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Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 26 September 2013 at 2.00 pm

Town Hall, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Julie Dore	
Councillor Jackie Drayton	
Councillor Harry Harpham	
Councillor Mary Lea	
Dr Amir Afzal	Clinical Commissioning Group
Dr Margaret Ainger	Clinical Commissioning Group
Ian Atkinson	Clinical Commissioning Group
Dr Ted Turner	Clinical Commissioning Group
Dr Tim Moorhead	Clinical Commissioning Group
Margaret Kitching	South Yorkshire and Bassetlaw Cluster
Jayne Ludlam	Executive Director, Children, Young People & Families
John Mothersole	Chief Executive
Richard Webb	Executive Director, Communities
Dr Jeremy Wight	Director of Public Health
Jason Bennett	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.

Members of the public have the right to ask questions at Board meetings and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and details of the Council's protocol on audio/visual recording and photography at Council meetings. If you require any further information please contact Jason Dietsch on 0114 273 4117 or email jason.dietsch@sheffield.gov.uk

FACILITIES

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

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

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

4. Joint Health and Wellbeing Strategy 2013-18 Approval (Pages 5 - 46)

5. Health and Wellbeing Outcome Indicators for Sheffield (Pages 47 - 52)

6. Presentation on Healthwatch and the Health and Wellbeing Board

7. Winterbourne View - Sheffield's Actions in Response to the National Programme of Action (Pages 53 - 60)

8. Presentation on the Health and Wellbeing Board's Progress with Integration

9. Minutes of the Previous Meeting (Pages 61 - 69)
To approve the minutes of the meeting of the Sheffield Health and Wellbeing Board held on 27 June 2013.

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 12 December 2013 at 2.00 pm

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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**

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Sheffield Clinical Commissioning Group

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Councillor Julie Dore and Dr Tim Moorhead Co-Chairs of the Sheffield Health and Wellbeing Board
Date:	26 September 2013
Subject:	Joint Health and Wellbeing Strategy 2013-18 Approval
Author of Report:	Louisa Willoughby, 0114 205 7143

Summary:

Producing a Joint Health and Wellbeing Strategy is one of the Health and Wellbeing Board's key duties. It is a plan to improve the health and wellbeing of Sheffield people. It identifies things that will *directly* make a difference to people's health and wellbeing, such as investing in cancer services, but it also looks at the health and wellbeing system in Sheffield and its ways of working.

The Strategy is divided into ten principles and five outcomes, and is supported by five work programmes. These are built on the evidence as set out in the Joint Strategic Needs Assessment, and the views of Sheffield people heard through extensive consultation and engagement.

The Health and Wellbeing Board cannot do everything, but it can make a difference in some key areas. This Strategy therefore does not cover every health and wellbeing service provided in Sheffield, but instead seeks to set out the biggest things that the Health and Wellbeing Board would like to see happen and which the Board believes would make the biggest difference to health and wellbeing.

In some cases this will require the Board to do something new. In other cases it will require the Board to support initiatives that are already in place, and ensure such initiatives are geared up to improve health and wellbeing in Sheffield and aligned to the work of the Health and Wellbeing Board.

The Strategy is a long-term Strategy, recognising that big changes to health and wellbeing take time to develop and implement, and that progress and performance targets have to be given time to be demonstrated.

It is a sustainable Strategy in that it recognises the financial climate that the Health and Wellbeing Board is operating in, but aims to offer innovative services that are value for money by working in new and different ways.

Sheffield's Health and Wellbeing Board published a draft Strategy in autumn 2012. After a year of consultation and development, a more detailed Strategy has been produced for 2013-18. This paper asks for the Health and Wellbeing Board's approval for this final version of the Strategy.

Questions for the Health and Wellbeing Board:

- Is the Health and Wellbeing Board happy to approve this Strategy in its entirety, committed to publishing it within the next few weeks?

Recommendations:

- That the Health and Wellbeing Board approves this Strategy.
- That the Health and Wellbeing Board's partner organisations commit to delivering the Strategy.

Reasons for Recommendations:

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

Background Papers:

- Sheffield's Joint Health and Wellbeing Strategy 2013-18 – appended to this paper.
- Joint Health and Wellbeing Strategy Equality Impact Assessment – appended to this paper.
- Joint Strategic Needs Assessment – available online at: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA/positionstatement.html.
- Joint Health and Wellbeing Strategy Consultation Report – available online at: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/strategy-consultation.html.
- Fairness Commission Report – available online at: https://www.sheffield.gov.uk/your-city-council/policy--performance/fairness-commission.html.

JOINT HEALTH AND WELLBEING STRATEGY APPROVAL

1.0 SUMMARY

1.1 Producing a Joint Health and Wellbeing Strategy is one of the Health and Wellbeing Board's key duties. It is a plan to improve the health and wellbeing of Sheffield people. It identifies things that will *directly* make a difference to people's health and wellbeing, such as investing in cancer services, but it also looks at the health and wellbeing system in Sheffield and its ways of working.

1.2 The Strategy is divided into ten principles and five outcomes, and is supported by five work programmes. These are built on the evidence as set out in the Joint Strategic Needs Assessment, and the views of Sheffield people heard through extensive consultation and engagement.

1.3 The Health and Wellbeing Board cannot do everything, but it can make a difference in some key areas. This Strategy therefore does not cover every health and wellbeing service provided in Sheffield, but instead seeks to set out the biggest things that the Health and Wellbeing Board would like to see happen and which the Board believes would make the biggest difference to health and wellbeing.

1.4 In some cases this will require the Board to do something new. In other cases it will require the Board to support initiatives that are already in place, and ensure such initiatives are geared up to improve health and wellbeing in Sheffield and aligned to the work of the Health and Wellbeing Board.

1.5 The Strategy is a long-term Strategy, recognising that big changes to health and wellbeing take time to develop and implement, and that progress and performance targets have to be given time to be demonstrated.

1.6 It is a sustainable Strategy in that it recognises the financial climate that the Health and Wellbeing Board is operating in, but aims to offer innovative services that are value for money by working in new and different ways.

1.7 Sheffield's Health and Wellbeing Board published a draft Strategy in autumn 2012. After a year of consultation and development, a more detailed Strategy has been produced for 2013-18. This paper asks for the Health and Wellbeing Board's approval for this final version of the Strategy.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 The Joint Health and Wellbeing Strategy is a broad, overarching strategy which recognises that good health and wellbeing is a matter for every service area, and that people are healthy and well not just because of the health and social care they receive, but also because of the nature of the housing, environment, communities, amenities, activities and economy surrounding them. The Strategy focuses therefore not just on specific interventions to improve health and social care, but also on the 'wider determinants' of health.

2.2 This means that the Health and Wellbeing Board aims for *all* Sheffield people to be *positively* affected by the Joint Health and Wellbeing Strategy. The Strategy focuses on people, arguing that the people of Sheffield are the city's biggest asset. The Strategy aims that people are able to take greater responsibility for their own wellbeing by making good choices.

2.3 In creating the Joint Health and Wellbeing Strategy, the Health and Wellbeing Board has been careful to engage closely with Sheffield people and service users, providers and members of the public. The Board can be confident that its Strategy

reflects the needs and concerns of Sheffield people. Services will work together with Sheffield people to design and deliver services which best meet the needs of an individual.

3.0 THE STRATEGY'S OUTCOMES

At the heart of the Strategy are five outcomes, listed below with the vision for each outcome:

1. **Sheffield is a healthy and successful city.**
    - Partners and organisations across the city to actively look to improve health and wellbeing through all areas, even those not traditionally seen as being about health and wellbeing.
    - Housing across the city to be of a good quality, well–insulated with affordable bills and healthy and safe facilities.
    - Sheffield people to be well-trained and able to access a range of fairly paid employment opportunities irrespective of disability, and for the city's economy to grow supporting the health and wellbeing of the people of Sheffield.
    - Poverty, such as income poverty, fuel poverty and food poverty, to reduce, and that those affected by poverty are supported and encouraged to lead healthy lives.

2. **Health and wellbeing is improving.**
    - Sheffield children, young people, families adults to be emotionally strong and resilient, and for emotional wellbeing to be promoted across the city.
    - Sheffield children, young people and adults to be living healthily – exercising, eating well, not smoking nor drinking too much alcohol – so that they are able to live long and healthy lives.

3. **Health inequalities are reducing.**
    - Data about health inequalities in Sheffield to be excellent so that commissioners can be well-informed in tackling the issues.
    - Sheffield's communities to be strong, connected and resilient, able to withstand crises and to support members of the community to live whole and healthy lives.
    - Those groups especially impacted by health inequalities to have sensitive and appropriate services that meet their needs and improve their health and wellbeing.

4. **People get the help and support they need and is right for them.**
    - Sheffield people receiving excellent services which support their unique needs.
    - Clear availability of information and support about health and wellbeing so that Sheffield people are able to help themselves.
    - Patients and service users involved in decisions and their opinions valued.

5. **Services are innovative, affordable, and deliver value for money.**
    - Sheffield people at the centre of the Sheffield health and wellbeing system, underpinned by strong working relationships between commissioners with a clear methodology for joint working and pooled budgets underpinned by an

innovative and affordable health and wellbeing system fit for the twenty-first century.
- A preventative system that seeks to help and identify people before they are really sick, enabling Sheffield people to stay healthy and well for longer.
- Frontline workers aware of health and wellbeing needs and able to signpost and support service users in obtaining the help they need.

Each outcome area sets out clearly where the Health and Wellbeing Board will focus its attentions over the coming years. Each outcome has a range of actions which are built on the evidence base and feedback from consultations the Board has done.

The Health and Wellbeing Board is aware that the Strategy is aspirational and that the economic situation is difficult. National priorities within the fields of health and wellbeing may develop over time, which may affect the Strategy. However, the Board believes that this is an opportunity for change and a redefinition of priorities. The Board wants to be clear about what it wants to achieve but it will be flexible about how this will be done depending on capacity, demands and other pressures.

3.2 HOW WILL THE JOINT HEALTH AND WELLBEING STRATEGY BE IMPLEMENTED?

The actions of this Joint Health and Wellbeing Strategy will be delivered in several different ways. The Health and Wellbeing Board will work together in partnership to:

- **Approve the annual commissioning plans of Sheffield City Council and NHS Sheffield Clinical Commissioning Group.**

  Sheffield City Council, NHS Sheffield Clinical Commissioning Group and NHS England all directly commission health and wellbeing services in Sheffield. The Health and Wellbeing Board will oversee all of these commissioning plans, and although it will not take a direct or detailed role in creating the plans, it will expect the organisations represented on the Health and Wellbeing Board to take the Strategy's actions and goals forward.

- **Support and influence the work of NHS England.**

  NHS England plays a key role on the Health and Wellbeing Board in Sheffield. As commissioners of GPs and other services in Sheffield and across the region and country, NHS England makes crucial decisions affecting Sheffield people.

- **Work with Healthwatch Sheffield to actively engage with the people of Sheffield.**

  Healthwatch Sheffield's role is to represent service user and citizen voice and experiences. The Health and Wellbeing Board will welcome Healthwatch Sheffield's role in bringing the views of children, young people and adults, framing the Board's agendas and way of thinking.

- **Hold partners and providers to account if issues are identified which do not support the outcomes of the Strategy.**

  If there is evidence that the Strategy's outcomes are not being achieved, the Health and Wellbeing Board will hold commissioners and providers to account. This may be in a

formal Health and Wellbeing Board meeting, particularly if it concerns Sheffield City Council, NHS Sheffield Clinical Commissioning Group and NHS England.

The Health and Wellbeing Board also advocates a strong role for the city's scrutiny committees. If required, the Health and Wellbeing Board will report issues for scrutiny committees to investigate. However, the Health and Wellbeing Board will not play a detailed role in the management of specific contracts.

- **Seek to influence local partners and providers to act in a positive way for the health and wellbeing of the people of Sheffield, valuing the Sheffield community of professionals who work in health and wellbeing and/or have an interest or connection to it.**

  A key role of the Health and Wellbeing Board is to be a city leader, influencing others to act in the interest of improving health and wellbeing in the city. Not every action of this Strategy has financial implications. Some, instead, require the Health and Wellbeing Board to work with others to bring about whole-system change. The Board will consider issues escalated to it requiring a city level response and will ensure that essential links are made across work programmes and initiatives.

- **Support further consultation and development of the Joint Strategic Needs Assessment when required.**

  The Joint Strategic Needs Assessment is a key process to understand and define the health and wellbeing needs of Sheffield people.

- **Monitor the health and wellbeing of Sheffield people on an annual basis in accordance with the measures outlined in this Strategy.**

  A set of outcome indicators are set out in section 7 of the Strategy. These are our way of monitoring and finding out if the health and wellbeing, and the experiences of Sheffield people using health and wellbeing services, are improving.

- **Advocate for Sheffield on a national level when it is needed and appropriate.**

  Sometimes change is required on a national level, and as system leader for health and wellbeing in Sheffield it is appropriate that the Health and Wellbeing Board plays a national role when required.

3.3 EQUALITIES IMPACT ASSESSMENT

A full EIA has been carried out and has been appended to this paper. The interests of protected groups have been taken into account throughout the drafting process, with many focus groups and consultation events held directed at specific groups and across the whole city. More information can be found in our consultation report, available online at https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/strategy-consultation.html, where there is a specific section on the views of specific Sheffield communities.

A 'You Said, We Did' report will be written to demonstrate how the views of Sheffield's communities has been taken into account in the final version of the Strategy. Particular reference should be made to the actions included under the third outcome.

4.0 QUESTIONS FOR THE BOARD

4.1 Is the Health and Wellbeing Board happy to approve this Strategy in its entirety, committed to publishing it within the next few weeks?

5.0 RECOMMENDATIONS

5.1 That the Health and Wellbeing Board approves this Strategy.

5.2 That the Health and Wellbeing Board's partner organisations commit to delivering the Strategy.

6.0 REASONS FOR THE RECOMMENDATIONS

6.1 Following the publishing of its draft Strategy in autumn 2012, the Health and Wellbeing Board has heard from over 1,500 people who have fed into the process of developing this final Strategy for 2013-18. The Board can be confident that this is an evidence-based Strategy based on the views and perspectives of Sheffield people.

6.2 It is important to approve this Strategy at this stage so that it can be used to inform the plans for the 2014-15 financial year.

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Sheffield Health and Wellbeing Board

Sheffield Joint Health and Wellbeing Strategy 2013-18

NHS England

NHS Sheffield Clinical Commissioning Group

healthwatch Sheffield

Sheffield City Council

Contents

1. Foreword

Health and wellbeing matters to everyone. Being as healthy and well as we can be helps us to do the things we want to do and means that we can play an active role in our families, our communities and our city. Health and wellbeing is not just about being free from disease: it's about feeling physically, mentally and socially well and socially engaged.

Health in Sheffield has improved considerably over the last few decades but our city is still blighted by inequalities and so we need to take a new approach. The city's new Health and Wellbeing Board is a big opportunity to stand up for Sheffield and start to make a real difference to the health and wellbeing of Sheffield people of all ages.

Sheffield's Health and Wellbeing Board has for the first time brought together the city's GPs, the City Council, a national perspective from NHS England, and an effective consumer voice through Healthwatch Sheffield into a strong partnership which has a shared strategy and a shared ambition. It is an opportunity to tackle the health and wellbeing problems that have affected Sheffield for generations by using our shared financial resources to invest in the things that make the biggest difference to people's health and wellbeing in the city. The Health and Wellbeing Board will challenge Sheffield people, businesses, public services and community organisations to work with us and share the responsibility for making Sheffield a healthier, successful city.

We now know that health and wellbeing can be affected by poverty, aspiration, education, employment and the physical environment as well as by individual genetics. Our mission therefore is to tackle the main reasons why people become ill or suffer health inequalities in the first place, as well as to work with and empower people to improve their health and wellbeing today. Sheffield is an ambitious city and we know there are things we can do together to be a healthier and more successful place to live. But we acknowledge that we are living through financially tough times and we need to do what we can to stop the improvements in health and wellbeing over recent years being reversed.

In this, our *Joint* Health and Wellbeing Strategy, we have identified some of the things we need to do to make Sheffield a healthy, successful city. These can't be achieved by the NHS, Council or the public services on their own, and people have told us that they want and can take greater responsibility for their own wellbeing. Therefore, everyone has a role in making Sheffield a healthier place to live, work, grow up and grow older.

