint working with Rotherham, Barnsley and Doncaster

What are we planning to do next?
Working with Learning and Skills and Policy teams and CCG +JCP to develop new pathway from health system into employment system to increase

inclination and opportunity for employment for those with disabilities and health conditions. Also aiming to develop wider Employment Support Allowance (ESA) pilot as part of SCC Devolution Deal, using existing pilot as 'initial test'
Ensure supported employment commissioning activity is complementary and effective, and if not, secure re-alignment
Secure LEP collaboration and alignment of resources from their Economic and Social Inclusion commitments.
The contracts for the ESA pilot are about to be mobilised, and this work will be evaluated. Each contract(3 contracts) is seeking to work with around 140 ESA claimants and return 50 -60 back into employment during the contract (currently Work Programme providers can claim over £10,000 for returning those furthest from the labour market back into work for sustained periods)
Sign up 30 businesses across the City to the Workplace Wellbeing Charter in 2015/6

Action 3.10

To promote health literacy and earlier engagement with health services in disadvantaged communities.

Action to date

Health Literacy is important part of the plan to improve appropriate access to services. Research indicates that community-based peer support is likely to improve health literacy. This is particularly the case when peer supporters have something in common with the participants and get them involved in social networks; where there are opportunities to talk about their problems and get advice on how to manage from each other, and where participants are in control of identifying what they would like to do to address health and other issues.

Community programmes such as the CWP and the Health Trainer programme are able to help people understand factual health information. Health Trainers have been instrumental in improving health and wellbeing by setting and achieving goals as well as increasing health literacy in their clients. Clients have developed psychological and physical capabilities. As they experience success they become more motivated to change habits and routines and are more confident to try new things. Increased confidence in turn leads people to seek out opportunities independently and need less help from the Health Trainer.[1]

What are we planning to do next?

We will continue to work with local communities, community organisations and professionals working in those communities to increase health literacy by

[1] Janet Harris1, Tim Williams2, Oliver Hart3, Chris Hanson4, Gareth Johnstone5, Aziz Muthana5 and Chris Nield5 (2013) Using health trainers to promote self-management of chronic pain: can it work? British Journal of Pain 2014, Vol 8(1) 27– 33

increasing connections between and within communities and develop peer support.
There are opportunities to build on the success and integrate the programme with GP Personal Centred Care. We will further develop and extend the Community Wellbeing Programme, Health Champion, and Health Trainer model which embraces peer support so that disadvantaged areas have access to these services.
A health literacy and empowerment approach is central to self-management of health and learning from this approach will also inform the development of work to improve access to services. (See response to action 3.5)

Action 2.1

Promote a citywide approach to emotional wellbeing and mental health, focussing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.

Action 2.4

Support the “More More” initiative to encourage people to be more physically active as part of their daily lives.

Actions to date
A Move More Officer has been appointed and is now in post and being effective. A digital hub has been established as a ‘go to’ resource for information about physical activity in the City. An active Move More network has been established.

What are we planning to do next?
Further implementation of the ‘Move More’ Strategy. Discussion about Governance arrangements due at the Health and Wellbeing Board at end Feb.

Action 2.5

Commission and implement an integrated approach to reducing levels of tobacco use through integrated work on: 1 – helping people to stop smoking, 2 – smoke free environment, 3 – smokefree children and young people, 4 – community based action on illegal tobacco, 5 – social marketing and communications to reduce smoking prevalence and de-normalise tobacco use, 6 – reduce smoking prevalence amongst pregnant women.

Actions to date

A comprehensive programme of tobacco control to reduce smoking prevalence within Sheffield was launched on 1 April 2014. The three year programme is based on best evidence from the World Health Organisation, a comprehensive

consultation with key stakeholders and based on local health need. The programme comprises of six services, which together, in partnership aim to reduce smoking prevalence amongst adults, pregnant women and children (in line with the Public Health Outcome Framework indicator targets). The services are delivered by a range of private, public and VCF provider organisations. The providers are brought together on a quarterly basis in a 'Tobacco Control Hub' to share learning and develop a common tobacco control brand for the city. Performance is reviewed quarterly in contract monitoring meetings.

