Sheffield City Council

Equality Impact Assessment

Name of policy/project/decision: Joint Health and Wellbeing Strategy

Status of policy/project/decision: New

Name of person(s) writing EIA: Louisa Willoughby

Date: 21 September 2012 **Service:** Commissioning

Portfolio: Communities

What are the brief aims of the policy/project/decision?

The Joint Health and Wellbeing Strategy 2012-13 sets out the strategic mission and associated outcomes for the city and ultimately, ambitions of the Health and Wellbeing Board (HWB). It is a developing and growing document, formed out of the evidence of the Joint Strategic Needs Assessment, and is subject over 2012-13 to revision.

The JHWS contains a clear mission:

- Tackle the main reasons why people become ill or unwell and in doing so reduce health inequalities in the city.
- Focus on people – the people of Sheffield are the city's biggest asset. We want people to take greater responsibility for their own wellbeing by making good choices. Services will work together with Sheffielders to design and deliver services which best meet the needs of an individual.
- Value independence – stronger primary care, community-based services and community health interventions will help people remain independent and stay at or close to home.
- Ensure that all services are high quality and value for money.
- Value independence - stronger primary care, community based services, preventative housing support and community health.

The HWB will look to influence people and organisations in Sheffield, commission and jointly commission services, and provide direct strategic leadership to 5 'work programmes' in order to deliver the five outcomes identified in the Strategy.

A short period of consultation was carried out in summer 2012. The decision to do this, made by the Board in June 2012, was based on the premise that the Health and Wellbeing Board would carry out a wider and broader consultation exercise in summer 2013. The consultation carried out was therefore not intended to be definitive, but to form part of the strategy's wider development. Invariably a short period of consultation means that not everyone or every group is able to feed back into the process, but the consultation was not the only opportunity that people and groups will have to have their say. The action plan included at the end of this EIA lists a number of measures to ensure the input of protected groups is received.

Information about the short consultation - which included an online questionnaire and an open shop on the Moor - was emailed and posted out to key partners, health, children's and other networks, providers, GP surgeries, libraries, Community Assemblies and adult social care users, encompassing a variety of statutory, voluntary and private sector groups alongside members of the public.

Four key questions were asked:

1. To what extent do you agree or disagree that we are focussing on the right outcomes for Sheffield?

2. What do you think are the most important things we need to do to achieve our outcomes?
3. How do you think doctors and the Council can work differently to improve health and wellbeing in Sheffield?
4. Would you like to be involved in improving health and wellbeing in Sheffield?

In addition, nearly 400 members of the public, including children and young people, were asked about what would help them to be healthier on small postcards. A wide range of people of all ages from a cross-section of Sheffield neighbourhoods was asked.

The online survey gave people the option of giving their gender, age, ethnicity, neighbourhood and sexuality; however, few people took the option of filling this out. It was ensured that information about the consultation was sent to representatives of all protected groups, and comments were received from the following groups:

- Children and young people's groups, including those with mental health illness.
- Environmental groups.
- Health interest and involvement groups, including PDSI and carers.
- Linked statutory bodies, e.g. NHS.
- Political groups.
- Public health.
- Sheffield City Council.
- Sports and exercise.
- Universities.
- Vulnerable people.

There are some gaps in the responses received. For example, no response was knowingly received from BME groups, those with a learning disability, LGBT or older people, although respondents from those groups may have been anonymous respondents to the online questionnaire or formed part of responses from other groups from the list above.

As noted earlier, it is the intention of the Health and Wellbeing Board that once the Health and Social Care Act 2012 comes into force in April 2013, the Strategy will be refreshed and a further period of consultation will take place in spring/summer 2013. This further consultation will make a strong effort to ensure that all key groups identified in this EIA are consulted and engaged with. Further development of the JSNA as part of this process will include a strong focus on involving the VCF sector, which represents many of the protected groups.

Are there any potential Council staffing implications, include workforce diversity?

There are no direct Council staffing implications; however, the Board will use the strategy to assess commissioning plans which may amount to changes. However, there is a potentially positive impact in that the positive outcomes within the strategy apply to Sheffield citizens, which will include SCC staff.

The strategy also states that, "A key component of good health and wellbeing is finding and maintaining long term, meaningful and satisfying employment." This will benefit Council workers, and the strategy's aim to manage barriers to work will benefit people with mental ill health and physical disabilities, which could benefit staff workforce positively.

Under the Public Sector Equality Duty, we have to pay due regard to: "Eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations."