After listening carefully to what Sheffield people have told us and the evidence set out in our Joint Strategic Needs Assessment, we've set out in this Strategy what we believe we need to do to improve health and wellbeing in the city. It is a clear statement of intent for the coming years and we have taken the time to develop it and to frame it with your help. Everyone in Sheffield has a role in making our city a successful, healthier, better place to live and that is why your views and your involvement matter.

Councillor Julie Dore

Doctor Tim Moorhead

Co-Chairs

Sheffield Health and Wellbeing Board

September 2013

2. Introduction

1. Sheffield's Health and Wellbeing Board

The establishment of Sheffield's Health and Wellbeing Board presents an unprecedented opportunity to transform health and wellbeing in the city. The Board brings together GPs who are responsible for commissioning £700m of health services every year and Sheffield City Council who are responsible for £1.5bn of local government services every year and who have influence over many other services in the city. NHS England has a key seat in representing the national NHS picture, while Healthwatch Sheffield's role is to bring the views and experiences of Sheffield people.

Sheffield's Health and Wellbeing Board is focussed on **what the Board can uniquely do to improve health and wellbeing in Sheffield**. It therefore does not replace work going on in other areas and organisations, but seeks to add value and a system-wide partnership perspective.

The Health and Wellbeing Board's mission is to:

- 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 Sheffield people 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.

2. Sheffield's Joint Health and Wellbeing Strategy

This Joint Health and Wellbeing Strategy is a plan to improve the health and wellbeing of Sheffield people. It identifies things that will *directly* make a difference to people's health and wellbeing, such as investing in cancer services or tobacco control, but it also looks at the health and wellbeing system in Sheffield and its ways of working.

The Strategy is divided into **ten principles** and **five outcomes**, and is supported by **five work programmes**.

We know that this Strategy is aspirational and that we are operating in a difficult economic situation. We also know that national priorities within the fields of health and wellbeing may change and develop over time, which may affect our Strategy. However, we also believe that this is an opportunity for change and a redefinition of priorities. We want to be clear about what we want to achieve but will be flexible about how this will be done depending on capacity, demands and pressures that we may face. We know things may need to change and that organisations need to adapt to ensure the money spent in this challenging financial climate is making the biggest difference to health and wellbeing in Sheffield.

The Health and Wellbeing Board cannot do everything, but it can make a difference in some key areas. **This Strategy therefore does not cover every health and wellbeing service provided in Sheffield, but instead seeks to set out the biggest things that the Health and Wellbeing Board would like to see happen and which the Board believes would make the biggest difference to health and wellbeing.**

In some cases this will require the Board to do something new. In other cases it will require the Board to support initiatives that are already in place, and ensure such initiatives are geared up to improve health and wellbeing in Sheffield and aligned to the work of the Health and Wellbeing Board.

3. Our process for writing and agreeing this Joint Health and Wellbeing Strategy

We have spent a considerable amount of time researching and refining this Strategy, talking to people around the city, to make sure that it is the right Strategy containing the elements that will make the biggest impact.

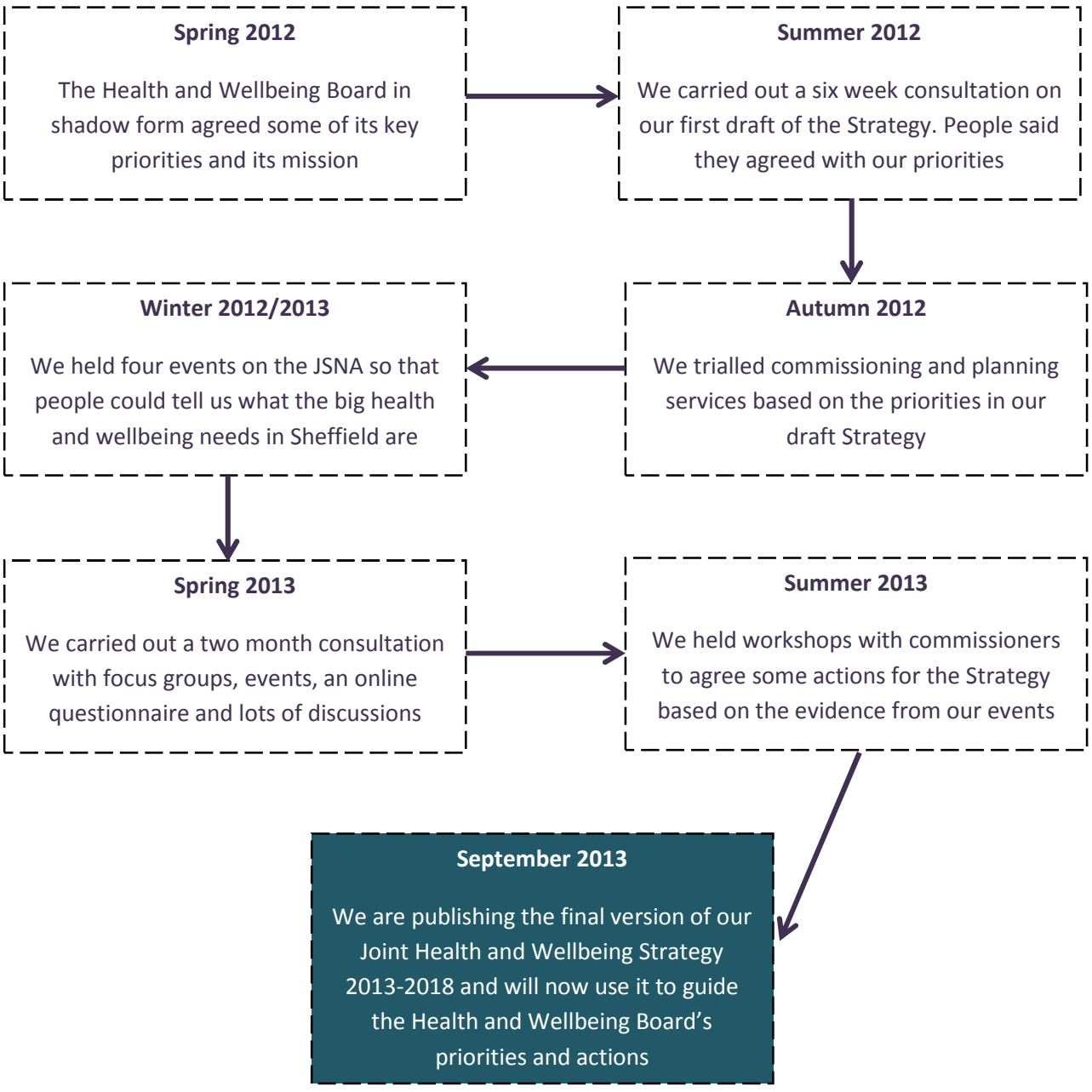
The evidence base used as the basis for this Strategy has been the **Joint Strategic Needs Assessment**. A Joint Strategic Needs Assessment (JSNA) is the means by which we assess the current and future health and wellbeing

needs of the Sheffield population. It is **joint** because it involves working with a range of partners; it is **strategic** as it influences the Joint Health and Wellbeing Strategy and commissioning plans; and it is a **needs assessment** because it analyses and interprets health and wellbeing need in the city. A new JSNA for Sheffield was produced and published in June 2013. This followed a series of events held in January-March 2013 which were open to members of the public, providers and commissioners, all of whom attended to discuss the key needs of Sheffield people and to bring forward evidence.

The Health and Wellbeing Board put a key emphasis on working with members of the public and finding out what is important to them and what would make a big difference to their health and wellbeing. An **initial consultation** on this Joint Health and Wellbeing Strategy was carried out in summer 2012. A **second consultation**, which focussed on specific themes, was carried out in spring 2013. This was based firmly on the principles of **co-production**, and Sheffield citizens were very involved in shaping the consultation and the questions asked. A report about this consultation was produced and published in July 2013.

Through this consultation process and the work done to develop the JSNA, Sheffield's Health and Wellbeing Board can be sure that it has spoken to a range of Sheffield people and collected their views and opinions. This makes the Joint Health and Wellbeing Strategy all the more focussed and supported by the wider Sheffield community. We look forward to working with Healthwatch Sheffield to continue to speak to and hear the views of Sheffield people.

We have set out what we have done and who we have talked to below.



3. Ten principles

We have ten principles which will guide all the decisions we make about the health and wellbeing services we pay for and deliver as a city. The application of these principles should shape the commissioning strategies of partner organisations across the city and the shape of future services.

1. **Valuing the people of Sheffield** – we want the best for Sheffield and Sheffield people will be at the heart of everything we do. People will be able to make informed choices about their wellbeing, be resilient and informed about short and long-term health and wellbeing issues, be supported to take charge of their lives, and able to make decisions about the services they choose to access.
2. **Fairness and tackling inequality** – everyone should get a fair chance to succeed in Sheffield. Some people and families need extra help to reach their full potential, particularly when they face multiple challenges and significant deprivation. Tackling inequality is crucial to increasing fairness and social cohesion, reducing health problems, and helping people to have independence and control over their lives. Fairness and tackling inequalities will underpin all that we do.
3. **Tackling the wider determinants of health** – to become a healthier Sheffield, health and wellbeing must be everyone's responsibility. We cannot improve health and wellbeing alone so we will encourage people and organisations in the city to focus on improving wellbeing and tackling the root causes of ill-health.
4. **Evidence-based commissioning** – we will use local and national research and evidence of what works to ensure Sheffield's services are efficient, effective and meet the needs of people.
5. **Partnership** – we will work in partnership with people, communities and all public, private and voluntary, community and faith sector organisations to get the right services provided for the needs of people in Sheffield. We will join up health, social care, education, children's services, housing and other local government services to make a fundamental change to the city's health, wellbeing and quality of life.
6. **Prevention and early intervention throughout life** – we will prioritise upstream activity, support early intervention and prevent issues escalating at the earliest opportunity. A focus on prevention and early intervention is the key means of making Sheffield's health and social care system sustainable and affordable for future generations. Risk stratification and targeting will be crucial in making sure services and effective interventions reach the people who need them most.
7. **Independence** – we will help people maintain and improve their quality of life throughout their lives and increase individual, family and community resilience. Where people need support from health and social care services, those services will be tailored to individual needs and help people and their support networks to maintain or regain the greatest level of independence.
8. **Breaking the cycle** – we want to improve the life chances of each new generation by tackling the way in which poverty and inequality is passed through generations. We also want to stop the cycle of poverty, low aspiration, poor educational attainment, low income, unemployment, ill-health and in some cases, homelessness, crime, alcohol, domestic and sexual abuse and drug misuse which undermine the health and wellbeing of some people in Sheffield.
9. **A health and wellbeing system designed and delivered with the people of Sheffield** – we will uphold the principles and values set out in the NHS Constitution and will design and deliver health, social care, children's, housing and other services which are co-produced with the people of Sheffield. We will work to ensure active participation and engagement of all ages with Healthwatch Sheffield.
10. **Quality and innovation** – we will ensure that the health, social care, children's and housing services provided in Sheffield are high quality and innovative in meeting people's needs. We will improve quality and stimulate innovation in the provision of health, social care and public health services in the city.

4. Five outcomes

The following pages are the heart of our Joint Health and Wellbeing Strategy. We have designed our Strategy so that all our aims and actions come under five outcomes which represent what we want to achieve for the people of Sheffield. We have included our **vision** for each outcome below:

Outcome 1 – Sheffield is a healthy and successful city

- Partners and organisations across the city to actively look to improve health and wellbeing through all areas, even those not traditionally seen as being about health and wellbeing.
- Housing across the city to be of a good quality, well–insulated with affordable bills and healthy and safe facilities.
- Sheffield people to be well-trained and able to access a range of fairly paid employment opportunities irrespective of disability, and for the city's economy to grow supporting the health and wellbeing of the people of Sheffield.
- Poverty, such as income poverty, fuel poverty and food poverty, to reduce, and that those affected by poverty are supported and encouraged to lead healthy lives.

Outcome 2 – Health and wellbeing is improving

- Sheffield children, young people, families adults to be emotionally strong and resilient, and for emotional wellbeing to be promoted across the city.
- Sheffield children, young people and adults to be living healthily – exercising, eating well, not smoking nor drinking too much alcohol – so that they are able to live long and healthy lives.

Outcome 3 – Health inequalities are reducing

- Data about health inequalities in Sheffield to be excellent so that commissioners can be well-informed in tackling the issues.
- Sheffield's communities to be strong, connected and resilient, able to withstand crises and to support members of the community to live whole and healthy lives.
- Those groups especially impacted by health inequalities to have sensitive and appropriate services that meet their needs and improve their health and wellbeing.

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

- Sheffield people receiving excellent services which support their unique needs.
- Clear availability of information and support about health and wellbeing so that Sheffield people are able to help themselves.
- Patients and service users involved in decisions and their opinions valued.

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

- Sheffield people at the centre of the Sheffield health and wellbeing system, underpinned by strong working relationships between commissioners with a clear methodology for joint working and pooled budgets underpinned by an innovative and affordable health and wellbeing system fit for the twenty-first century.
- A preventative system that seeks to help and identify people before they are really sick, enabling Sheffield people to stay healthy and well for longer.
- Frontline workers aware of health and wellbeing needs and able to signpost and support service users in obtaining the help they need.

We will measure the impact of these actions through indicators laid out in section 7.

Outcome 1 – Sheffield is a healthy and successful city

What's this about?

This outcome is about making health and wellbeing part of everything the city does, recognising that the city needs to be healthy to be successful and successful to be healthy. The wider determinants of health are often described as the 'causes of the causes' of ill health. These wider determinants include issues such as: employment, education and skills, housing, the environment and crime, and all of them impact upon our health in one way or another. These factors are often inter-related and outside of an individual's control. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet their needs and deal with changes to their circumstances. **Tackling the 'wider determinants of health' will not happen overnight so this must be a long-term aim for the city over the next 30 years.**

Where are we now? *What the JSNA and consultations have told us*	What do we want to achieve?	How will we achieve it?
City-Wide Influence		
▪ How we feel about our environment has a real impact on our health and wellbeing. Sheffield's green spaces are an asset for the City, and it is crucial this land is well maintained and used to its full advantage Air pollution is an issue and the 'Air Quality Action Plan' should be delivered comprehensively across the City. ▪ Making public transport accessible is key if we are to reduce isolation and enable people to have more control over their own lives.	**Partners and organisations across the city to actively look to improve health and wellbeing through all areas, even those not traditionally seen as being about health and wellbeing**, such as employment, education and skills, transport, housing, the environment, crime and criminal justice, business, leisure, economic growth.	1.1 Influence partners and organisations across Sheffield to consider and demonstrate the positive health and wellbeing impacts of policies, encouraging all organisations to make health and wellbeing a part of what they do.
Housing		
▪ The poor condition of properties in the private rented sector is a big challenge facing the Council going forward, especially given the significant cuts to government funding in this area. ▪ People in Sheffield are concerned about the quality of the private rented sector.	**Housing across the city to be of a good quality, well–insulated with affordable bills and healthy and safe facilities.** We know that the private rented sector in Sheffield has particular challenges in this area.	1.2 Commission a plan to improve the standard of private rented sector housing in the city with a focus on the key impacts of poor housing on health and wellbeing. 1.3 Support the creation and implementation of a city-wide fuel poverty strategy.
Health and Employment		
▪ The long term unemployment trajectory and the issue of youth unemployment have significant implications for the health and wellbeing of the	**Sheffield people to be well-trained and able to access a range of fairly paid employment opportunities irrespective of disability, and**	1.4 Support activity and actions with schools, colleges and employers (as set out in the city's Economic Strategy) that increases educational and skills attainment for all ages.

City. The quality of work is important for our health and steps should be taken to try and measure this and to increase awareness of the issue. ▪ Sheffield must continue to improve its KS2 and KS4 results to narrow the gap with the national average. The focus must be on school age education and lifelong learning. ▪ Poor quality underpaid work and a lack of opportunities affect healthy living and wellbeing.	**for the city's economy to grow supporting the health and wellbeing of the people of Sheffield.**	1.5 Work with employers to create employment pathways for young people, and emphasise the role of health and wellbeing amongst all employers in the city.
		1.6 Recognise that a Living Wage has positive health and wellbeing impacts for everyone, and emphasise to statutory, private and voluntary sectors working in health and wellbeing the Fairness Commission's aspiration that all employees should receive a Living Wage by 2023.
		1.7 Support the Health, Disability and Work Plan and further work to understand and evaluate the costs of poor health to employment.
		1.8 Pursue the development of broader approaches to health and the economy both with the Core Cities and in Sheffield City Region.
Poverty		
Over one fifth of households in Sheffield are living in poverty and food and fuel poverty are growing concerns. Welfare reforms will impact negatively on health and affect the poorest and more vulnerable members of the community disproportionately. There is the potential of a 'double negative' impact for families with children under five, families with two or more children and lone parent families.	**Poverty, such as income poverty, fuel poverty and food poverty, to reduce, and that those affected by poverty are supported and encouraged to lead healthy lives.**	1.9 Support the actions set out in the Child Poverty Strategy and the recommendations of the Fairness Commission, especially recognising the importance of actions to mitigate the increasing impact of 'in work' poverty upon families in the city.