The newly commissioned tobacco control programme is as follows:

1) Smokefree Service, with prioritised action amongst population groups with the highest smoking prevalence, most addicted and need the most support to quit smoking, including residents living in the 20% most deprived areas of the city, certain BME groups and those with a diagnosed mental health condition.
   Unfortunately take up of this service has fallen off significantly in the last year, probably because would be quitters are increasingly using e-Cigarettes rather than accessing the service. This has led to a significant underspend against this budget in year.
2) Smokefree Spaces Service, to protect children under five and families from exposure to harmful tobacco smoke in homes and cars and help denormalise tobacco use within communities
3) Smokefree Children and Young People, to reduce smoking prevalence amongst young people by introducing a 'whole school approach to tobacco control' including Smokefree lessons and support for young people and staff who smoke.
4) Community development action for illegal tobacco, raising the harm caused within communities and how illegal tobacco encourages and actively enables young people to become 'hooked' on cigarettes, and remain smoking into adulthood.
5) A programme of marketing and communications for tobacco control, cross cutting all strands of the tobacco control programme. The provider is commissioned to deliver three campaigns each year. This service is delivered in partnership with Doncaster and Rotherham Councils.
6) A stop smoking relapse prevention service for pregnant women – to help women remain Smokefree post pregnancy (please note, this service launched January 1st 2015 after a successful open procurement process).

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

What are we planning to do next?

The introduction of a comprehensive programme of tobacco control will ensure the city has comprehensive strategy in place to reduce smoking prevalence and the harm caused by tobacco across all communities in Sheffield.
An increase in the use of e-cigarettes has had a considerable impact on numbers accessing the Smokefree Services for support to quit. This is not a unique situation to Sheffield, instead is an issue being dealt with across the country. In Sheffield, at this stage, we are not considering stop smoking service as being non-viable because evidence clearly points to them providing the best overall success rates and we cannot let down those smokers who whose lives would be saved by them. However we are working locally with tobacco control partners to harness the potential health gain associated with e-cigarettes as a harm minimisation tool. Alongside which we are also working to improve service uptake by increasing marketing and communications whilst introducing 'new routes to quit', including telephone support, quitting online and a greater use of social media to make the service more accessible to smokers who want to quit.
At the same time there is an intention to carry forward £400K of PH Grant underspend to use in other areas of tobacco control to counteract the reduction in the number of smokers accessing support locally. This will likely include enhanced media work and increasing the level of resource for enforcement action across the City.

Action 2.6
Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.

Actions to date
Sheffield DACT has successfully implemented the Commissioning and Procurement Plan for community drug and alcohol services. The Cabinet approved the DACT's plan for three end to end services for Opiates, Non-Opiates and Alcohol in January 2014 and they were successfully awarded in July 2014. Services for Opiates and Non Opiates went live on 1st October 2014. A decision has been reached to delay the tender for Alcohol Services to allow opportunities for integrated commissioning with the CCG to be explored and a waiver has been secured to this end.
The Drug Interventions Programme (DIP) continues to provide an effective link between the criminal justice and substance misuse systems with 41% of referrals to structured treatment in Sheffield coming from the criminal justice system. DIP and other DACT interventions provide identification, assessment, harm reduction and engagement services into both drugs and alcohol services.
The Hidden Harm Service will continue to be resourced by DACT and a service level agreement has been agreed between Sheffield Safeguarding Children's Board and DACT and is now with Commercial Services.

What are we planning to do next?

There is an opportunity in that SHSC have won both contracts for Opiates and Non Opiates and are the incumbent provider for alcohol, therefore there is a single provider in the City at present. Any issues will be addressed in ongoing proactive contract and performance management.

Recent changes to provider organisations including the division of the Probation Service and the subsequent changes to delivery structures has led to a number of strategic reviews of integrated working with partner organisations, more effectively targeting a broader range of substance misusing offenders.

Action 2.8

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

Both the council and the CCG continue to have multiple strategies and programmes of work that aim to reduce levels of heart disease and cancer in people in Sheffield. This action in the HIAP overlaps with many other actions in the plan, including action 3.4 'improving access to services' and action 3.7 'commissioning disease specific interventions'. For example, the Council's strategies to reduce tobacco consumption, increase physical activity and improve diet in the Sheffield population will reduce illness and death from heart disease and cancer. The Council is also working with Sheffield Action for African-Caribbean Health (SAACH) to explore a strategy for engaging African-Caribbean men and their partners in an effective way around prostate cancer.

In the CCG, specific cardiovascular disease action is focused on stroke prevention in atrial fibrillation; improved detection and treatment of chronic heart failure; and improved detection and treatment of familial hypercholesterolaemia. For cancer, the CCG supported the Be Clear on Cancer campaigns on breast, lung, and bladder and kidney cancers.