Areas of possible impact	Impact	Impact level	Explanation and evidence

Areas of possible impact	Impact	Impact level	Explanation and evidence
Age	Positive	High	The strategy has a focus on all Sheffield citizens, from young to old. There is also a particular focus on Early Years outcomes, including assistance to families to promote a best start in life, and increase of children and young people with increased complex needs and increase in health inequalities. ▪ It is right to do this because whilst children and young people growing up in Sheffield today are generally healthier than ever, between the 'best' and the 'worst' wards in the city we have: ▪ 2 fold difference in achievement at Early Years Foundation Stage; ▪ 4 fold difference in infant mortality rates; ▪ an 8 year gap in male and female life expectancy at birth ▪ Young people are also at risk of obesity. The strategy also recognises the growing older population in Sheffield and seeks to respond to the potential impacts on health and wellbeing from this. ▪ It is right to do this because Sheffield has seen longer life expectancy with a 24% increase in the number of people aged over 75 and more than a doubling of people aged over 85. ▪ Currently around 9,000 older people receive support, and by 2025 it is estimated that there will be a 23% increase in people aged over 75 years living alone, and an increase of 21% in people over 65 years old unable to manage at least one self-care activity (such as washing or dressing) on their own. Comments on behalf of this group were submitted to the Health and Wellbeing Board to be considered as part of its summer 2012 consultation on the strategy. Information about how the revised version of the strategy responded to these comments will be included in a 'You Said, We Did' report (see action plan).
Disability	Positive	High	The strategy has a strong focus on helping and supporting the disadvantaged and improving access to services. The strategy is particularly specific in its mention of mental wellbeing, helping those with learning disabilities, and supporting those with dementia. ▪ It is right to do this, because we predict significant increases in the number of disabled people over the next 10 to 15 years. In particular, we expect there will be an increase the number of people with the most complex disabilities (including people with disabilities from black and ethnic minority groups) who require high levels of support from health, housing and social care services. ▪ There has been a large increase in the number of children and young people with a learning disability since 2000, and in the last ten years the number of 10 to 20 year olds with a learning disability increased by 120%, although in the last five years the number increased by 38%, suggesting that the rate of increase may be slowing. ▪ Data also indicates a significant increase in the number of people in Sheffield with severe or complex needs, and again particularly in younger age groups. The overall number of people with such needs rose by 17% between 1998 and 2008. However, the number of 15 to 19 year olds with severe or complex needs increased by 70% over the same time. ▪ Although deaths from suicide and undetermined injury in Sheffield are lower than the average for England, local audit has indicated that depression was a key factor in 40% of deaths between 2006 and 2010. ▪ In Sheffield we currently have 6,382 people living with dementia and this is expected to rise to 7,342 by 2020 and 9,340 by 2030. The biggest increase will be in the people aged 85+ which will nearly double over the same period. A relatively small number of people with dementia are from black and ethnic minority groups, but this will increase substantially in future years. The increases projected in the City's population means that by 2020 there will be an

Areas of possible impact	Impact	Impact level	Explanation and evidence
			increase of over a thousand older people projected to suffer from dementia; by 2030 there may be an additional 3,000 people with this illness. Comments on behalf of this group were submitted to the Health and Wellbeing Board to be considered as part of its summer 2012 consultation on the strategy. Information about how the revised version of the strategy responded to these comments will be included in a 'You Said, We Did' report (see action plan).
Pregnancy /maternity	Positive	High	The strategy has a strong focus on offering children the best start in life, recognising that this starts with pregnancy/maternity. ▪ This is important, because smoking during pregnancy is reducing in Sheffield but is still above the national rate and there is a seven fold difference at Community Assembly level in the proportion of women who are smoking 'at delivery'. ▪ Breastfeeding rates are above the national average - currently 52.3% women are breastfeeding at 6-8 weeks compared to a national average of 45.2%, but again wide inequalities exist within the city. ▪ Numbers of pregnant women with substance misuse issues has remained stable (c.60 per annum) despite an overall national decline in problematic substance misuse. The limited consultation held over summer 2012 did not identify a specific response from those affected by pregnancy/maternity. However, those affected will be a focus of summer 2013's wider consultation.
Race	Positive	High	The strategy states that it wishes to, "Increase health promotion and support better engagement of BME groups to improve health outcomes." Several of the priority measures in the strategy include targeting health interventions for BME groups and asylum seekers. ▪ This is important, because there are similar inequalities between different groups of people in the city – generally speaking, Black and Minority Ethnic (BME) people in the city have lower attainment at school, are more likely to be victims of crime and anti-social behaviour and are less likely to be able to find work than Sheffield's population as a whole. ▪ Similarly, there is clear evidence that particular BME communities also have a range of specific health and wellbeing needs, reflecting distinct communities of people with strong identities, and different cultural backgrounds, beliefs and experiences. Many of these communities, although not all, experience relatively poor health and wellbeing, and a number experience relative poor health in respect to coronary heart diseases (stroke is 70% more common among African Caribbean and South Asian populations); Type 2 diabetes (six times more prevalent in South Asian communities); and mental health (31% of people detained under the Mental Health Act were from BME communities in 2006/7, although BME communities only make up around 15% of Sheffield's population). The limited consultation held over summer 2012 did not identify a specific response from BME communities. However, those affected will be a focus of summer 2013's wider consultation.
Religion/belief	Positive	Low	The strategy does not impact on religion/belief specifically, but those of particular religions/beliefs may find themselves fitting other categories, such as pregnancy/maternity, disability or race. The limited consultation held over summer 2012 did not identify a specific response from religion/belief communities. However, those affected will be a focus of summer 2013's wider consultation.
Sex	Positive	High	The strategy has a strong positive focus on pregnancy/maternity issues and on improving the life expectancy of men. The strategy also seeks to help those experiencing domestic abuse. This can affect