Outcome 2 – Health and wellbeing is improving

What's this about?

This outcome focusses on specific aspects of children's and adults' health and social care and the wider determinants of health to improve health and wellbeing in Sheffield. Health in Sheffield has improved significantly in the past few decades. People in all parts of the City are living longer and deaths from major illnesses, especially heart disease and cancer, have reduced. However, there are a number of areas of concern, such as infant mortality rates, unhealthy lifestyles, dementia and poor mental health and wellbeing that will require concerted action over the coming years if this trend in improving health and wellbeing is to be maintained.
Unlike Outcome 1, this is focused on the ongoing, shorter term improvements in health and wellbeing which we need to be a well and healthy city in the long-term.

Where are we now? *What the JSNA and consultations have told us*	What do we want to achieve?	How will we achieve it?
Emotional wellbeing		
▪ 1 in 4 people will experience a mental health problem at some point in their life. Half of adults with mental health problems first experienced symptoms before the age of 14. In terms of severe mental health problems, Sheffield has a higher excess premature mortality rate for people with a severe mental illness than England as a whole and may also experience poorer levels of wellbeing. Promoting mental health and wellbeing for all is crucial to achieving health and wellbeing outcomes across the board. ▪ It's important to get things right from an early age for children. ▪ The 'Five Ways to Wellbeing' were well known by the consultation's respondents, but it was felt that more work was needed to enable communities to connect.	**Sheffield children, young people and adults to be emotionally strong and resilient, and for emotional wellbeing to be promoted across the city.**	2.1 Promote a city-wide approach to emotional wellbeing and mental health, focusing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.
		2.2 Commission a needs-led response to support children and young people's emotional development to enable them to develop personal resilience and manage transition from childhood to adulthood.
		2.3 Support the implementation of the new city Parenting Strategy which focuses on positive parenting and developing resilient families and communities so that all children have a stable and enriching environment in which they will thrive.
Living Longer		
▪ Life expectancy is currently 78.1 years for men and 81.8 years for women. Whilst this represents a longstanding trend of year on year improvements, both remain lower than the national average of 78.58 years for men and 82.57 years for women. ▪ In terms of the major killers, cancer and cardiovascular disease account for around 60% of premature deaths in Sheffield, consistent with the national picture. For both the premature mortality rate from all cancers and cardiovascular disease, Sheffield	**Sheffield children, young people and adults to be living healthily – exercising, eating well, not smoking nor drinking too much alcohol – so that they are able to live long and healthy lives.**	2.4 Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.
		2.5 Commission implement an integrated approach to reducing levels of tobacco use through integrating work on: smoke-free environments; helping people to stop smoking; using mass media by reducing the promotion of tobacco; regulating tobacco products;

has the lowest rates amongst the Core Cities but figures remain higher than the national average. We are detecting a worrying upward trend in both ill health and mortality linked to liver disease. ▪ We currently have around 6,400 people living with dementia in the City, and this is expected to rise to over 7,300 by 2020 and over 9,300 by 2030. Early diagnosis and intervention improves quality of life and can delay or prevent premature and unnecessary admission to care homes. ▪ The infant mortality rate in Sheffield is 5.2 per 1,000 live and still births (2011) compared with a national rate of 4.3 per 1,000. Infant mortality has been slowly rising, widening the gap with national outcomes. ▪ Smoking remains the single largest, reversible cause of ill health and early death in Sheffield. Continued action is required here and across a range of unhealthy or risky lifestyle issues in Sheffield including alcohol consumption, drug use, levels of child and adult obesity, diet and nutrition, physical activity and sexual health. ▪ People in Sheffield know that a healthy lifestyle can be achieved by eating more healthily and doing more exercise. However, many said it was not a priority due to other pressures in their lives. Others felt safe or affordable places to exercise were declining, and that unhealthy food was too easily accessible – and healthy food too expensive. ▪ Children and young people were motivated to do exercise when it was fun. Some did not like healthy food and the healthier school meal option. ▪ Schools have a crucial role to play in tackling obesity and combatting other unhealthy lifestyle choices.		reducing the affordability of tobacco; and substance misuse services. 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. 2.7 Commission a joint plan and integrated pathway across the city including schools and the commercial sector to act preventatively and with lower-tier interventions to tackle obesity, providing accessible information. 2.8 Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.

Outcome 3 – Health inequalities are reducing

What's this about?

This outcome focusses on those people and communities who experience the poorest health and wellbeing. We need to address those communities who experience the worst health and wellbeing inequalities. Sheffield is characterised by stark inequalities between different groups of people and between different geographical communities. People in the most deprived parts of the City still experience a greater burden of ill-health and early death than people in less deprived areas, demonstrating that inequalities in health and wellbeing are linked to wider social, cultural and economic issues. It is acknowledged that putting additional support into the most disadvantaged areas and raising standards there will have a beneficial effect on the whole community. Groups such as 'Looked After Children', children with learning difficulties and disabilities, some BME communities, migrant and asylum communities, homeless people, victims of domestic and sexual abuse, carers and lesbian, gay, bisexual and transgender people, are all reported nationally to have below average health.

The focus for this outcome is over the next 10 years.

Where are we now? *What the JSNA and consultations have told us*	What do we want to achieve?	How will we achieve it?
Address the root causes of health inequalities – improve data about health inequalities		
▪ There are large inequalities in life expectancy. For males, the gap between the lowest and highest life expectancy is 8.6 years, whereas for females, the gap is 8.2 years. These gaps in life expectancy have not remained static. Whilst inequality in life expectancy has decreased for males, it has increased for females. ▪ Whilst children and young people growing up in Sheffield today are generally healthier than ever, there are wide variations. For example, between the most and least deprived wards in the City there is a four-fold difference in infant mortality rates. Health and wellbeing outcomes for Looked After Children require particular attention.	**Data about health inequalities in Sheffield to be excellent so that commissioners can be well-informed in tackling the issues.**	3.1 Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.
Address the root causes of health inequalities – build and develop communities		
▪ More work needs to be undertaken to understand the extent of isolation in the City, the way in which it impacts on health and wellbeing and the health benefits of interventions that enable people to meet new people and develop social networks (such as lunch clubs for older people).	**Sheffield's communities to be strong, connected and resilient, able to withstand crises and to support members of the**	3.2 Work with partners to 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.

▪ There is a lack of knowledge about community activities and community support, which can lead to social isolation and loneliness. ▪ Social networks are absolutely crucial, and social isolation is a risk for all age groups. ▪ Parenting is essential to ensure healthy living and wellbeing in children and young people. ▪ Well-connected cities and localities with good links enable people to live healthy lives.	**community to live whole and healthy lives.**	3.3 Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined-up city localities.
Address poor health in specific populations		
▪ The people who are most in need of health services are often least likely to receive or access them. ▪ Demographic changes of an increasing population of under 5s and over 75s, an increasing proportion of population, especially in the younger age groups from Black and minority ethnic population, and new arrivals all present significant challenges for health, education social care and housing sectors in the city. ▪ Sheffield has longer waiting times for social care assessments than the national average, performs poorly in terms of the self-reported quality of life of people receiving adult social care, and its record on helping working age adults with on-going care and support needs into paid employment is weak. ▪ A need for more cultural understanding and language support, including sign language, in accessing services. ▪ Not everyone is able to access the internet. ▪ Health inequalities will grow as welfare reform impacts on certain groups.	**Those groups especially impacted by health inequalities to have early support and sensitive and appropriate services that meet their needs and improve their health and wellbeing.**	3.4 Identify which groups are least able to access services and establish reasons for difficulties and the health consequences of this. Work to improve access, prioritise those areas where the difficulties in access have significant health consequences, and simplify how people access care. 3.5 Ensure every child has the best possible start in life, including: focused action with the most deprived areas and groups, reducing infant mortality, developing strategies that improve parent/child attunement in early years, increasing the uptake of childhood immunisations, reducing the number of under 5s A&E attendances, reducing smoking rates in expectant mothers, improving children's dental health, increasing the rate of breastfeeding, reducing teenage conceptions, reducing obesity in children and young people. 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. 3.7 Commission disease-specific interventions to tackle poor health in population groups that have worse health, including a programme to improve the physical health of the severely mentally ill or those with a learning disability. 3.8 Support quality and dignity champions to ensure services meet needs and provide support. 3.9 Work to remove health barriers to employment through the Health, Disability and Employment Plan.

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

What's this about?

This outcome is about how people of all ages should experience services in Sheffield. This is about Sheffield's health and wellbeing system working better based on the needs of people in the city. It is important to focus not only on outcomes for people, but to consider people's knowledge of, access to, and experience of services. Currently, these are not all accurately measured but are important and must be given greater emphasis.
We need to make these changes now to support the achievement of outcomes 1, 2, and 3.

Where are we now? *What the JSNA and consultations have told us*	What do we want to achieve?	How will we achieve it?
Person-centred care and support		
▪ Whilst the level of emergency hospital admissions in Sheffield is broadly in line with the national and regional averages, the average length of stay in hospital following an emergency admission in Sheffield is 28% higher than the national average and the joint highest nationally. Services for children with speech, language and communication needs, new-borns, and 16/17 year olds with mental health needs require attention and particular consideration should be given to the ability of services in the City to meet the needs of these three groups. ▪ Sheffield is just above the national average for helping people to stay living at home but has reduced permanent admissions to residential and nursing care homes at a faster rate than the national average. ▪ There are often long waits for GP appointments and that the opening hours can cause difficulty for the working population. ▪ People felt they had to wait a long time to get a referral to a specialist, which often led to a worsening of illness. ▪ Quality of care, perhaps especially for older people, was seen as being an issue. ▪ It is important that services are accessible for those who do not speak English as a first language, or who are blind, deaf or have some other sensory impairment. ▪ Advocacy services are important. ▪ Administering personal budgets can be very difficult. ▪ Young people in the transition phase to adulthood find services	**Sheffield people receiving excellent services which support their unique needs.**	4.1 Continue to work with providers in the city to integrate the health, social care, education and housing support and care that is available, to establish a person centred approach to care. 4.2 Commit to implementing the statutory requirements of the Children and Families Act supporting the integration of planning for children with complex needs and disabilities. 4.3 Ensure the experience of transition from child to adult services supports and promotes health and wellbeing. 4.4 Work with GP practices to improve the ways people can access their services. 4.5 Ensure equality of access to services. 4.6 Commit to reducing waiting times to at least national standards/averages for health and social care. 4.7 Commit to: providing care closer to home; keeping hospital and short term care as effective as possible; and providing rehabilitation to help people stay independent for as long as possible.

do not meet their needs. ▪ Ex-armed forces personnel have told us that services do not take account of their needs.		
Self-help		
▪ It is sometimes hard to know what services exist and how to access them. ▪ It's important to help people with simple messages and tools so they can make the changes they want to make in their lives. ▪ GPs and other health professionals also need to be aware of the services and support that is available.	**Clear availability of information and support about health and wellbeing so that Sheffield people are able to help themselves.**	4.8 Encourage an integrated 'Sheffield offer' on the help, care and support available to people so that they can access guidance, advice, signposting, advocacy and self-assessment tools themselves. 4.9 Commit to working with partners on a model of active citizenship that promotes health literacy and supports people to look after themselves as well as possible.
Engagement and Participation		
Patient experience is a critical measure of performance and there are already significant efforts being made locally and nationally to enhance mechanisms for collecting, analysing and interpreting this on a systematic basis. ▪ It's really important to involve people from all walks of life	**Patients and service users involved in decisions and their opinions valued.**	4.10 Require both commissioners and providers to have effective engagement processes in place that take what service users think into account in all decisions. 4.11 Use patient/service user experience as a significant measure of quality.

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

What's this about?

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

In Sheffield we have developed an 'investment profile' of the City's NHS and Council budgets using a model that apportions budgets to the following categories: promoting lifelong health and wellbeing; early, short-term or one-off interventions designed to promote recovery and independence; and medium to long term support focused on stability and maintaining quality of life. This profile indicates that around 80% of all the money invested in health and wellbeing services in Sheffield in 2012/13 went into acute hospital care and medium to long term care and support services. The growth in our population and the economic situation mean that this balance of investment is unsustainable and greater emphasis should be placed on promoting lifelong health and wellbeing, recovery and independence.

Where are we now? *What the JSNA and consultation have told us*	What do we want to achieve?	How will we achieve it?
Joint commissioning and whole-system transformation		
▪ Frustration with the at times lack of communication between health and social care services, with people feeling like they are passed 'from pillar to post'.	**Sheffield people at the centre of the Sheffield health and wellbeing system, underpinned by strong working relationships between commissioners with a clear methodology for joint working and pooled budgets underpinned by an innovative and affordable health and wellbeing system fit for the twenty-first century.**	5.1 Build on existing joint working to establish a clear joint commissioning methodology, including the consideration of pooled budgets in areas such as the health and social care budget for older people with long term conditions and children with complex needs. The joint commissioning methodology will include a commitment to the co-production of strategic plans to ensure services are delivered in the most effective way for the benefit of all.
		5.2 Address city-wide causes of high hospital use by promoting innovative ideas and models for whole system change. This will include working with providers to find the best way to redesign systems upstream, and engagement to build awareness of appropriate access to services.

Prevention and early intervention		
▪ Around 80% of all the money invested in health and wellbeing services in Sheffield is in acute hospital services, and in medium to long term care and support services. The growth in demand for services from an ageing and growing population, and the current economic situation, mean we need to find different ways of meeting people's needs. ▪ Preventing problems from arising and intervening early can be better for people and more cost effective than the traditional reactive approach to problems. More schemes that emphasise prevention and early action, that reduce demand for acute and long term care, are needed. Health care needs to be better integrated with social and community care if we are to reduce dependency on hospitals and provide higher quality care. ▪ Prevention is really important – one way of doing this is ensuring carers have access to all the information they need. ▪ The Health and Wellbeing Board should be brave enough to put resources into prevention.	**A preventative system that seeks to help and identify people before they are really sick, enabling Sheffield people to stay health and well for longer.**	5.3 Establish more preventative and targeted approaches to the provision of health and social care by extending the application of population risk profiling (predicted risk of future health crisis) to enable a closer alignment between services and people's needs. This should inform the development of integrated care and reablement services to help people stay at home, be healthy for longer and avoid hospital and long-term care. 5.4 Make best use of available and emerging technology to support early and local intervention.
Health and wellbeing workforce		
▪ It is important to ensure that community-based work can flourish and dedicated commitment, time and resource should be made available to support the Voluntary, Community and Faith sector.	**Frontline workers aware of health and wellbeing needs and able to signpost and support service users in obtaining the help they need.**	5.5 Commission a basic training programme for all frontline workers that raises the profile of public health, mental health and safeguarding issues and ensures an understanding of services and tools available to make 'Every Contact Count'. 5.6 Commit to working with VCF organisations to find the best way of meeting people's needs locally and ensuring we benefit from the added value VCF organisations can bring. 5.7 Continue to seek greater efficiency from providers, without putting service users' safety or experience at risk.

5. Five work programmes

Some of the actions benefit from being joined up and the Health and Wellbeing Board has therefore created five work programmes. These will be commissioned from partner organisations and the Board will oversee the delivery of the outcomes. These work programmes will feed in on an annual basis to the Board.

Work programme 1 – A Good Start in Life

The foundations for lifelong social, emotional and physical health, and educational and economic achievement, are laid in early childhood. Nutrition (including in pregnancy), speech and language development, the family learning environment and most importantly the quality of the parent/care giver and child relationship in the first 2-3 years are powerful determinants of outcomes in childhood and later life. Investment in early years preventative and early intervention services can be not only cost saving but also the key to achieving better health and wellbeing, and reduced inequalities in the whole population that can impact a family environment and issues such as parenting, diet and obesity, foundation stage attainment and hospital admissions and attendances at A&E.

Work programme 2 – Building Mental Wellbeing and Emotional Resilience

Mental wellbeing can positively affect almost every area of a person's life - education, employment and relationships. It can help people achieve their potential, realise their ambitions, cope with adversity, work productively and contribute to their community and society. Promoting mental wellbeing for all has multiple benefits. It improves health outcomes, life expectancy, productivity and educational and economic outcomes and reduces violence, crime and drug and alchol use. One-in-four people will experience mental illness at some point in their lives. Mental health problems are more common in the most deprived parts of Sheffield, and in the current economic climate problems such as anxiety and depression are expected to increase.

Work programme 3 – Food, Physical Activity and Active Lifestyles

Food has a big impact on many parts of our lives. It gives us pleasure and connects us to our environment and our culture as well as giving us the energy to function. A nutritious and healthy diet can contribute to better wellbeing for people of all ages but we know that for many people in Sheffield, access to a healthy diet is a major problem. A lack of food or poor quality food reduces people's ability to go about their daily lives (such as a lack of energy, lack of concentration) but also undermines long-term health, contributing to conditions such as diabetes, heart disease and cancer. Physical activity has a positive impact on physical and mental wellbeing, improving self-esteem and reducing stress. Although Sheffield has high quality sports facilities and open spaces, not everyone in the city is able to access or take advantage of these.

Work programme 4 – Health, Disability and Employment

Employment is important for improving health as being in work, job security and attaining 'better' jobs has a positive effect on the way people live and feel, and the choices they make with respect to their health. Being out of work has negative effects on an individual's health, reducing household incomes, increasing social isolation and increasing stress and depression. Most health risks associated with unemployment get worse over the time a person is out of work. Mental health issues and musculoskeletal problems are the largest causes of workplace absence. Also developing a Long Term Condition can be a significant barrier to work. It is important to support those with these health problems to stay in work, thereby reducing the impact of their conditions and aiding recovery.

Work programme 5 – Supporting People At or Closer to Home

Care still relies too heavily on individual expertise and expensive professional input; 'patients' and service users want to play a much more active role in their own care and treatment. We want to reduce the dependency in Sheffield on high level or 'acute' hospital and residential care support. Not only is it expensive (and will become more so as more and more people live longer), it isn't what people tell us they want and doesn't always improve people's health and wellbeing in the longer term. Supporting patients to self-care can change people's attitudes and behaviours, improve quality of life, clinical outcomes and health service use including reducing avoidable hospital admissions. We need to make sure that, as far as possible, people can get on with their lives and have the right support in place to help them live independently and happily in the place they feel most comfortable.

6. Action

1. How will the Joint Health and Wellbeing Strategy be implemented?

Of course, one of the most important parts of any strategy is what happens as a result of it. For this Joint Health and Wellbeing Strategy, it is perhaps most useful to see the Health and Wellbeing Board's role as that of a *strategic overseer*.

The actions of this Joint Health and Wellbeing Strategy will be delivered in several different ways. The Health and Wellbeing Board will work together in partnership to:

- **Approve the annual commissioning plans of Sheffield City Council and NHS Sheffield Clinical Commissioning Group.**

  Sheffield City Council, NHS Sheffield Clinical Commissioning Group and NHS England all directly commission health and wellbeing services in Sheffield. The Health and Wellbeing Board will oversee all of these commissioning plans, and although it will not take a direct or detailed role in creating the plans, it will expect the organisations represented on the Health and Wellbeing Board to take the Strategy's actions and goals forward. In some cases the actions in the Strategy will require something to be directly commissioned, and the Health and Wellbeing Board will take a particular interest in the commissioning of these actions, although the actions will not be commissioned directly by the Board.

  At the start of each financial year, the Health and Wellbeing Board will agree their objectives for the year ahead based in part on the commissioning plans, and will demonstrate what has changed over the previous year.

- **Support and influence the work of NHS England.**

  NHS England plays a key role on the Health and Wellbeing Board in Sheffield. As commissioners of GPs and other services in Sheffield and across the region and country, NHS England makes crucial decisions affecting Sheffield people. We will work with NHS England to connect priorities and commissioning intentions and influence how services are delivered in Sheffield.

- **Work with Healthwatch Sheffield to actively engage with the people of Sheffield.**

  Healthwatch Sheffield's role is to represent service user and citizen voice and experiences. The Health and Wellbeing Board will welcome Healthwatch Sheffield's role in bringing the views of children, young people and adults, framing the Board's agendas and way of thinking. We will work with Healthwatch Sheffield to ensure our engagement events, held several times a year, are representative and properly reflect and welcome different viewpoints and perspectives.

- **Hold partners and providers to account if issues are identified which do not support the outcomes of the Strategy.**

  If there is evidence that the Strategy's outcomes are not being achieved, the Health and Wellbeing Board will hold commissioners and providers to account. This may be in a formal Health and Wellbeing Board meeting, particularly if it concerns Sheffield City Council, NHS Sheffield Clinical Commissioning Group and NHS England.

  The Health and Wellbeing Board also advocates a strong role for the city's scrutiny committees. If required, the Health and Wellbeing Board will report issues for scrutiny committees to investigate. However, the Health and Wellbeing Board will not play a detailed role in the management of specific contracts.

- **Seek to influence local partners and providers to act in a positive way for the health and wellbeing of the people of Sheffield, valuing the Sheffield community of professionals who work in health and wellbeing and/or have an interest or connection to it.**

  A key role of the Health and Wellbeing Board is to be a city leader, influencing others to act in the interest of improving health and wellbeing in the city. Not every action of this Strategy has financial implications. Some, instead, require the Health and Wellbeing Board to work with others to bring about whole-system change. The Board will consider issues escalated to it requiring a city level response and will ensure that essential links are made across work programmes and initiatives.

  The Sheffield Executive Board is chaired by the Health and Wellbeing Board's co-chair, Councillor Julie Dore, and the Health and Wellbeing Board will work with the Sheffield Executive Board to promote health and wellbeing messages across Sheffield and amongst a range of organisations and providers.

  In addition, the Health and Wellbeing Board has its own regular events for professionals and providers who work in health and wellbeing, and uses a range of communications tools to facilitate information and networking. This means that professionals and providers are linked to the work of the Health and Wellbeing Board and are able to influence the Board's priorities and direction.

- **Support further consultation and development of the Joint Strategic Needs Assessment when required.**

  The Joint Strategic Needs Assessment is a key process to understand and define the health and wellbeing needs of Sheffield people. This will continue to develop and expand, documented on our webpages at http://www.sheffield.gov.uk/jsna.

- **Monitor the health and wellbeing of Sheffield people on an annual basis in accordance with the measures outlined in this Strategy.**

  A set of outcome indicators are set out in section 7. These are our way of monitoring and finding out if the health and wellbeing, and the experiences of Sheffield people using health and wellbeing services, are improving. We will review and publish these annually.

- **Advocate for Sheffield on a national level when it is needed and appropriate.**

  Sometimes change is required on a national level, and as system leader for health and wellbeing in Sheffield it is appropriate that the Health and Wellbeing Board plays a national role when required.

2. How will the Health and Wellbeing Board be held accountable?

There are three main ways that the Health and Wellbeing Board will be held accountable:

- **By scrutiny committees and other statutory committees and organisations holding us to account.**

  The scrutiny committees of Sheffield City Council have the power to scrutinise not only the delivery of the Strategy but also the health service providers in the city. The committees will challenge organisations to make sure they are delivering the things set out in the Strategy. Healthwatch Sheffield representatives sit on the scrutiny committees and play a key role on them.

  Throughout the Strategy, we have made clear the importance of a good start in life for children and young people and supporting vulnerable people in Sheffield. We will work in close collaboration with Sheffield's Safeguarding Children Board and Adult Safeguarding Partnership to promote and protect the welfare of vulnerable people in the city.

  Sheffield's health and wellbeing system will also be held to account nationally and we are expected to make progress against the Government's new outcome frameworks for NHS, adults' and children's social care and public health. Performance against these frameworks will also be available online. In addition, independent

organisations such as the Care Quality Commission, Monitor and OFSTED will have a vital role in assessing the quality of the health, social care and wider wellbeing services provided in the city.

- **By Healthwatch Sheffield consistently presenting the views of service users and Sheffield people.**

  Healthwatch Sheffield is the main channel into the Health and Wellbeing Board for Sheffield children, young people and adults to contribute their voice and influence. Healthwatch Sheffield will enable local people to shape decisions and will provide a direct link for the people of Sheffield to the Health and Wellbeing Board, ensuring that issues with local health and wellbeing services are known and responded to by the Board.

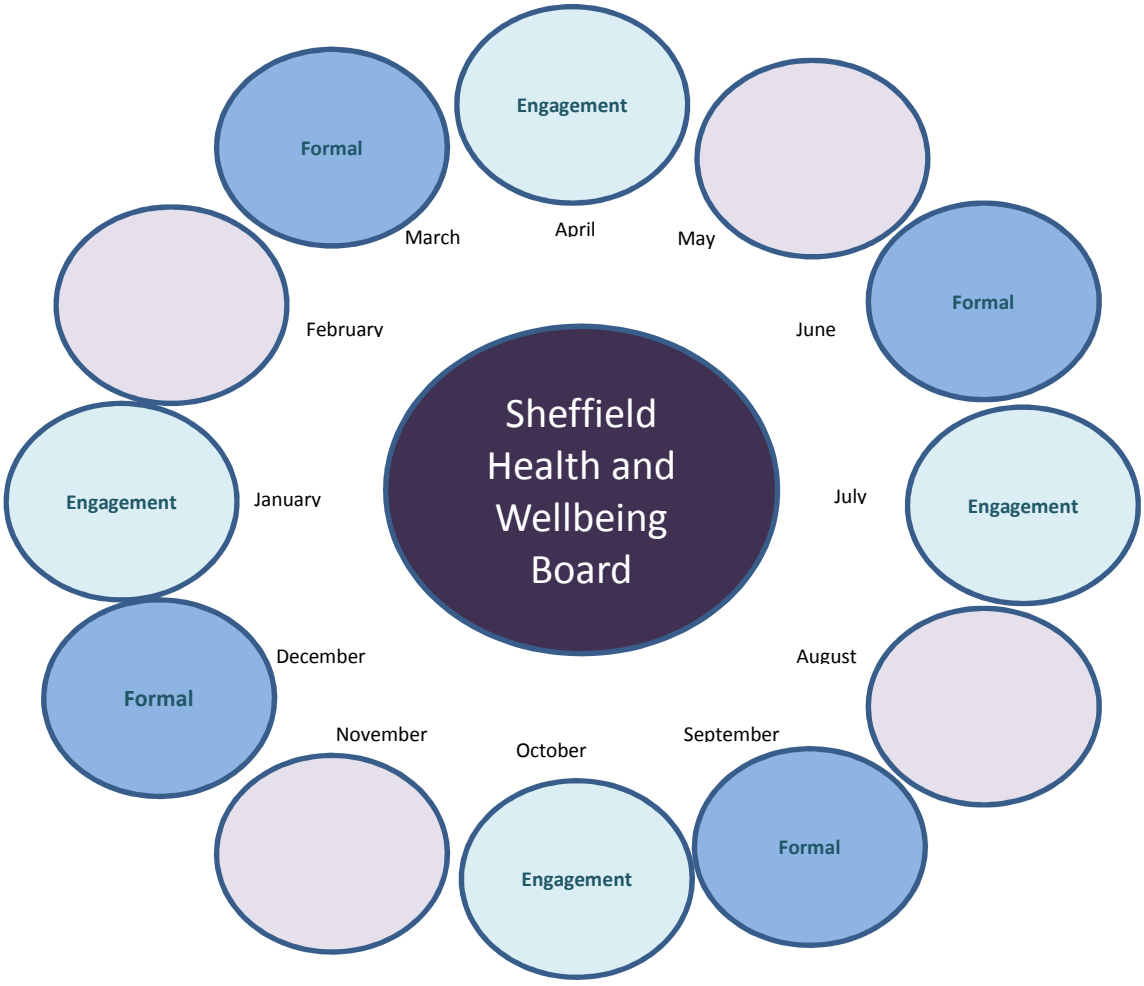
  Healthwatch Sheffield will also play a role in developing the work that underpins the Strategy, and shaping the Strategy's delivery.

- **By members of the public attending our meetings and getting involved.**

  As a Health and Wellbeing Board we hold regular events to hear the views of members of the public, service users and providers. We will engage with health, social care and wider service providers to ensure that the Board's work is informed by best practice in service delivery and will make full use of Sheffield's existing strong partnership to ensure that organisations in the city are fully involved in working to improve Sheffield's health and wellbeing.

  The Health and Wellbeing Board meets formally every quarter in public where there is an opportunity to ask questions and receive answers. All agendas, papers and minutes from these meetings are available to members of the public on the Board's website. The Board will also hold engagement events every few months, usually the month after each formal meeting.

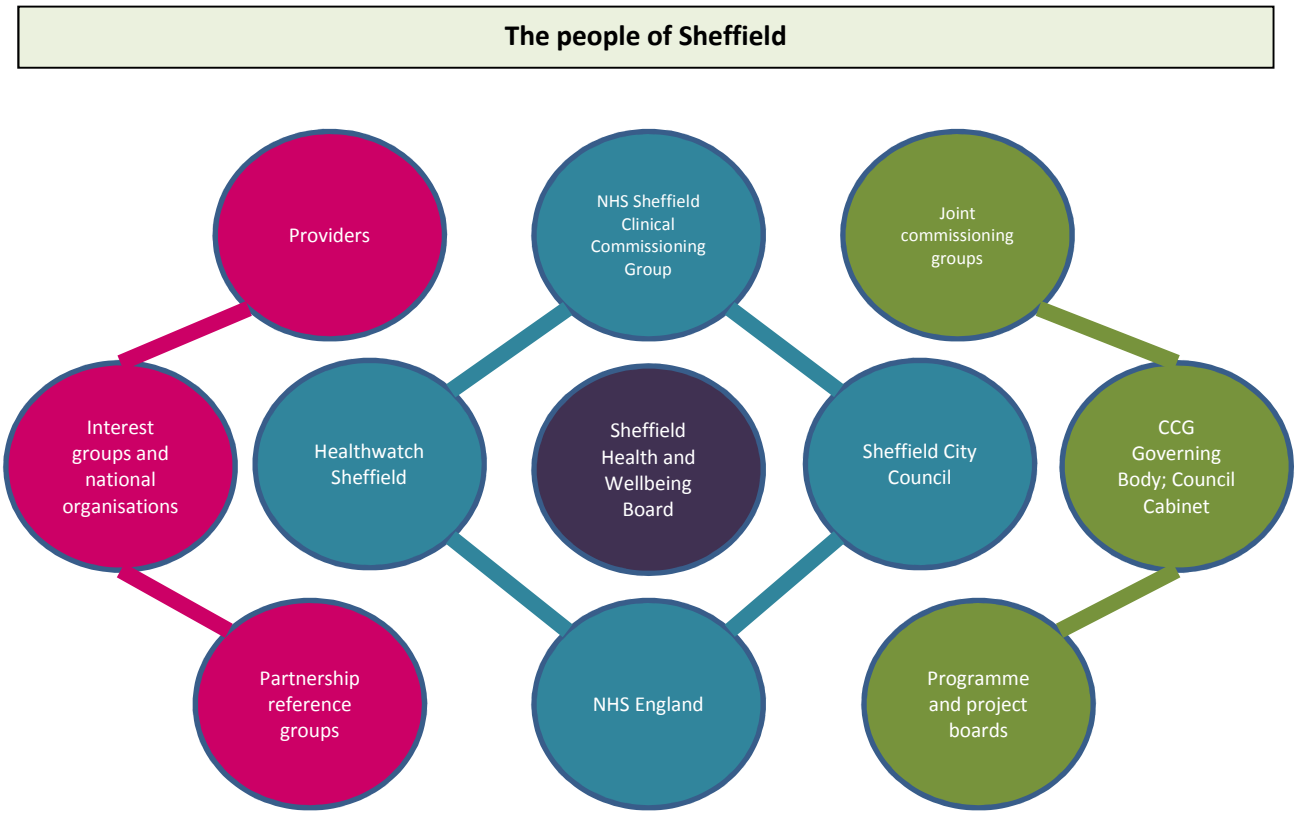
  The diagram below shows our yearly meeting cycle, with many things happening between meetings:



3. What is the organisational structure around the Health and Wellbeing Board?

Sheffield's Health and Wellbeing Board is at its heart a partnership: between the NHS, Healthwatch and the local authority; between statutory organisations and members of the public; and between the Board itself and its providers, interest groups and the people of Sheffield. The partnership between GPs and councillors is perhaps particularly interesting, with both people on the frontline, meeting Sheffield people on a daily basis.