Areas of possible impact	Impact	Impact level	Explanation and evidence
			both men and women although statistically more women. ▪ In 2009, Home Office estimates suggested that 16,616 women and girls were victims of domestic and sexual abuse in Sheffield and 8,576 women and girls were victims of sexual assault. Estimates also suggest that there are between 1,092 and 3,185 hospital attendances a year in Sheffield which are directly attributable to domestic abuse. ▪ Partnership working is targeting pregnant women at risk of domestic abuse in order to offer early support and ensure, via the MARAC system, that agencies are aware of families with children under 1 where the risk of serious harm or homicide is high. ▪ There is clear evidence of the adverse effects of domestic violence on women's mental health, that it can last for many years and that it leads to increased use of mental health services. A meta-analysis of 18 studies found an average rate of post-traumatic stress disorder among victimised women of 64%, a rate of depression of 48% and a suicide rate of 18%. Comments on behalf of this group were submitted to the Health and Wellbeing Board to be considered as part of its summer 2012 consultation on the strategy. Information about how the revised version of the strategy responded to these comments will be included in a 'You Said, We Did' report (see action plan).
Sexual orientation	Positive	High	The strategy is clear that it will assist and support those who are disadvantaged, which may be those of a particular sexual orientation. There is a specific reference to lesbian, gay and bisexual people and the health disadvantages experienced by them. The limited consultation held over summer 2012 did not identify a specific response from LGB communities. However, those affected will be a focus of summer 2013's wider consultation.
Transgender	Positive	High	The strategy is clear that it will assist and support those who are disadvantaged, which may be those who are transgender. The limited consultation held over summer 2012 did not identify a specific response from transgender communities. However, those affected will be a focus of summer 2013's wider consultation.
Carers	Positive	High	One of the strategy's central aims is to provide support to people at or closer to home. It aims to give people the services that they need and feel is right for them. The strategy states that the aim is that "carers are valued and treated as equal partners", and recognises the disadvantage they sometimes face. The strategy also mentions the need to look after young carers. ▪ This is important because the estimated the number of carers in Sheffield will be 66,715 by 2015, higher than the national estimates suggest. Although caring can be an immensely positive experience, there is also evidence that caring can increase physical stress, lack of sleep and long term limiting illness, with a strong association between long hours of caring (50+) per week and mental health issues, including increased stress, anxiety and depression. Caring commitments can reduce opportunities for training and education, loss of income (including increased likelihood of poverty and reliance on benefits), increased costs and reduced levels of social interactions and friendships. ▪ There are also inequalities in caring, with a higher proportion of carers providing at least 50 hours care per week in the more deprived areas of Sheffield. Comments on behalf of this group were submitted to the Health and Wellbeing Board to be considered as part of its summer 2012 consultation on the strategy. Information about how the revised version of the strategy responded to these comments will be included in a 'You Said, We Did' report (see action plan).
Voluntary, communit	Positive	High	The strategy recognises the crucial role that the VCF sector plays in improving health and wellbeing and delivering key services in Sheffield.