No structure diagram fully conveys the intricacies of relationships between different organisations. Sometimes, partnership working makes governance structures confusing and hard to work out. We have produced the diagram below to show you some of the different organisations involved with health and wellbeing in Sheffield. It has deliberately not been shown as a hierarchy of organisations.



Sheffield's Health and Wellbeing Board is in purple at the centre.

In blue are the organisations which make up the Health and Wellbeing Board.

In green are selected meetings which take place regularly in NHS Sheffield Clinical Commissioning Group and Sheffield City Council. More detailed commissioning decisions will be made in these meetings.

In pink are the organisations that might want to feed into the Health and Wellbeing Board and who have an interest in strategic and commissioning decisions.

Above all of these are the people of Sheffield.

7. How we will measure health and wellbeing

The Health and Wellbeing Board will monitor this set of indicators annually to assess the progress and development of health and wellbeing in Sheffield. These are not measures designed to analyse the performance of the Health and Wellbeing Board, or of specific services, but are instead intended as a way of seeing how healthy and well Sheffield people are overall.

	Outcome	Indicator
1	HWBO1	**Child Poverty** – Children (under 16) living in families in receipt of Child Tax Credit (CTC) whose reported income is less than 60 per cent of the median income or are in receipt of income support (IS) or Income-Based Jobseeker Allowance (JSA), as a proportion of the total number of children in the area.
2	HWBO1	**Average gross annual income** – of employees on adult rates who have been in the same job for more than one year.
3	HWBO1	**Long term unemployment** – percentage of the working age population claiming job seekers allowance for more than 12 months.
4	HWBO1	The proportion of **16-18 year olds not in education, employment or training**.
5	HWBO1	**Good level of development at age five** - Foundation Stage Profile Attainment: Proportion achieving 78+ points.
6	HWBO1	Proportion of 15/16 year olds at **Key Stage 4** achieving 5 A*-C GCSE grades including in English & Maths.
7	HWBO1	**Homelessness Acceptances (unintentionally homeless and in priority need)** - per 1,000 households.
8	HWBO1	**Air pollution** – estimated proportion of annual all-cause adult mortality attributable to anthropogenic (human-made) particulate air pollution.
9	HWBO2	**Life expectancy at birth – Males.**
10	HWBO2	**Life expectancy at birth – Females.**
11	HWBO2	**Under 75 all-cause mortality** rate per 100,000 population.
12	HWBO2	**Infant mortality** rate (3 year rate) per 1,000 live births.
13	HWBO2	**Prevalence of mental health problems** – percentage of GP registered patients with a mental health condition (Adults).
14	HWBO2	**Prevalence of smoking** among persons aged 18 years and over.
15	HWBO2	**Proportion of children aged 10-11 (Y6) classified as overweight or obese**.
16	HWBO2	Admission episodes for **alcohol attributable conditions**, rate per 1,000.
17	HWBO2	Percentage of infants that are totally or partially **breastfed at age 6-8 weeks** after delivery.
18	HWBO3	**Gap in life expectancy (Males)** – as measured by the slope index of inequality.
19	HWBO3	**Gap in life expectancy (Females)** – as measured by the slope index of inequality.
20	HWBO3	**Excess winter deaths** – ratio of excess winter deaths to average non-winter deaths.
21	HWBO3	**Excess premature mortality in people with serious mental health problems** per 100,000 population.
22	HWBO4/5	**Access to GP services** – proportion of patients able to get an appointment last time they tried.
23	HWBO4/5	**A&E attendance rate** (all ages) per 1,000.
24	HWBO4/5	Emergency admission rate for **conditions usually managed within primary care** per 100,000 population.
25	HWBO4/5	**Antenatal assessment** under 13 weeks - Proportion of women who have seen a midwife or maternity healthcare professional by 12 weeks and 6 days of pregnancy.
26	HWBO4/5	Proportion of people using adult social care who receive **self-directed support.**
27	HWBO4/5	Proportion of people using adult social care who reported they **have control over their life**.
28	HWBO4/5	Proportion of older people (65+) **still at home 91 days after discharge** from hospital into reablement/rehabilitation service.
29	HWBO4/5	**Permanent admissions to residential/nursing care** per 100,000 population.
30	HWBO4/5	**Delayed transfers of care** from hospital per 100,000 population.

8. Get involved

The Health and Wellbeing Board in Sheffield is keen to be open, transparent and honest about how it is working and how it is delivering its Joint Health and Wellbeing Strategy. We know that we will not have thought of or covered everything, and therefore want people to get involved.

There are two main areas you can get involved with:

1. **Get involved with and find out about the work of the Health and Wellbeing Board**

You can:

- **Come to our Board meetings.**

We have formal Board meetings every three months where there will be the opportunity to ask questions. All agendas, papers and minutes of these Board meetings are published online and are available in print on request.

- **Come to our events and get involved in our consultations.**

There will usually be at least one event every three months. All information is published online and sent out through our networks. You can also call us for information: 0114 205 7143.

- **Stay informed.**

The best way you can do this is by signing up to receive our e-newsletter. We also have a regularly updated website.

- **Get connected with others.**

Improving health and wellbeing is a task for all of us, as individuals and as organisations. You can share with others in lots of ways, for example using our LinkedIn group (if you're a provider) or our Twitter feed. All of our events include opportunities to get to know other people in the city.

2. **Tell Healthwatch Sheffield what you think about the services you receive**

Healthwatch Sheffield has a key seat on the Health and Wellbeing Board, with its main role to be a champion for the views of service users and Sheffield people. You can:

- **Visit Healthwatch Sheffield's hub.**

Healthwatch Sheffield has a ground-floor information hub, open during office hours at The Circle, 33 Rockingham Lane, Sheffield, S1 4FW.

- **Attend meetings and events run or supported by Healthwatch Sheffield.**

You can find out about these online or by calling 0114 253 6688.

- **Stay informed.**

The best way you can do this is by signing up to receive Healthwatch Sheffield's e-newsletter and other information.

- **Get advice and support.**

Healthwatch Sheffield wants to support you in using services in Sheffield and in managing your own health and wellbeing. You can find out about services online or by calling 0114 205 5055.

9. Linked documents

The Joint Health and Wellbeing Strategy does not mean that all other existing plans and strategies in the city need to be rewritten. Organisations and service providers are already doing things which will make a significant contribution to achieving the outcomes set out in this Strategy. This Strategy is primarily about beginning a social, organisational and cultural change in Sheffield so that long-term health and wellbeing is an important consideration in everything we do. Clearly, there are some key documents which are linked to tackling the wider determinants of health in Sheffield and the Health and Wellbeing Board will contribute to the delivery of other strategies to ensure that there is a strong wellbeing focus and a coherent link with the Joint Health and Wellbeing Strategy. Some of these key documents and strategies that underpin the Joint Health and Wellbeing Strategy are:

- CCG prospectus 2012.
- Fairness Commission Report 2013.
- Joint Strategic Needs Assessment 2013.
- Joint Health and Wellbeing Strategy Consultation Reports 2012 and 2013.
- Sheffield City Council Corporate Plan Standing Up for Sheffield 2011-2014.

10. Glossary

Clinical Commissioning Group (CCG)	Clinical Commissioning Groups are groups of GPs that from April 2013 have been responsible for commissioning local health services In England. They will do this by working in partnership with local communities, local authorities; patients and professionals.
Commissioning	Commissioning is the process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased.
Health and Wellbeing Board (HWB)	Health and Wellbeing Boards exist in every upper-tier local authority to improve services and the health and wellbeing of local people. They bring together the key commissioners in an area, including representatives of GPs, directors of public health, children's services, and adult social services, with at least one democratically elected councillor and a representative of Healthwatch. The boards will assess local needs and develop a shared strategy to address them, providing a framework for individual commissioners' plans.
Joint Health and Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy is the way of addressing the needs identified in the Joint Strategic Needs Assessment and to set out agreed priorities for action.
Joint Strategic Needs Assessment (JSNA)	The Joint Strategic Needs Assessment identifies the health and wellbeing needs of the local population to create a shared evidence base for planning and commissioning services.
Healthwatch Sheffield	Healthwatch Sheffield is the consumer champion for both health and adult's and children's social care. Healthwatch England exists at a national level.
NHS England (NHSE)	NHS England sits at arm's length from the government and will oversee local GPs. It makes sure that CCGs have the capacity and capability to commission successfully and meet their financial responsibilities. It will also commission some services directly.
Outcome	'Outcome' means 'result', 'goal' or 'aim'.
Sheffield City Council (SCC)	Local authorities play a crucial role in ensuring that day-to-day services of their communities are efficient and effective, offer good value for money and deliver what people need. Sheffield City Council provides many services that are related to health and wellbeing. It is largely independent of central government and is directly accountable to the people of Sheffield when they elect their councillors.
Voluntary, Community and Faith Sector (VCF)	The voluntary, community and faith sector, also referred to as 'the third sector', is made up of groups that are independent of government and constitutionally self-governing, usually with an unpaid voluntary management committee. They exist for the good of the community, to promote social, environmental, health, cultural or other objectives.

We would like to thank all those who have been part of developing this Strategy: who came to our events, to provide us with information, who helped us identify the key actions – and who will help us implement this Strategy to make Sheffield a healthy and successful city.

To request a printed copy of this Strategy, or if you have a query, contact:

Email: healthandwellbeingboard@sheffield.gov.uk.

Website: www.sheffield.gov.uk/healthwellbeingboard.

Phone: 0114 205 7143.

Postal address: Sheffield Health and Wellbeing Board, c/o Commissioning (Communities), Sheffield City Council, Redvers House, Union Street, Sheffield S1 2JQ.

www.sheffield.gov.uk.
www.sheffieldccg.nhs.uk.
www.healthwatchsheffield.co.uk.
www.england.nhs.uk.

Sheffield Health and Wellbeing Board
Equality Impact Assessment

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

Status of policy/project/decision: Revised version – initial EIA approved September 2012

Name of person(s) writing EIA: Louisa Willoughby

Date: 12 September 2013 **Service:** Commissioning, Sheffield City Council

Portfolio: Communities, Sheffield City Council

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

- The Health and Wellbeing Board (HWB) brings together Sheffield's councillors (from Sheffield City Council), GPs (members of the city's Clinical Commissioning Group), senior managers (from the Council, CCG and NHS England), and a representative of Sheffield people through Healthwatch Sheffield. Producing a Joint Health and Wellbeing Strategy is one of the Health and Wellbeing Board's key duties.
- This Equalities Impact Assessment (EIA) builds on the EIA approved in September 2012. **It assesses the impact of the final version of the Joint Health and Wellbeing Strategy**, which once approved and published by the Health and Wellbeing Board will be available on the Health and Wellbeing Board's website at: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html.
- The Joint Health and Wellbeing Strategy (JHWS) 2013-18 sets out the strategic mission and associated outcomes for the city with regard to health and wellbeing, and ultimately brings together the ambitions of the Health and Wellbeing Board (HWB).
- An initial Strategy for 2012-13 was produced and approved by the HWB, by the CCG's Governing Body, and by the Council's Cabinet, in autumn 2012. This was used to inform commissioning plans and intentions for the 2013-14 financial year.
- Over 2012-13 a significant programme of consultation, engagement and development has taken place with the aim of suggesting some clear actions for the JHWS. This consultation, engagement and development process has been directed at the whole Sheffield community; with third sector, independent and private sector organisations; at particular protected or seldom heard groups; as well as at professionals who work in health and wellbeing.
- Over 400 people attended our Joint Strategic Needs Assessment (JSNA) events in January-March 2013. These were widely advertised and enabled a wide range of organisations and individuals to attend and feed in their knowledge and experience. Specific groups were approached to attend if we felt we had gaps in our knowledge. Reports on all the events held can be found at: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA/events.html, and the final report, available online at https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA/positionstatement.html, contains extensive data which it is hoped will inform commissioners and providers to ensure services in Sheffield meet the needs of Sheffield people.
- Over 1,500 people were involved in our consultation on the JHWS in April-June 2013. This involved an online survey but primarily a range of focus groups were held. Officers

also attended a number of events and locations across the city. Reports on all our consultation and the focus groups held can be found at: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/events/strategy-consultation.html. The consultation report available at that webpage includes a detailed section on the views of hard to reach communities.

- In addition, the Fairness Commission report was a crucial source of information and was used in the drafting of the Strategy. This can be viewed online at: https://www.sheffield.gov.uk/your-city-council/policy--performance/fairness-commission.html.
- All the feedback from the JSNA events, the consultation and the Fairness Commission has been included in the first column of the table under every outcome, entitled 'Where are we now? What the JSNA and consultations have told us'. This sets out very clearly how the views of Sheffield people have impacted on the Strategy. In addition, a 'You Said, We Did' report will be produced in winter 2013-14 to demonstrate the impact such views had on the final version of the Strategy.
- The JHWS is set to be approved for the following five years. This is subject to inevitable financial and organisational changes over the following five years, but it seeks to set out an evidence-based and people-centred framework for making decisions over the following five years.
- The HWB cannot do everything, but it can make a difference in some key areas. This JHWS therefore does not cover every health and wellbeing service provided in Sheffield, but instead seeks to set out the biggest things that the HWB would like to see happen and which the HWB believes would make the biggest difference to health and wellbeing. Officers from both Sheffield City Council and the city's Clinical Commissioning group will continue to commission services that meet the needs of Sheffield people.
- The HWB will look to influence people and organisations in Sheffield, commission and jointly commission services, as well as working on some direct projects in order to deliver the five outcomes identified in the Strategy.

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
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.

Areas of possible impact	Impact	Impact level	Explanation and evidence
			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. Both groups were involved in the JSNA and consultation and feedback has informed the final Strategy version. Information about how the revised version of the strategy responded to comments from this and other groups 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. Outcome 3 is about addressing health inequalities, while outcome 4 talks about improving equality of access to services. The strategy is particularly specific in its mention of mental wellbeing and helping those with learning disabilities. ▪ 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

Areas of possible impact	Impact	Impact level	Explanation and evidence
			an 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. This group was involved in the JSNA and consultation and feedback has informed the final Strategy version. Information about how the revised version of the strategy responded to comments from this and other groups 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. In addition, outcome 2 supports the implementation of a city-wide Parenting Strategy. ▪ 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. Information about how the revised version of the strategy responded to comments from this and other groups will be included in a 'You Said, We Did' report (see action plan).
Race	Positive	High	Several of the priority measures in the strategy include targeting health interventions for BME groups. ▪ 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). This group was involved in the JSNA and consultation and feedback has informed the final Strategy version. Information about how the revised version of the strategy responded to comments from this and other groups will be included in a 'You Said, We Did' report (see

Areas of possible impact	Impact	Impact level	Explanation and evidence
			action plan).
Religion/belief	Positive	Low	The strategy does not impact on religion/belief specifically, but we would not expect the impact to be negative. Those of particular religions/beliefs may find themselves fitting other categories, such as pregnancy/maternity, disability or race.
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 under outcome 2's actions focussing on mental wellbeing and outcome 3 focussing on health inequalities. This can affect 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. ▪ 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%. Information about how the revised version of the strategy responded to comments from this and other groups 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. Those who are LGBT do experience health inequalities, something that outcome 3 recognises and seeks to address. This group was involved in the JSNA and consultation and feedback has informed the final Strategy version. Information about how the revised version of the strategy responded to comments from this and other groups will be included in a 'You Said, We Did' report (see action plan).
Transgender	Positive	High	The strategy is clear that it will assist and support those who are disadvantaged, which may be those who are transgender. Those who are LGBT do experience health inequalities, something that outcome 3 recognises and seeks to address. Information about how the revised version of the strategy responded to comments from this and other groups will be included in a 'You Said, We Did' report (see action plan).
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. ▪ 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

Areas of possible impact	Impact	Impact level	Explanation and evidence
			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. Information about how the revised version of the strategy responded to comments from this and other groups will be included in a 'You Said, We Did' report (see action plan).
Voluntary, community & faith sector	Positive	High	The strategy recognises the crucial role that the VCF sector plays in improving health and wellbeing and delivering key services in Sheffield. Outcome 5 recognises the role that they play. This group was involved in the JSNA and consultation. Information about how the revised version of the strategy responded to comments from this and other groups will be included in a 'You Said, We Did' report (see action plan).
Financial inclusion, poverty, social justice:	Positive	High	One of the key outcomes of the strategy is that health inequalities reduce - outcome 3 is focussed on this. The strategy is also clear and strong in its focus on the wider determinants of health – outcome 1 is focussed on this. The Fairness Commission's evidence was an important part of the Strategy's drafting process. ▪ 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. ▪ 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 concerns about financial inclusion, poverty and social justice from this and other groups will be included in a 'You Said, We Did' report (see action plan).
Cohesion:	Positive	High	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. 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

Areas of possible impact	Impact	Impact level	Explanation and evidence
			for strong, resilient communities which enable people to have control over their lives. Information about how the revised version of the strategy responded to concerns about cohesion from this and other groups will be included in a 'You Said, We Did' report (see action plan).
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, outcome 4 is 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."