Areas of possible impact	Impact	Impact level	Explanation and evidence
y & faith sector			Comments on behalf of this group were submitted to the Health and Wellbeing Board to be considered as part of its summer 2012 consultation on the strategy. A Third Sector Assembly health themed meeting was attended which sought to identify how engagement with the VCF sector can be improved. A member from VAS is present on the JSNA programme management group, while representatives from LINk are present on the Health and Wellbeing Board.
Financial inclusion, poverty, social justice:	Positive	High	One of the key outcomes of the strategy is that health inequalities reduce. The strategy is also clear and strong in its focus on the wider determinants of health. ▪ For example, 12% of households rely on benefits and 8% of older people are on some sort of state support. Around 24% of Sheffield's dependent children and 28% of the population over 60 years old live in households claiming Housing and/or Council Tax Benefit. There are 29 neighbourhoods in the city that are within the most 20% deprived within England, in total accounting for 28% of the city's population, whilst there are seven neighbourhoods in the 10% of least deprived locations in England. ▪ Whilst social cohesion has to date remained positive in the city, the continuing financial and economic crisis is beginning to impact on the people who live in Sheffield. This affects people's health, including their mental health. For example, a key concern is the number of young people becoming homeless with almost half of priority homeless cases aged 16 to 24 years old. ▪ 19% of private households in the city experience fuel poverty compared to 13% in England as a whole. ▪ The economic climate also affects people's mental health. For example: 11,000 people in Sheffield claim Employment Support Allowance because of mental health conditions and 87% of these have been claiming for over two years. Information about how the revised version of the strategy responded to these comments will be included in a 'You Said, We Did' report (see action plan).
Cohesion:	Positive	High	One of the key outcomes of the strategy is that health inequalities reduce. Through its ten key principles the strategy states that its aim is for strong, resilient communities which enable people to have control over their lives. The limited consultation held over summer 2012 did not identify a specific response about cohesion. However, those affected will be a focus of summer 2013's wider consultation.
Other/additional: Independence	Positive	High	The strategy is clear that it values independence and allowing people to make their own choices for their lives. For example, one of the outcomes is that "People can get health, social care, children's and housing services when they need them, and they're the sort of services they need and feel is right for them." The limited consultation held over summer 2012 did not identify a specific response about independence. However, those affected will be a focus of summer 2013's wider consultation.

Overall summary of possible impact (to be used on EMT, cabinet reports etc): Positive.

Review date: As the strategy is going through a process of constant revision and development over 2012-13, with final approval in September 2013, we propose regular revision of this EIA to ensure the strategy's development involves and consults the right people. As such it is proposed that this EIA is updated and reviewed in January 2013, April 2013 and August 2013.

Approved (Lead Manager): **Date:**

Approved (EIA Lead person for Portfolio): Phil Reid **Date:** 01 October 2012

Does the proposal/ decision impact on or relate to specialist provision: -Select-

Action plan

As the Strategy is going through regular revision and development over 2012-13, the following actions are suggested:

- Reviewing and where necessary updating the EIA in January, April and August 2013. (Lead officer: Louisa Willoughby.)
- Issuing a consultation report (in a 'You said, We Did' format) which will demonstrate how the responses from protected groups to the consultation has been utilised in the strategy and/or state why this has not been the case. (Lead officer: Louisa Willoughby.)
- Including monitoring of progress and performance of outcomes in the final version of the strategy to ensure that as far as possible the groups listed in the table above are positively affected by the strategy's progress and development and face no negative impacts. This may also consider the possibility of having equalities sub-indicators under each outcome's performance measures. (Lead officer: TBC.)
- Identifying opportunities to build an EIA approach into Health and Wellbeing Board activity and scrutiny, e.g. commit to carry out/monitor EIAs for all jointly commissioned services. (Lead officer: Miranda Plowden.)
- Working to ensure that each of the 5 work programmes systematically considers equality issues/impacts. (Lead officer: Joanne Knight.)
- Ensuring that the consultation carried out in summer 2013 seeks the views of those groups listed in the table above. This could be done by holding focus groups, engaging with community/interest groups and networks, and relevant professionals in the field. The consultation in summer 2012 identified some gaps, e.g. LGBT, older people's and BME representation, and so these groups will be a focus of summer 2013's consultation. (Lead officer: Louisa Willoughby.)
- Updating the JSNA to ensure that the data and evidence surrounding protected groups is up-to-date, appropriate and relevant. This will include working with the VCF sector. (Lead officer: James Henderson.)

Approved (Lead Manager): **Date:**

Approved (EIA Lead Officer for Portfolio): Phil Reid **Date:** 01 October 2012

This page is intentionally left blank