Action plan

The following actions are suggested:

- Issuing a 'You said, We Did'-type report which will demonstrate how the responses the consultation has been utilised in the strategy and/or state why this has not been the case. This will supplement existing reports available at http://www.sheffield.gov.uk/healthwellbeingboard and is expected by winter 2013-14. (Lead officer: Louisa Willoughby.)
- The HWB will monitor the high-level progress of the outcomes. This will happen on a yearly basis, starting in September 2013. (Lead officer: Louise Brewins.)
- 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. This will happen as and when services are commissioned. (Lead officer: Joe Fowler, Tim Furness.)
- Working to ensure that each of the 5 work programmes systematically considers equality issues/impacts. The work programmes report back to the HWB once a year. (Lead officer: Joanne Knight.)

Overall summary of possible impact: Positive.

Review date: A yearly review date is recommended, with the next expected in September 2013.

Approved (Lead Managers):

Joe Fowler, Director of Commissioning, Sheffield City Council

Tim Furness, Director of Business Planning and Partnership, NHS Sheffield Clinical Commissioning Group

Date: 17th September 2013

EIA Approved

Phil Reid, Development Manager, Sheffield City Council

Date: 18th September 2013

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Sheffield Clinical Commissioning Group

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Dr Jeremy Wight, Director of Public Health
Date:	26th September 2013
Subject:	Health and Wellbeing Outcome Indicators for Sheffield
Author of Report:	Louise Brewins 0114 205 7455

Summary:
The attached outcome indicator framework provides an overview of how the Joint Health and Wellbeing Strategy outcome areas are progressing. The Framework uses the latest nationally comparable data and provides a R.A.G. rating (where available) for each of the 30 indicators. Measures for outcome 5 (about the health and wellbeing system and its effectiveness and affordability) will require further work over the next 12 months.

Questions for the Health and Wellbeing Board:
Questions or clarifications regarding indicator definitions, data or interpretation.

Recommendations:
Subject to any final amendments, agree the indicators as a key means by which progress on the Health and Wellbeing Strategy outcomes will be reviewed and reported.

Reasons for Recommendations:
The Board requested such a framework be developed to support annual reporting and review of its strategic outcomes.

Health and Wellbeing Outcome Indicator Framework

1.0 SUMMARY

1.1 At its meeting in February 2013, the Board agreed that a set of indicators be developed to provide an overall view of progress against the outcomes set out within the Joint Health and Wellbeing Strategy.

1.2 Based on work undertaken to source appropriate indicators, and alignment with evidence and feedback from consultations held in relation to the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy, this paper presents the set of indicators to be used.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE

2.1 The framework uses the latest relevant data available. It is therefore possible to provide a brief narrative summary of what it is telling us. Overall Sheffield is doing reasonably well but there are a number of areas of concern within each outcome area, as follows:

Outcome 1 - Sheffield is a healthy and successful city

All indicators, with the exception of mortality attributable to (particulate) air pollution, are worse than average, although not markedly so. In most cases the local trend is improving. Average income levels and long term unemployment are worsening however and therefore remain key concerns for this outcome area, not least because of the identified concerns regarding negative impact of the welfare reforms on those already hardest hit.

Outcome 2 - Health and wellbeing is improving

All indicators are broadly on a par with the England average and generally trends are improving. The main exception is the rate of infant mortality, which has continued to increase. This is being addressed as part of the City's infant mortality strategy.

Outcome 3 - Health inequalities are reducing

The main concern here is the wider than average gap in life expectancy between the most and least deprived people in Sheffield. In particular, the gap in female life expectancy has continued to widen. Work to tackle health inequalities is identified in the City's Health Inequalities Action Plan, as part of implementing the recommendations of the Fairness Commission.

Outcome 4 - People get the help and support they want and need

Broadly Sheffield performs better than or close to the average. There are two key areas of concern however; proportion of women receiving an antenatal assessment at 13 weeks of pregnancy, which is below average (although the trend is improving) and the rate of permanent admissions to care homes, which is increasing locally. Both are identified priorities within

local health and social care commissioning plans.

3.0 OUTCOME AND SUSTAINABILITY

3.1 The purpose of the framework is to provide a basis for annual review and reporting on the outcomes of the Joint Health and Wellbeing Strategy. With the exception of the further work planned in relation to Outcome 5, the framework may be used immediately and as such can be considered as providing a baseline position from which to consider improvement in subsequent years.

3.2 The indicators use national data sources to ensure: consistency of definition across time and place; comparability with other areas; and accessibility (in terms of collection and timeliness).

4.0 MAIN BODY OF THE REPORT

4.1 The framework consists of 30 indicators grouped according to the first four outcome areas of the Joint Health and Wellbeing Strategy. Further work is needed to develop an appropriate approach to measuring progress in relation to the fifth outcome – 'services are innovative, affordable and deliver value for money'. Detailed definitions for each of the indicators appear on the second page of the framework (or reverse if printed off double-sided). National data sources are used for all indicators and, where relevant, have been checked for consistency within and across organisational boundaries

4.2 For each indicator the Sheffield value is shown alongside the England average value. This is then represented graphically using a 'spine' chart. On the spine chart, the vertical black line (or spine) represents the England average. The grey horizontal bars represent the range of values nationally for each indicator. The Sheffield value is represented as a circle. This is coloured red if the Sheffield value is significantly worse than the England average or coloured green if it is significantly better. A yellow circle indicates that the difference between the Sheffield value and the England average is not significantly different. A white circle means it has not been possible to calculate significance for this particular indicator. Values that are worse than average always appear to the left of the black vertical line and values that are better than average always appear to the right.

4.3 The framework also provides information on whether the trend in Sheffield is improving or not. This is depicted as a coloured arrow. An upwards green arrow means the trend is improving, a horizontal yellow arrow that it remains unchanged and a downwards red arrow that the trend is worsening. Trend is not calculated where there is only one year's worth of data available.

5.0 QUESTIONS FOR THE BOARD

5.1 Please raise any questions or clarifications regarding selection, definition, calculation, presentation or interpretation of the indicators used within the framework?

6.0 RECOMMENDATIONS

6.1 Subject to any final amendments, agree the indicators as a key means by which progress on the Joint Health and Wellbeing Strategy outcomes will be reviewed and reported.

7.0 REASONS FOR THE RECOMMENDATIONS

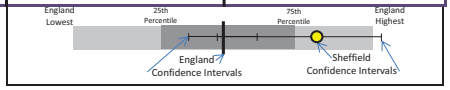
7.1 The Board requested such a framework be developed.

Sheffield Outcomes Framework for Joint Health and Wellbeing Strategy

The table and chart below shows how the health of people for Sheffield compares with England. The average rate for England is shown as the vertical black line, which is always at the centre of the chart. The confidence intervals for England are shown in grey where they are available / applicable.
A red circle implies that Sheffield is significantly worse than England for that indicator; a green circle indicates that it is significantly better. A white circle is shown where confidence intervals were not available but may still indicate an important health problem.

- Confidence intervals not available
- Sheffield is statistically WORSE than England
- " " " THE SAME as "
- " " " BETTER than "

Outcome		Indicator	Date of Data	England	Sheffield	Sheffield Trend	England Worst	Spine Chart	England Best
Healthy and Successful City	1	Children in Poverty (HMRC) (all children), %	2010	21.09	24.76	↑	45.95		3.23
	2	Gross income (annual), £	2012	21,794	19,818	↓	15,174		39,665
	3	Long Term unemployment, aged 16-64, %	2013	1.00	1.50	↓	3.40		0.10
	4	16-18 year olds not in education, employment or training (NEETS), %	2012	5.73	7.69	↑	10.58		2.00
	5	Foundation stage Profile attainment: Achieving 78+ points, %	2011/12	64.0	63.0	↑	51.0		78.0
	6	Achieving GCSE 5A*-C inc. Eng. & Maths, %	2011/12	59.4	55.6	↑	40.9		86.4
	7	Homelessness Acceptances (unintentionally homeless and in priority need), per 1,000 households	2012/13	2.37	5.03	↑	11.36		0.03
	8	Air Pollution: mortality attributable to particulate air pollution, %	2010	5.60	5.50	N/A	9.00		3.20
Health and Wellbeing Improving	9	Life Expectancy at Birth Male, Years	2009-2011	78.8	78.4	↑	73.8		83.0
	10	Life Expectancy at Birth Female, Years	2009-2011	82.8	82.1	↑	79.3		86.4
	11	Under 75 all cause mortality (three year), DASR per 100,000 population	2009-2011	268	285	N/A	466		170
	12	Infant Mortality Rate (three year), per 1,000 live births	2009-2011	4.40	5.10	↓	8.00		0.00
	13	Adults (18+) with Depression, %	2011/12	11.68	12.27	→	20.29		4.75
	14	Adult smoking prevalence from the Integrated Household Survey (age 18+), %	2011/12	20.0	21.6	→	29.3		13.8
	15	Children in Year 6 (age 10-11) Overweight and obese, %	2011/12	33.9	33.6	↑	43.1		26.6
	16	Alcohol attributable hospital admissions, DASR per 100,000 population	2011/12	1,974	1,722	↑	3,557		934
	17	Breastfeeding prevalence at 6-8 weeks after birth, %	2012/13 Q4	47.2	49.5	↓	17.5		83.3
Health Inequalities	18	Slope Index of Inequality for Life Expectancy Male, Years of life	2006-2010	8.90	10.70	↑	16.90		3.10
	19	Slope of Index Inequality for Life Expectancy Female, Years of life	2006-2010	5.90	7.70	↓	11.60		1.20
	20	Excess Winter Deaths, %	2008-2011	19.10	17.60	↓	61.11		-0.45
	21	Excess Under 75 year old mortality in Adults with Serious Mental Illness, DASR per 100,000 population	2010/11	921	988	↑	1,863		210
Care and Support When Needed	22	Patient experience of primary care - good access to GP services, %	2011/12	79.1	75.4	N/A	64.3		87.4
	23	A&E Attendances, per 1,000 population	2011/12	309	321	↓	742		176
	24	Emergency admissions for acute conditions that should not usually require hospital admissions (all age), DASR per 100,000	2011/12	1,131	1,141	↓	2,101		249
	25	Antenatal assessment under 13 weeks, %	2011/12	70.70	46.50	↑	3.10		90.30
	26	Proportion of people using social care who receive self directed support, %	2012/13	55.57	69.35	↓	7.40		95.70
	27	People using adult social care who have control over their daily life, %	2012/13	75.9	74.7	↑	64.1		93.3
	28	Older people (65+) still at home 91 days after discharge from hospital into re-ablement/rehabilitation services, %	2012/13	81.5	76.8	↑	53.7		98.1
	29	Permanent Admissions to nursing/residential care, per 100,000 population	2012/13	708.8	796.0	↓	1,398.3		28.0
	30	Delayed transfers of care from hospital, per 100,000 population	2012/13	9.49	3.65	↓	27.10		1.10



Sheffield value is WORSE than previous time period
" " " BETTER " " " "
" " " the SAME as " " " "

See page 2 for definitions of indicators

v0.5, 7th August 2013

Outcome		Indicator Definitions
Healthy and Successful City	1	**Children in Poverty (HMRC) (all children), %** PHOF Indicator 1.1. % of Children in "Poverty": The proportion of children living in families in receipt of out of work benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income. Dependent children are defined as all children aged <16 and those aged 16-19 not married or in a civil partnership, living with parents and in full-time non-advanced education or unwaged government training. Denominator is the total number of children receiving Child Benefit. NOTE: the local authority definition is slightly different to the national level definition of % children in relative poverty (living in households where income is less than 60% of median household income before housing costs). Used to be National indicator 116.
	2	**Gross income (annual), £** ASHE. Average gross annual income of employees on adult rates who have been in the same job for more than a year.
	3	**Long Term unemployment, aged 16-64, %** The percentage of 16-64 year olds who are claiming JSA for longer than 12 months. As measured by ONS in March of each year.
	4	**16-18 year olds not in education, employment or training (NEETS), %** PHOF Indicator 1.5. The percentage of 16 to 18 year olds who are not in education, employment or training (NEET). The estimated number of 16-18 year olds not in education, employment or training divided by the total number of 16-18 year olds known to the local authority whose activity is either not in education, employment or training (NEET), or in education, employment or training (EET). This uses the average proportion of 16-18 year olds NEET between November and January each year. These figures are collected by local authorities, and cannot be compared with the DfE estimate of young people NEET which uses different definitions.
	5	**Foundation stage Profile attainment: Achieving 78+ points, %** % of children who achieve at least 78 points across the Early Years Foundation Stage with at least 6 in each of the scales in Personal, Social and Emotional Development and Communication, Language and Literacy for schools each Local Authority Area. Note that figures are sum of schools in each Local Authority, rather than children resident in that Local Authority. Was National Indicator 72. Sourced from the Local Area Interactive Tool - provides access tp a uniform set of performance data on education and childrens services
	6	**Achieving GCSE 5A*-C inc. Eng. & Maths, %** Percentage of pupils at the end of Key Stage 4 in LEA maintained schools at the end of the academic year achieving 5 or more GCSEs at grades A*-C or equivalent including English and maths, at end of Key Stage 4. Sourced from the Local Area Interactive Tool - provides access tp a uniform set of performance data on education and childrens services
	7	**Homelessness Acceptances (unintentionally homeless and in priority need), per 1,000 households** PHOF Indicator 1.15i. Crude rate of statutory homeless households per 1,000 estimated total households. Number of households who are eligible, unintentionally homeless and in priority need, for which the local authority accepts responsibility for securing accommodation.
	8	**Air Pollution: mortality attributable to particulate air pollution, %** PHOF Indicator 3.1. The indicator is an estimated proportion. It represents the estimated annual mortality attributable to air pollution in the population aged 30+, as a proportion of total deaths of those aged 30+. Mortality burden associated with long-term exposure to anthropogenic (human-made)particulate air pollution (measured as fine particulate matter, PM2.5) at current levels.
Health and Wellbeing Improving	9	**Life Expectancy at Birth Male, Years** PHOF Indicator 0.1i. Life expectancy at birth. Calculated using deaths at all ages, from all causes, registered in the respective calendar years.
	10	**Life Expectancy at Birth Female, Years** PHOF Indicator 0.1i. Life expectancy at birth. Calculated using deaths at all ages, from all causes, registered in the respective calendar years.
	11	**Under 75 all cause mortality (three year), DASR per 100,000 population** Directly age-standardised mortality from all cause in persons less than 75 years in the respective calendar years, per 1000,000 population. Standardised using the European Standard Population. Sourced from Public Health England Longer Lives Tool.
	12	**Infant Mortality Rate (three year), per 1,000 live births** PHOF Indicator 3.1. Crude mortality rate of infants aged under 1 year per 1000 live births
	13	**Adults (18+) with Depression, %** QOF. The percentage of patients aged 18 and over with depression, as recorded on practice disease registers. Sheffield value is for PCT. (Note the range is of PCTs)
	14	**Adult smoking prevalence from the Integrated Household Survey (age 18+), %** PHOF Indicator 2.14. Prevalence of smoking among persons aged 18 years and over from the Integrated Household Survey.
	15	**Children in Year 6 (age 10-11) Overweight and obese, %** PHOF Indicator 2.6ii. Proportion of children aged 10-11 (Year 6) classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
	16	**Alcohol attributable hospital admissions, DASR per 100,000 population** PHOF 2.18. Hospital Admission episodes for alcohol-attributable conditions (previously NI39): All ages, Directly age standarised rates per 100,000 population
	17	**Breastfeeding prevalence at 6-8 weeks after birth, %** PHOF Indicator 2.2 ii. Percentage of infants who are totally or partially breastfed at 6-8 week check. Babies with unknown feeding status at 6-8 weeks are excluded from the numerator and denominator.
Health Inequalities are Reducing	18	**Slope Index of Inequality for Life Expectancy Male, Years of life** Marmot Indicator. The Slope Index of Inequality (SII) of life expectancy at birth within each English upper tier local authority based on local deprivation deciles of LSOA (LA level). The SII is a deprivation-based inequalities measure that can be applied to any indicator and has been approved by the NHS Sheffield Director of Public Health as the standard inequalities measure to be used for Public Health indicators. It represents the gap in indicator values between the most deprived and least deprived people in a given area. Sourced from London Health Observatories.
	19	**Slope of Index Inequality for Life Expectancy Female, Years of life** Marmot Indicator. The Slope Index of Inequality (SII) of life expectancy at birth within each English upper tier local authority based on local deprivation deciles of LSOA (LA level). The SII is a deprivation-based inequalities measure that can be applied to any indicator and has been approved by the NHS Sheffield Director of Public Health as the standard inequalities measure to be used for Public Health indicators. It represents the gap in indicator values between the most deprived and least deprived people in a given area. Sourced from London Health Observatories.
	20	**Excess Winter Deaths, %** PHOF Indicator 4.15. This indicator measures excess winter deaths expressed as the EWD Index, in order that comparisons can be made easily between different geographies. It indicates whether there are higher than expected deaths in the winter compared to the rest of the year. The year runs from August to July. Winter months are December to March, Non-Winter months are August to November and April to July. The ratio (5) of extra deaths from all causes that occur in the winter months compared to the average of the number of non-winter deaths of the same period.
	21	**Excess Under 75 year old mortality in Adults with Serious Mental Illness, DASR per 100,000 population** PHOF Indicator 4.9 and NHSOF Indicator 4.5. The mortality rate in the mental health population is directly standardised to the national population. This is then compared to the national rate. The mental health population is defined as anyone who has been in contact with the secondary mental care services in the current financial year or in ether of the two previous financial years who is alive at the beginning of the current financial year. The mental health rate is directly standardised by age and sex to the England population.
Care and Support When Needed	22	**Patient experience of primary care - good access to GP services, %** NHSOF Indicator 4.4i. The percentage of GP patient survey respondents who said they had a good experience of making an appointment. Data for this indicator is from the GP Patient Survey. July 2011 to March 2012. Sheffield value is for PCT. (Note the range is of PCTs)
	23	**A&E Attendances, per 1,000 population** The rate in terms of activity per 1000 population for A&E attendances. Based on registered population. England rate is adjusted at source and cannot be used as comparator, England figure is 'sum(standardised rate x population) / sum(population)'. Sourced from NHS Comparators.
	24	**Emergency admissions for acute conditions that should not usually require hospital admissions (all age), DASR per 100,000** CCG OIS Indicator 3.1. Data is at CCG level. Total number of emergency admissions episodes for people of all ages* where acute conditions that should not usually require hospital admission was the primary diagnosis. The indicator will show information on the number of emergency admissions per 100,000 population. This indicator has been indirectly age and sex standardised. The number of finished and unfinished continuous inpatient (CIP) spells, excluding transfers, for patients with an emergency method of admission and with any of the following primary diagnoses (DIAG_01in the 1st episode of the spell, ICD 10 codes) in the respective financial year. Indirectly age standardised per 100,000 population for area
	25	**Antenatal assessment under 13 weeks, %** CCG OIS Indicator 1.13. Data is at CCG level. Number of women in the relevant CCG population who have seen a midwife or a maternity healthcare professional for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy
	26	**Proportion of people using social care who receive self directed support, %** ASCOF Indicator 1C part 1.
	27	**People using adult social care who have control over their daily life, %** ASCOF Measure 1B uses responses to question 3a in the Adult Social Care Survey which asks service users how much control they have over their daily lives. The measure is calculated as the proportion of respondents who say they have as much control as they want or adequate control, or who respond that they can make all the choices they want in response to the easy read version of the question which asks how much control the service user has in their life. It is expressed as a percentage of all service users who gave a valid response to question 3a.
	28	**Older people (65+) still at home 91 days after discharge from hospital into re-ablement/rehabilitation services, %** ASCOF Measure 2B part 1. NHSOF Indicator 3.6.i . The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator. The collection of the denominator will be between 1 October 2011 and 31 December 2011, with a 91-day follow-up for each case included in the denominator to populate the numerator i.e. the numerator will be collected from 1 January 2012 to 31 March 2012.
	29	**Permanent Admissions to nursing/residential care, per 100,000 population** ASCOF Measure 2A part 2. People counted as a permanent admission should include: • Residents where the local authority makes any contribution to the costs of care, no matter how trivial the amount and irrespective of how the balance of these costs are met; • Supported residents in: o Local authority staffed care homes for residential care; o Independent sector care homes for residential care; and, o Registered care homes for nursing care. o Residential or nursing care which is of a permanent nature and where the intention is that the spell of care should not be ended by a set date. For people classified as permanent residents, the care home would be regarded as their normal place of residence. Where a person who is normally resident in a care home is temporarily absent at 31 March 2011 (e.g. through temporary hospitalisation) and the local authority is still providing financial support for that placement, the person should be included in the numerator. Trial periods in residential or nursing care homes where the intention is that the stay will become permanent should be counted as permanent. Whether a resident or admission is counted as permanent or temporary depends on the intention of the authority making the placement.
	30	**Delayed transfers of care from hospital, per 100,000 population** ASCOF Measure 2C part 1. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.

PHOF = Public Health Outcome Framework
NHSOF = NHS Outcome Framework
CCG = Clinical Commisioning Group

Sheffield Clinical Commissioning Group

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Councillor Mary Lea
Date:	26th September 2013
Subject:	Winterbourne View – Sheffield's actions in response to the National Programme of Action
Author of Report:	Jo Daykin-Goodall, Interim Head of Learning Disabilities Service Kevin Clifford, Chief Nurse Sheffield CCG

Summary:
The Winterbourne Programme of Action requires NHS Sheffield CCG and Sheffield City Council to reduce the number of people in inappropriate out of city hospital placements and to make available high quality care closer to home.

A Department of Health (DH) review into care at Winterbourne View private hospital and 150 units nationwide uncovered significant poor practice. A multi-organisation Concordat enshrined a national Programme of Action.

Sheffield meets or exceeds the key requirements of the Concordat:
- Registers of all people with challenging behaviour in NHS-funded care
- Reviews of inpatient care for all people with a learning disability or autism
- Individuals have the information, advice and advocacy support they need
- By June 2014, all individuals receive personalised care and support in appropriate community settings – Sheffield is working towards this challenging timescale
- By April 2014, each area will have a locally agreed joint plan to ensure high quality care and support – senior managers from SCC, SHSCT and the CCG are overseeing an action plan around: reviews, developing local services; quality and safety of care; health and social care professionals.

Recommendations:
- The Health and Wellbeing Board is asked to approve the approach described in this report and to consider the value of further updates from the Winterbourne steering group.

- The Health and Wellbeing Board is asked to seek 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 are not missed.
- The Health and Wellbeing Board is asked to request that Sheffield City Council 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 city.
- The Health and Wellbeing Board is asked to request the CCG to work with community health services and GP practices so that they are ready to provide suitable health support to this group of people on their return to the city.
- The Health and Wellbeing Board is asked to request the CCG to work with acute psychiatric and mainstream hospital services to accommodate people with a learning disability who have a crisis in either their mental or physical health.
- The Health and Wellbeing Board is asked to consider whether the pooled budget arrangements recommended by the Department of Health would have benefits over and above helping to meet the requirements of the Winterbourne Programme of Action.

Reasons for Recommendations:

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

Background Papers:

Transforming care: a national response to Winterbourne View hospital
Department of Health, December 2012

Concordat: Programme of Action
Department of Health, December 2012

Sheffield Stocktake of Progress
June 2012

Winterbourne View – Sheffield's actions in response to the National Programme of Action

1.0 SUMMARY

1.1 The Winterbourne Programme of Action requires NHS Sheffield CCG and Sheffield City Council to reduce the number of people in inappropriate out of city hospital placements and to make available high quality care closer to home.

1.2 A Department of Health (DH) review into care at Winterbourne View private hospital and 150 units nationwide uncovered significant poor practice. A multi-organisation Concordat enshrined a national Programme of Action.

1.3 Sheffield meets or exceeds the key requirements of the Concordat:

- Registers of all people with challenging behaviour[1] in NHS-funded care
- Reviews of inpatient care for all people with a learning disability or autism
- Individuals have the information, advice and advocacy support they need
- By June 2014, all individuals receive personalised care and support in appropriate community settings – Sheffield is working towards this challenging timescale
- By April 2014, each area will have a locally agreed joint plan to ensure high quality care and support – senior managers from SCC, SHSCT and the CCG are overseeing an action plan around: reviews, developing local services; quality and safety of care; health and social care professionals.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 We need to reduce the number of children or adults in out of city placements in favour of care closer to home, in models of care that are consistent with best practice and delivered in the least restrictive environment.

3.0 MAIN BODY OF THE REPORT

3.1 Until its closure in 2011, **Winterbourne View**, in Bristol, was registered as a private hospital for people with learning disabilities. In May of that year, the BBC's *Panorama* exposed shocking evidence of abuse.

[1] In keeping with the Department of Health's terminology, the term 'challenging behaviour' is used in this report and refers to 'all children, young people and adults with learning disabilities or autism who also have mental health conditions or behave in ways that are often described as challenging', (*Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report*). It relates to severity, intensity and duration of these behaviours that means that services are unable to easily respond to meet the persons' needs.

3.2 A **Department of Health (DH) review** into Winterbourne and the care practices at 150 adult units followed, the findings of which included:

- Inappropriate and non-personalised placements and care models
- Placements too far away from families and funding authorities
- Poor care standards, including too much use of physical restraint
- Agencies failing to pick up on warning signs
- Inadequate management and staffing skills

3.3 Over 50 organisations signed up to a **Concordat Programme of Action**. This included the key action that:

- All current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014.

3.4 **Sheffield's Performance against key Concordat action**

3.4.1 **By 1 April 2013, registers of all people with challenging behaviour in NHS-funded care will be in place and, from that date, maintained by Clinical Commissioning Groups (CCGs)**

- Sheffield meets this requirement through its database of people placed out of city, managed by the Deputy Head of the Joint Learning Disabilities Service on behalf of Sheffield CCG and Sheffield City Council, which identifies named contacts for each client. Information is shared regularly with commissioners from the CCG, CHC and Commissioning Support Unit.

- Currently, there are 166 individuals recorded on the register, in a mixture of supported living; care homes; residential college; independent and NHS inpatient settings; regional specialist commissioned services (low, medium and secure).

- Sheffield also has had a comprehensive Case Register of people with a learning disability since 1974, which gathers data from birth and identifies clinical needs, including behaviour that challenges.

3.4.2 **By 1 June 2013, health and care commissioners will work together and with service providers, people who use services and families to review the care of all people in learning disability or autism inpatient beds and agree personal care plans for each individual.**

- As required, all 18 individuals in independent hospital settings or specialist commissioned services (low, medium and secure facility) were reviewed by 1 June 2013.

- Sheffield extended this requirement to review the suitability of all 51 NHS-funded and 26 joint-funded individuals and, by the end of September, all 89 individuals funded solely by the Local Authority.[2]

- All reviews have been carried out by the Joint Learning Disability Service Out of City Team. This was already well-established before the Concordat and working to bring people back to Sheffield. Through a CCG Complex Needs Business Case, savings are reinvested to support people with complex needs locally through clinical and social work posts. This has enabled the Concordat's review timescale to be met. The CCG is exploring how the Complex Needs Business Case can be accelerated to provide increased capacity in local clinical expertise.

- All out of city reviews and subsequent support packages are quality checked against established quality standards. The Deputy Head of the Joint Learning Disability Service is responsible for ensuring all individuals who are placed out of city receive a review.

- Clinical leads, lead social workers and the Deputy Head of the Learning Disabilities Service are collating the overall picture of out of city placements in order to inform local commissioners of the needs of individuals returning to the city.

3.4.3 **By 1 June 2014, put these plans into action, so that all individuals receive personalised care and support in appropriate community settings.**

- The reviews have confirmed that not everyone living out of city is inappropriately placed. However, for inpatients for whom a return to Sheffield is suitable, achieving the Concordat's timescale of 1 June 2014 will be challenging because of the need to work with complex individuals in an appropriate way and timeframe; the range of current services involved; and the need to develop specific accommodation and other appropriate local services.

- Close work with SCC housing services and housing associations has commenced to address accommodation needs.

- Health and social care commissioners are discussing the service and financial implications of discharge plans for people either returning to the city or awaiting discharge from local Assessment and Treatment facilities. The Concordat requires coordination of responsibilities and roles across a number of organisations and teams.

- It may not be possible to develop independent supported living schemes for all those inappropriately in hospital by the target date of June 2014, and, in some cases, people may require a more extended

[2] Some NHS funded packages (including Continuing Healthcare) are contributed to by CCGs from other authorities. Some young people are placed out of city with three-way funding from the Education Service, Local Authority and children's CHC.

period of preparation before they are ready for an arrangement of that kind.

- Some in-patients may therefore be discharged to care homes as a step down from hospital if this is the best environment in which to continue to meet their needs. However it would not meet the objectives of the DH Final Report[3], or the Concordat, if current in-patients were transferred permanently from hospitals to residential care.

- A number of individuals may be subject to restrictions on discharge under sections 37 or 41 of the Mental Health Act (MHA). Children placed under the MHA in Tier 4 CAMHS placement are now the responsibility of the NHS National Commissioning Board. Sheffield commissioners will need to continue to liaise with Regional Specialist Commissioners to plan for return to the city for these children, as appropriate.

3.4.4 **Ensure that all individuals have the information, advice and advocacy support they need to understand and have the opportunity to express their views.**

- People living out of city, and, where appropriate, their family members, are supported to participate in their review alongside relevant health and social care professionals, within the framework of the Mental Capacity Act and Best Interest Decision-making process.

- Through a contract with Mencap, advocacy is available to support assessment, care planning and reviews. Further advocacy can also be purchased through Assessment and Care Management processes from local providers. The services of an Independent Mental Capacity Advocate are obtained if appropriate.

3.4.5 **By April 2014, each area will have a locally agreed joint plan to ensure high quality care and support, ideally with Health and Wellbeing Board oversight. Consideration of the use of pooled budget arrangements is required, with local commissioners offering justification where this is not done.**

- A steering group of senior managers from the City Council, Sheffield Health & Social Care NHS Foundation Trust (SHSC) and Sheffield CCG is overseeing the programme of work and have developed an action plan for Winterbourne which covers:

1. Reviewing people placed out of city, or at risk of going out of city, and planning for change where appropriate.

[3] Transforming care: a national response to Winterbourne View hospital
Department of Health, December 2012

2. Developing and ensuring housing, specialist clinical support and specialist provider services are in place to meet local need.

3. Improving quality and safety of care – including standards and monitoring; customer feedback and whistleblowing; safeguarding and specialist provider training; multi-agency communication.

4. The roles, responsibilities and skills of health and social care professionals.

- An integral part of the joint plan is the introduction of a new **Intensive Support Service (ISS)** from June 2013. The ISS replaced the Assessment and Treatment Unit and merged clinical teams. It provides a stepped model of care from community through to inpatient care for people whose behaviour challenges services.

3.5 **National Monitoring – stocktake of progress**

3.5.1 In line with the Department of Health's commitment to monitor and report on progress nationally, the Winterbourne Joint Improvement Board required all areas to undertake a stocktake of their position in June 2013.

3.5.2 The collation of Sheffield's stocktake was jointly undertaken by Sheffield City Council and Sheffield CCG, and was completed to time. It was signed off by the Health and Wellbeing Board Chairs, in anticipation of the agenda item at the September Board.

3.6 **Safeguarding**

3.6.1 Frequent multi-disciplinary meetings share information and intelligence about care providers in Sheffield, assess their performance and the level of support/intervention needed to maintain standards of care. The Joint Learning Disabilities Service (JLDS) and the CCG Continuing Healthcare team have completed inspections of all local adult units, prioritising those that have been identified through the process above.

3.6.2 The JLDS has developed a Good Practice Framework on the Prevention and Management of the Use of Restraint (with city wide ownership), a robust restraints referral and review process.

3.6.3 There are growing links between safeguarding, work to report disability Hate Crime and the development of the Sheffield Safe Places scheme, which so far has over 60 premises. In accordance with expectations in the Programme of Action, Winterbourne View is on the agenda of the Adults Safeguarding Executive Board and an update is next due to be reported to the Board on 8 November.

3.7 **Finances**

3.7.1 There is currently no pooled budget in place, however, there are financial risk sharing arrangements for the delivery of specific packages of care in the form of joint funding. There are agreed joint delivery plans which

identify the shared objectives and risks in delivering alternative models of care. These are identified in the Complex Needs Business Case, and the monitored Implementation Plan.

3.7.2 There is a wider discussion on-going between NHS Sheffield CCG and Sheffield City Council around pooled budget arrangements and integrated commissioning.

4.0 RECOMMENDATIONS

4.1 The Health and Wellbeing Board is asked to approve the approach described in this report and to consider the value of further updates from the Winterbourne steering group.

4.2 The Health and Wellbeing Board is asked to seek 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 are not missed.

4.3 The Health and Wellbeing Board is asked to request that Sheffield City Council 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 city.

4.4 The Health and Wellbeing Board is asked to request the CCG to work with community health services and GP practices so that they are ready to provide suitable health support to this group of people on their return to the city.

4.5 The Health and Wellbeing Board is asked to request the CCG to work with acute psychiatric and mainstream hospital services to accommodate people with a learning disability who have a crisis in either their mental or physical health.

4.6 The Health and Wellbeing Board is asked to consider whether the pooled budget arrangements recommended by the Department of Health would have benefits over and above helping to meet the requirements of the Winterbourne Programme of Action.

5.0 REASONS FOR THE RECOMMENDATIONS

5.1 The Department of Health recommends the involvement of local Health and Wellbeing Boards in the development of joint action plans.

5.2 The recommendations will help to mitigate the risks of Sheffield not meeting its Winterbourne obligations.

SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 27 June 2013

PRESENT: Dr Tim Moorhead, Clinical Commissioning Group (Chair)
Councillor Julie Dore, Leader of the Council
Dr Margaret Ainger, Clinical Commissioning Group
Ian Atkinson, Clinical Commissioning Group
Jason Bennett, Healthwatch Sheffield
Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families
Sue Greig, Consultant in Public Health
Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living
John Mothersole, Chief Executive
Dr Ted Turner, Clinical Commissioning Group
Dr Jeremy Wight, Director of Public Health

IN ATTENDANCE: Joe Fowler, Director of Commissioning, Sheffield City Council
Tim Furness, Director of Business Planning and Partnerships, NHS Sheffield Clinical Commissioning Group
James Henderson, Director of Policy, Performance and Communications, Sheffield City Council

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Harry Harpham, Dr Amir Afzal, Margaret Kitching, Jayne Ludlam and Richard Webb.

Sue Greig attended an appointed deputy.

2. DECLARATIONS OF INTEREST

There were no declarations of interest by members of the Board.

3. PUBLIC QUESTIONS

(a) Public Question concerning Early Years and the Joint Strategic Needs Assessment

Jo Hemmingfield made reference to the financial cuts to early years provision on the grounds of affordability and stated that there was particular concern about services for families with children aged from 0 to 4 years and that mothers were especially vulnerable when they had recently given birth. The Joint Strategic Needs Assessment (JSNA) made mention of the effect, indeed double negative impact, of welfare reform on the health and wellbeing of families with young

children, more than two children and lone parent families. In this context, she asked about the impact of a reduction of nursery and early years services which have a significant contribution to health and wellbeing outcomes.

Councillor Jackie Drayton, the City Council's Cabinet Member for Children, Young People and Families and Member of the Board responded to the question. She stated that health inequalities started with young children and research had shown that the first 3 years of a child's life can make a real difference to their health, academic achievement and future employment.

Councilor Drayton stated that both she and Dr Margaret Ainger were the Health and Wellbeing Board's leads with a focus on young children under the theme 'a great start in life'. This theme included stages of pre-birth, birth and early years and subjects including breastfeeding attunement and obesity.

The Government had changed the way it funded local authorities to provide early years' services. Previously, Surestart had provided a wrap-around set of services for young families, which encompassed early intervention, prevention and childcare. The present Government cut the Early Intervention Grant (which included funding for Early Years) and had put more money into Free Early Learning for 2, 3 & 4 year olds. The Council had made savings which took into account these changes and had protected areas where funding supported breastfeeding, attunement and attainment for younger families. She stated that she felt that the welfare reform would affect young families and also affected others, including older people.

Councillor Julie Dore, the Leader of the Council and Co-Chair of the Board, added that a priority within the JSNA, which was to be considered at this meeting of the Board, was to limit the negative effects of welfare reform and the JSNA acknowledged the impact of spending cuts. These factors would be fed into the Health and Wellbeing Strategy. The effect of changes to welfare had been identified as an issue and the Board would make sure the Strategy responded by considering how services were commissioned.

(b) Public Questions concerning the Children and Families Bill

Natalie Yarrow made reference to the Children and Families Bill and asked what steps were being taken by the Council, the Clinical Commissioning Group and health bodies in relation to clauses in the Bill concerning children and young people with special educational needs (SEN). She made particular reference to clauses concerning participation in decisions and the duty of health bodies where it is thought that a child may have special educational needs; and joint commissioning arrangements.

Dr Tim Moorhead, Sheffield Clinical Commissioning Group (CCG) and the Chair of the meeting, responded that the Health and Wellbeing Board would need to formalise its response the Bill and he suggested that a written response was made to the questions.

Councillor Jackie Drayton, the City Council's Cabinet Member for Children, Young People and Families and Member of the Board, stated that the Council had responded to the Green Paper and with regard to children with special educational needs. She had requested that Council officers examine the Children and Families Bill to see whether the comments which the Council had already submitted on the Green Paper had been taken into account within the Bill. Councillor Drayton stated that this issue would be a beneficial future agenda item for the Board to consider.

(c) Public Questions concerning the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy

Adam Butcher referred to the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy. He asked how it was intended to engage with other sectors and especially those people with more severe disabilities in respect of the two documents by producing alternative formats, which were easy to read or used pictorial presentation, so people could more easily understand issues presented within them.

Dr Tim Moorhead, Sheffield Clinical Commissioning Group (CCG) and the Chair of the meeting, responded that Board would need to consider the best way of producing the JSNA and the Health and Wellbeing Strategy in a form that properly represents the full versions of these documents. The necessary work would be likely to be finished in September or October 2013.

Councillor Mary Lea, the Council's Cabinet Member for Health, Care and Independent Living and Member of the Board, stated that easy to read versions of documents had been produced, for example, the Council's budget documents. The JSNA and Health and Wellbeing Strategy could also be submitted to the Learning Disabilities Partnership Board.

Jason Bennett, Healthwatch Sheffield and Member of the Board, stated that part of the role of Healthwatch was to make sure there is engagement and that people understand what the issues are, so they can reach informed conclusions. He stated that Healthwatch Sheffield would work on this issue in conjunction with other colleagues on the Board.

4. JOINT STRATEGIC NEEDS ASSESSMENT FOR SHEFFIELD 2013

The Board considered a report of the Director of Public Health, which presented the final version of the Joint Strategic Needs Assessment (JSNA) for Sheffield. The Board were asked to identify any corrections or amendments prior to the publication of the JSNA on the Council website. The JSNA provided an evidence base for the City's Joint Health and Wellbeing Strategy.

James Henderson, Director of Policy, Performance and Communications, gave a presentation concerning the JSNA and which summarised the main points in the document and the priorities which it identified.

Members of the Board discussed a number of issues relating to the JSNA.

- The Board thanked the team who had worked on producing the JSNA, which was a straightforward and honest document that presented a picture of the main needs in the City and focussed on the problems.

- It should be recognised that people were living longer and many older people were living healthy and independent lives, a fact which should be celebrated.

- However, there were also areas of concern, including the effects of rising youth unemployment. A strategy concerning mental health and low level mental health problems was near completion. It was thought that people in employment were less likely to suffer from poor mental health.

- Paragraph 2.13 of the JSNA indicated that Sheffield had a comparatively high number of people with learning disabilities and greater understanding was needed as to the explanation, whether it be more effective detection and recording of cases in the City or that the number of people with a learning disability is actually comparatively higher.

- Infant mortality was a continuing problem, although there was a strategy in place and a stakeholder event was due to take place in July. The level of infant mortality in Asian groups was also highlighted and work would need to done with the communities affected. Reference was made to drawing parents' attention to the issue of infant mortality and to the fact that things could be done to reduce it. A campaign in New Zealand, to use a specially designed cot, which could be placed in a parent's bed, had been found to reduce the incidence of child deaths connected with parents sleeping with a young child.

- Whilst Sheffield had a low number of looked after children compared to other Core Cities, these were children with the most complex needs and challenging behaviours and there was a need to support them. The Government had decided that any young person who is on remand would become a looked after child in the care of the local authority. The number of looked after children was therefore likely to increase and there was also concern that young people in care may become stigmatised as a result of this change.

- Whilst attainment in Sheffield had improved in two Key Stages, it was an issue which still needed attention and outcomes for every young person should be improved by raising both attainment and expectations through great schools and healthy and safe families.

- There were many areas upon which Healthwatch Sheffield and the partners on the Board might work together, utilising Healthwatch to develop the JSNA document and influence outcomes and involving communities including Lesbian, Gay, Bisexual and Transgender (LGBT) and Black and Minority Ethnic (BME) groups. Healthwatch Sheffield could

help with engagement and the communication of messages to the public and concerning decisions affecting them. Particular issues included mental health and wellbeing.

- Investment had been made in speech and language therapy services and it was hoped that this would have a positive effect on children with speech, language and communication needs.

- It was confirmed that the JSNA had previously been considered when the Board was meeting in shadow form and some of the issues contained within the JSNA were the already the subject of attention.

- How the Board and other stakeholders responded to the JSNA was an important matter, with the relevant strategy and initiatives being linked to other evidence, including the State of Sheffield report. It was suggested that the JSNA was published in July, once it was signed-off by the Board.

- In the NHS, the effects of demographic change and increasing demand, together with the efficiency challenge meant that it felt as though budgets were being reduced, despite the fact that the NHS budget had not been reduced. It was important not to lose sight of ambitions for the City.

- Health, social care and community services should be as integrated as possible to make sure every available pound was spent and used so as to ensure real outcomes for people.

- There was already a considerable amount of evidence relating to user experience, be it through GPs, providers or the third sector. There was an issue of how this evidence might be aggregated

- It was suggested that the order of the executive summary of the JSNA be changed to reflect what were considered to be the more important points.

4.1 RESOLVED: that the Health and Wellbeing Board:

1. agrees the final version of the JSNA for Sheffield (2013) subject to any final corrections or minor amendments being approved by the Co-chairs of the Board.
2. requests an update on the JSNA forward work plan to be submitted to a future meeting of the Board.

4.2 **REASONS FOR THE RECOMMENDATIONS**

The production, publication and maintenance of a JSNA complies with the requirements of the Health and Social Care Act (2012).

5. SHEFFIELD HEALTH AND WELLBEING BOARD RESPONSE TO THE FAIRNESS COMMISSION

Joe Fowler, Director of Commissioning, Sheffield City Council, introduced a

report of the Leader of Sheffield City Council and Co-Chair of the Health and Wellbeing Board, concerning the Board's response to the City's Fairness Commission. The report of the Fairness Commission was published in January 2013 and it included a framework of principles and a range of recommendations, four of which were specifically directed to the Health and Wellbeing Board. The report now submitted recommended ways in which the Board could support the work of the Fairness Commission.

Members of the Board discussed the report as summarised below:

- The response of Sheffield City Council to the recommendations of the Fairness Commission would be considered by Cabinet at its meeting on 17 July 2013.

- The work outlined in paragraph 4.1 of the report concerning more fairly utilising health spending and the initial analysis of the equity of health spending would be resourced in 2013/14. It was noted that this was a complex issue. The NHS was largely demand-led and it was difficult to ensure equitable spend. Analysis as to the equity of health spending should therefore be undertaken as far as possible.

- There was a correlation between a successful outcome for cancer patients and ensuring that people presented to their doctor as soon as possible and therefore received treatment in time.

- There were a large number of organisations, other than the CCG and the Council, which would contribute to fairness in relation to health in Sheffield. Members of the Board were asked to address issues raised in the Fairness Commission's recommendations both as part of the Board and in other places.

- In addressing the wider determinants of health, the Commission recognised, through its recommendations, a need to improve access to services for people who under-use them, through education and awareness and to build people's confidence to access services.

- The Board wished to examine health inequalities and their scale; explore the reasons why health inequalities exist; and undertake a policy discussion concerning what can be done about health inequalities.

- The analysis of the equity of health spend in the City, which was an action detailed at paragraph 3.3 of the report now submitted, should be carried out as far as possible. The Board should then oversee the fair utilisation of spend, which also achieved the best outcomes.

5.1 RESOLVED: that the Health and Wellbeing Board:

1. Endorses in full the Fairness Commission principles and that Health and Wellbeing Board members commit, if they have not done so already, as part of their respective organisations, to supporting and promoting

fairness across Sheffield.
2. Supports the actions detailed in section 3.3 of the report, which pertain to specific Fairness Commission recommendations for the Health and Wellbeing Board.
3. Supports the actions detailed in section 3.4 of the report, which suggest ways the Health and Wellbeing Board can support recommendations not directly aimed at the Board.
4. Undertakes to discuss further the respective responses of Sheffield City Council and NHS Sheffield Clinical Commissioning Group.

5.2 **REASONS FOR THE DECISION**

1. The Fairness Commission is an important city-wide commission that received a vast range of information about fairness across the City. Both NHS Sheffield Clinical Commissioning Group and Sheffield City Council have signed up to the principles of the Fairness Commission, and it is important that the Health and Wellbeing Board, as a system leader for health and wellbeing in Sheffield, supports the principles and recommendations of the Commission.
2. Four of the recommendations in the Fairness Commission's report are directed specifically at the Health and Wellbeing Board. It is important, therefore, that the Board provides a public response to the recommendations and works to bring about fairness across Sheffield.

6. QUALITY IN THE NEW HEALTH SYSTEM - A REVIEW OF RECOMMENDATIONS FROM RECENT NATIONAL REVIEWS AND THE IMPLICATIONS FOR SHEFFIELD CLINICAL COMMISSIONING GROUP

Tim Furness, Director of Business Planning and Partnership, Sheffield Clinical Commissioning Group, introduced a report concerning quality in the new health system. The report provided an update from the Clinical Commissioning Group of March 2013 relating to the second inquiry by Robert Francis concerning the Mid Staffordshire Hospital review.

The report included a review of recommendations and implications for commissioners and actions for the CCG. It also set out the implications, for the CCG, of the Government response. The report also outlined the National Nursing Strategy *Compassion in Practice* implementation plan and local actions from the Care Quality Commission (CQC) Winterbourne View recommendations. The CCG would develop an action plan, following the Government's final response in September 2013.

The report had also been presented to the CCG governing body and was submitted to the Health and Wellbeing Board for information.

The Board discussed issues arising from the report, as summarised below:

- The reports had implications for the NHS and providers and strengthened providers' duty in relation to quality.

- The Francis report included the themes of openness, transparency and accountability in relation to public bodies.

- Children and young people and developing management and leadership were two cross cutting themes emerging from the action plan. The experience of transition from child to adult services was problematic and more continuous services should be developed, with children and young people included on related working groups. This issue could be brought to the Board for the purpose of establishing how best to co-ordinate transition.

- In reference to the review of Winterbourne View, it was important that carers were able to have confidence in others to provide care when they themselves could not and shared values were needed, which would underpin this approach. The Safeguarding Board had considered the report concerning Winterbourne View and a joint response was due to be submitted to the Health and Wellbeing Board in September 2013.

- The reviews highlighted that people were identifying problems with care and there was a need for the health services and the local authority to make sure such voices were heard and that difficulties were not ignored in the early stages.

- Healthwatch Sheffield had a role in ensuring that issues of concern were identified before they begin to escalate further, using, for example, enter and view, focus groups and volunteers.

- There was a role for the Health and Wellbeing Board in making sure organisations are not duplicating effort or wasting resources in response to the reviews and with a view to streamlining.

- There was a need to co-ordinate joint work on quality, between the CCG and both adults and children's care.

6.1 RESOLVED: that the Health and Wellbeing Board, having considered the recommendations of all four reports:

1. Notes the current actions for commissioners to take forward the Francis (2) recommendations and the current position.
2. Supports the development of a Commissioning for Quality

Strategy for Sheffield CCG.

3. Requests that reports be submitted to future meetings of the Board upon the following:-

   (i) the response to the CQC Winterbourne View recommendations (September 2013); and
   (ii) the Commissioning for Quality Strategy for Sheffield CCG (December 2013).

6.2 **REASONS FOR THE DECISION**

To ensure that the Clinical Commissioning Group (CCG) is commissioning and implementing national recommendations in relation to safe and effective health care.

7. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the Health and Wellbeing Board held on 25 April 2013 were approved as a correct record, subject to the addition of the title “Dr”, in reference to Jeremy Wight, in the record of those present.

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